Accessibility of Primary Care Services in Safety Net Clinics in New York City

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Objectives. This study analyzed data from a survey of New York City ambulatory care facilities to determine primary care accessibility for low-income patients, as evidenced by the availability of enabling services, after-hours coverage, and policies for serving the uninsured.

Methods. Ambulatory care facilities were surveyed in 1997, and analysis was performed on a set of measures related to access to care. Only sites that provided comprehensive primary care services were included in the analysis. For comparison, sites were classified by sponsorship (public, nonprofit voluntary hospital, federally qualified health center, non-hospital-sponsored community health center).

Results. Publicly sponsored sites and federally qualified health center sites showed the strongest performance across nearly all the measures of accessibility that were examined.

Conclusions. As safety net clinics confront the financial strain of implementing mandatory Medicaid managed care while also dealing with declining Medicaid caseloads and increasing numbers of uninsured, their ability to sustain the policies and services that support primary care accessibility may be threatened. (*Am J Public Health.* 2001;91:1240–1245)

The health care delivery system's structure and organization are critical factors in making health care accessible to low-income individuals.[1] Ambulatory care sites can be organized in ways that make access more convenient by making services available at night, on weekends, and in emergencies. The services offered can be structured to help overcome barriers to access by including foreign language interpretation, outreach, transportation, and other support services. Sites' characteristics may also affect where the uninsured will seek care; sliding fee scales and the range of assistance offered can affect a site's attractiveness to those without coverage.

When they adopt managed care approaches, many state Medicaid programs articulate a goal of increasing access to care. In New York State, managed care plans contracting with the Medicaid program must demonstrate that their physicians are geographically accessible to beneficiaries, and plans must meet standards for service accessibility after regular business hours. While these contracts do not require that providers offer evening or weekend appointments, state grants have provided funds to facilities seeking to increase capacity in this way.[2]

At the same time, states are also using managed care as a vehicle for becoming more prudent purchasers of health care services. By law, managed care payments cannot exceed fee-for-service payments for a comparable population, and most states set managed care premiums as a percentage below their expected fee-for-service expenditures. These premiums often translate into reduced payments for health centers and hospital-sponsored ambulatory care clinics, facilities that traditionally provide a substantial share of primary care for Medicaid-covered as well as for uninsured individuals.[3]

In New York State, recent trends in health insurance coverage pose significant challenges for safety net providers. First, New York, like many other states, is experiencing a steep decline in Medicaid enrollment.[4,5] At the same time, private coverage has also declined in New York, particularly for low-wage workers. One in 5 New Yorkers was uninsured in 1997, an increase of 46% since 1990. The increase among the working poor was substantial (K. E. Thorpe, PhD, Emory University, unpublished data, October 1998).

These trends are creating a paradox for safety net facilities. Reduced revenues from managed care plans and declining Medicaid caseloads are generating new financial pressures, making it more difficult to support the services that may be critical for enhancing access. For facilities delivering primary care in New York City, this financial imperative is very real, as more than 1 million Medicaid beneficiaries will be required to enroll in managed care over the next several years.

Facilities can be expected to shape their response to financial pressure in various ways, reflecting differences in core mission with regard to serving low-income and uninsured patients. Facilities sponsored by public agencies and those qualifying for federal grants to subsidize services for the uninsured have a particular mission to maintain an open-door policy, serving all requiring assistance, regardless of ability to pay. In addition, facilities sponsored by hospitals, which rely on revenue from inpatient services, may behave differently than community-based facilities. In this report, we present findings related to access policies from the New York City Ambulatory Care Provider Survey administered by the United Hospital Fund and New York University. After describing the survey and our method of analysis, we present survey results describing the facilities that responded and their access characteristics: availability and staffing of enabling services, hours of availability for primary care services, and policies regarding services to the uninsured. We analyze facilities by using 4 categories of sponsorship: the Health and Hospitals Corporation (HHC; New York City's public hospital and health center system), voluntary hospitals, federally qualified health centers (FQHCs), and other freestanding health centers. We conclude with observations about the differences between types of sites and the implications for access as financial pressures increase.

METHODS

Samples and Survey Methods

Between December 1997 and February 1998, we mailed surveys to ambulatory care sites in New York City that are sponsored by hospitals, community health centers, or public

agencies. These sites typically serve low-income populations. Private physicians' offices and specialized clinics were not included in the survey, and clinics that provided only a narrow range of services (e.g., immunizations) were excluded from the analysis we conducted for this study. Only sites that provide comprehensive primary care services are included here.

To create a sampling frame of eligible ambulatory care sites, we contacted all hospitals and community health centers licensed by the State of New York that were likely to operate sites in New York City (i.e., city and suburban facilities). We attempted to collect data from all eligible sites. Extensive follow-up was conducted, including mailing reminder postcards 2 to 3 weeks after the initial questionnaire was mailed, followed by regular telephone follow-up and remailing questionnaires when needed. Data were collected by telephone for selected missing items.

Measures

Questionnaires included a broad range of items about institutional policies and practices, patient population, and visit volume. Questions about visit volume referred to the institutional fiscal year just before the survey, and questions about specific policies or practices referred to the first day of the facility fiscal year. One battery of questions asked about uninsured patient registration policies (whether uninsured were accepted, sliding fee schedules, fee collection policies).

Sites were also asked whether they provided selected "enabling" services (foreign language interpretation, Medicaid eligibility planning, case management, transportation assistance, outreach services, and child care services) and, if so, whether the services were formally staffed or provided informally, without dedicated staffing. Questions were included about the degree to which sites had managed care contracts and served managed care patients, and a battery of questions addressed practices that are typically preferred or required by managed care organizations (e.g., physician admission privileges and board certification status, automated data systems, evening and weekend hours, after-hours physician coverage). Questions to characterize each site's patient population focused on the percentage of patients who did not speak English and the range of preferred languages. In addition, visit volume by payer and managed care enrollment were used to characterize each site's patient mix.

Analysis

The unit of analysis used is the site (i.e., location) where primary care is delivered. The site was selected for analysis, rather than the sponsoring institution, because each site represents a point of access for the community. Sites were classified by whether they were sponsored by the New York City HHC, a nonprofit voluntary hospital, an FQHC (whether or not they received federal Section 330 grants), or other non-hospital-sponsored freestanding community health centers. Virtually all of the sites in the survey were sponsored by public or nonprofit corporations, except for 3 community health center–sponsored sites. In most cases, χ^2 tests were performed to determine whether categorical measures varied significantly by sponsorship categories. In instances where there were expected to be 1 or more groups of 5 or fewer sites, Fisher exact tests were used. Tests for variations among sponsorship categories in continuous measures were conducted by applying analysis of variance.

RESULTS

Survey Sample and Response Rate

In 1997, 226 sites were eligible for the survey, to which 79.2% responded. Sites sponsored by FQHCs had the lowest response rate (75.0%). Some sites failed to complete some of the questionnaire items; thus, item-specific n values are shown in each of the tables.

Payer Mix, Managed Care, and Patient Languages

The distribution of visits by payer confirms the safety net role of institutional ambulatory care providers in New York City, especially at publicly sponsored sites (Table 1). On average, HHC sites reported that nearly a third of visits were by uninsured patients, compared with just under 17% reported by FQHCs and other freestanding sites. Voluntary hospital sites reported serving the lowest proportion (about 10% of their visit volume) of uninsured. Medicaid played a dominant role at all types of sites, representing over two thirds of visit volume, except at HHC sites, which reported that fewer than half of its visits were made by Medicaid patients. Medicare and privately insured patients represented relatively small shares of visits at all types of sites. In addition to their significant role in serving the uninsured, HHC sites also stand out because they are typically much larger than other sites.

Fewer than 20% of patients across the sites were enrolled in managed care (Table 1). Nevertheless, the great majority of sites (78.2%) enrolled at least some Medicaid managed care patients, ranging from 95.8% of HHC sites to 52.4% of other freestanding health centers ($P = .001$). Many fewer sites reported enrolling patients from non-Medicaid managed care plans. In addition to serving a predominantly low-income population, the sites surveyed reported serving a diverse population, as measured by languages spoken (Table 1). All groups of sites reported that about one third of patients did not speak English, and 10% of sites reported that at least 4 different non-English languages were spoken by their patients.

Availability of Enabling Services

Ambulatory care facilities provide a range of services designed to address some of the problems that may limit a low-income person's ability to seek medical care and successfully complete a course of treatment. Among clinics where many different languages are spoken, patient–provider communication poses a challenge. Most of the sites reported offering interpretation assistance for non-English-speaking patients, but sites varied widely in how they provided this service (Table 1). Nearly 45% reported employing physicians or other trained medical staff who spoke a language other than English as their "most common" means of interpretation, while more than one quarter relied on other staff at the site. Nearly 30% reported that they relied on patients' family members to translate or used no method at all. Most sites (91.1%) reported that they used family members for medical interpretation at least "some of the time," and 41.1% sometimes used telephone translation services.

TABLE 1—Payer Mix, Visit Volume, Managed Care Enrollment, Patient Languages, and Indicators of Service Availability in Ambulatory Care Facilities in New York City, 1997

		Site Sponsorship				
	Total	HHC[a]	Voluntary Hospital	FQHC[b]	Other	*P*
Payer, % of visits						
Self-pay	14.8	30.4	10.4	16.9	16.8	<.001
Medicaid[c]	62.9	41.4	65.1	70.0	64.5	.002
Medicare[c]	11.2	8.3	14.9	6.6	5.7	.060
Private insurance[c]	10.9	19.9	9.5	6.5	13.0	.082
(n)	(114)	(13)	(63)	(16)	(22)	
Visits per year, mean	67 966	186 866	47 742	44 175	13 059	<.001
(n)	(128)	(25)	(63)	(16)	(24)	
Managed care enrollment, % of patients[d]	14.2	9.2	14.0	18.1	14.6	.662
(n)	(92)	(13)	(42)	(17)	(20)	
Non–English speaking, % of patients	37.1	37.3	39.1	34.3	31.0	.518
(n)	(171)	(26)	(101)	(18)	(26)	
Most common method of language interpretation, % of sites[e]						
Physicians or trained staff	43.4	41.7	44.3	50.0	37.5	.561
Other staff	27.0	16.7	26.1	25.0	41.7	
Family members or none	29.6	41.7	29.5	25.0	26.8	
(n)	(152)	(24)	(88)	(16)	(24)	
Evening or weekend hours, % of sites						
Pediatrics	65.4	96.3	63.2	87.5	26.9	<.001
Adult medicine	68.6	96.3	64.8	88.2	37.5	<.001
Obstetrics/gynecology	53.1	88.5	37.0	75.0	54.5	<.001
(n)	(145)	(26)	(81)	(16)	(22)	
Physician after-hours backup, % of sites						
Pediatrics	54.8	70.4	50.0	64.7	42.9	.176
Adult medicine	47.8	70.4	42.1	61.1	38.5	.028
Obstetrics/gynecology	50.6	74.1	41.1	61.1	57.7	.011
(n)	(146)	(27)	(88)	(17)	(14)	

Note. Data are from the New York City Ambulatory Care Provider Survey (1997) administered by the United Hospital Fund and New York University. All n values exclude cases with missing data.
[a]New York City Health and Hospitals Corporation.
[b]Federally qualified health centers (FQHCs) include both those receiving federal funds and those not receiving federal funds but certified as meeting the same standards.
[c]Includes both fee-for-services and managed care.
[d]All payers.
[e]*P* values are based on Fisher exact tests.

Of the sites providing information on their interpretation services, 57% indicated that more than one quarter of their patients did not speak English. While these sites tended to place slightly greater reliance on specially trained medical staff or other on-site staff for interpretation, many patients were commonly left to make arrangements on their own ($P = .057$). Sites may well have improved their interpretation services since the time of our survey in response to actions undertaken by the federal Office of Civil Rights to raise providers' awareness of their obligations to non-English-speaking patients.

Table 2 shows significant differences across types of sites regarding enabling services—community outreach, Medicaid eligibility planning, case management for supportive services to address nonmedical needs, clinical case management, transportation to and from medical appointments, and child care during clinic visits. Sites were asked to report whether services were offered and how they were staffed: formally or on an informal basis without dedicated staffing. Nearly 85% of sites reported undertaking some kind of outreach activity; three quarters targeted patients needing prenatal care. Outreach was nearly universal among FQHC and HHC sites. While many sites sponsored by the HHC and by voluntary hospitals staffed the function informally, most FQHC sites reported outreach as a formal element of someone's job.

Along with outreach services, most sites offered Medicaid eligibility planning in 1997, and just over half had staff dedicated to this function. HHC and FQHC sites were more likely to employ staff to provide eligibility assistance. Demand for these services may well be greater at these sites since, as noted earlier, a larger share of their patients are uninsured.

All FQHC sites and nearly all of the other non-hospital-sponsored sites offered support services case management, and most made this assistance available through staff formally assigned to the task. Though many sites sponsored by HHC and voluntary hospitals offered support services case management, they were more likely than freestanding health centers to rely on informal arrangements. While 80% of all sites reported clinical case management services, over half staffed these services informally.

Transportation assistance was also offered by a large majority of the sites. Unlike other enabling services, transportation can be reimbursed as a discrete service for Medicaid, either through reimbursement of the cost of transportation to the Medicaid patient or through reimbursement to the health care facility for the cost of providing transportation. At sites affiliated with voluntary hospitals, transportation, along with Medicaid eligibility planning, is the enabling service most likely to have a formally assigned staff person. Also, over 60% of HHC sites reported having staff dedicated to this function, second only to the share of HHC sites reporting Medicaid eligibility planning staff.

While nearly one third of sites reported making child care available, most of this care was offered on an informal basis. HHC sites

TABLE 2—Enabling Services Offered by Ambulatory Care Providers in New York City, 1997

	Total		Site Sponsorship								
			HHC[a]		Voluntary Hospital		FQHC[b]		Other		
	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	Formal	Informal	*P*[c]
Medicaid eligibility planning, %	50.3	31.0	74.1	14.8	45.5	35.6	76.5	17.6	26.9	38.5	.005
Support services case management, %	50.3	30.8	51.9	33.3	38.6	35.6	76.5	23.5	79.2	12.5	.002
Transportation, %	48.9	31.0	60.7	28.6	56.3	25.2	23.5	76.5	23.1	26.9	<.001
General outreach, %	46.8	37.4	51.9	40.7	39.2	43.1	88.2	11.8	44.0	28.0	.005
Prenatal outreach, %	37.4	38.6	39.3	57.1	34.7	37.6	52.9	35.3	36.0	24.0	.016
Clinical case management, %	34.5	45.6	33.3	63.0	28.4	44.1	47.1	47.1	52.0	32.0	.016
Child care, %	10.5	20.5	22.2	7.4	7.9	16.8	0.0	29.4	15.4	42.3	.003
(n)	(174)		(28)		(103)		(17)		(26)		

Note. Data are from the New York City Ambulatory Care Provider Survey (1997) administered by the United Hospital Fund and New York University.
[a]New York City Health and Hospitals Corporation.
[b]Federally qualified health centers (FQHCs) include both those receiving federal funds and those not receiving federal funds but certified as meeting the same standards.
[c]*P* values are based on Fisher exact tests.

were an important exception, with child care a formal job responsibility at most sites where child care was offered. Freestanding health centers that did not qualify for federal indigent care grants were more likely than other types of sites to make child care available, but in most cases they were offering it informally.

Availability of Primary Care Services

The survey looked at evening and weekend clinic hours and physician availability by telephone after hours as measures of the availability of primary care services (Table 1). More than half of the facilities offered at least 1 clinic session during evenings or weekends in pediatrics, adult medicine, and obstetrics/gynecology. On average, the sites reported almost 2 evening or weekend pediatric and adult medicine sessions each week, but they reported closer to 1 obstetrics/gynecology evening or weekend session per week. HHC and FQHC sites reported the greatest availability during evenings and weekends, whereas other freestanding sites reported the least accessibility during those times.

About half of all sites reported that a physician was available after hours by telephone, but coverage varied a great deal by facility sponsorship. About 70% of HHC sites and slightly more than 60% of FQHC sites reported that physicians were available by telephone after hours, but for most services, fewer than 50% of voluntary hospital sites and non-FQHC sites reported that physician backup was available.

Access for the Uninsured

Patient fees represent perhaps the greatest potential barrier to access for the uninsured. Table 3 shows 5 measures reflecting clinic policies and practices toward uninsured patients. All of the HHC and FQHC sites reported being willing to see any uninsured patient and offering sliding fee discounts for primary care visits. In contrast, while only a few of the other sites formally limited the number of uninsured patients seen in some way, 1 in 5 voluntary hospital and non-FQHC clinic sites reported not offering discounts. Discounts for prescription drugs were far less common than for primary care visits. Overall, less than a quarter of sites reported offering sliding fee discounts for prescription drugs, although the percentage offering discounts on "all or most drugs" varied from over half of HHC and FQHC sites to only 6.3% of voluntary hospital sites.

Among sites offering discounts for primary care visits, the average patient portion of the fee varied among the provider sponsorship groups. HHC, FQHC, and other freestanding clinic sites reported charging $22 to $24 per visit for patients at the federal poverty level, but fees for poverty-level patients at voluntary hospital sites were reportedly about one third higher. Reported patient fee levels at 150% and 200% of the federal poverty level did not differ significantly among sponsorship groups.

Variation in patient fee policies may mask important differences in actual collection practices. Requiring patients to pay before a provider will see them can discourage low-income patients from seeking services. Indeed, collection practices reported among sites varied a great deal by sponsorship. Fewer than 40% of HHC sites reported requiring patients to pay all or part of the fee before the medical visits, whereas the majority of each of the other sponsorship categories required up-front payment. Surprisingly, nearly 90% of FQHC sites required up-front payment.

The willingness to subsidize services not offered on site is another indicator of the degree to which care is made affordable by ambulatory care providers, particularly for patients with more complex medical needs. Overall, nearly half of the sites subsidized 1 or more of these services either at an affiliated site or at an unaffiliated facility. Not surprisingly, sites affiliated with hospitals—HHC or voluntary—were more likely to report subsidies for off-site services (although this relationship was not statistically significant for specialty care).

Unlike patients in traditional fee-for-service arrangements, managed care patients are effectively "uninsured" when they seek out-of-

TABLE 3—Uninsured Patient Registration Policies and Practices of Ambulatory Care Facilities in New York City, 1997

		Site Sponsorship				
	Total	HHC[a]	Voluntary Hospital	FQHC[b]	Other	*P*
Limits registration of uninsured patients, % of sites[c]	5.6	0.0	8.3	0.0	3.8	.308
(n)	(180)	(28)	(108)	(18)	(26)	
Offers sliding fee schedule, % of sites						
Primary care[c]	86.5	100.0	82.1	100.0	80.8	.009
Pharmacy[d]	22.7	53.8	6.3	44.4	37.5	<.001
(n)	(163)	(26)	(95)	(18)	(24)	
Mean primary care patient fees among sites with sliding fee schedules, $						
100% of FPL	28	22	32	24	24	.002
150% of FPL	51	45	54	47	47	.263
200% of FPL	81	97	79	87	67	.092
(n)	(134)	(19)	(77)	(18)	(20)	
Patient fees collected before visit all or most of time, % of sites	61.9	39.3	60.9	88.2	73.9	.006
(n)	(160)	(28)	(92)	(17)	(23)	
Subsidizes services at affiliated or other institutions, % of sites						
Specialty care	43.5	48.0	49.0	29.4	26.9	.126
Radiology	48.8	56.0	55.3	41.2	20.0	.012
Laboratory	48.5	66.7	53.0	41.2	16.7	.003
(n)	(165)	(24)	(100)	(17)	(24)	
Turns away all or most Medicaid managed care patients seeking out-of-network care, % of sites	18.2	7.1	18.1	33.3	20.0	.018
(n)	(176)	(28)	(105)	(18)	(25)	

Note. Data are from the New York City Ambulatory Care Provider Survey (1997) administered by the United Hospital Fund and New York University. FPL = federal poverty level. All n values exclude cases with missing data.
[a]New York City Health and Hospitals Corporation.
[b]Federally qualified health centers (FQHCs) include both those receiving federal funds and those not receiving federal funds but certified as meeting the same standards.
[c]*P* values are based on Fisher exact tests.
[d]Discounts offered on "all or most drugs" compared with "some or more."

network services without authorization. During the implementation of mandatory Medicaid managed care, out-of-network exposure of Medicaid patients is particularly important, as it is expected that many patients will be assigned to managed care plans and primary care providers, rather than voluntarily selecting them. Auto-assignment rates for New York's urban counties that began mandatory enrollment ahead of New York City have exceeded 1 in 5 recipients (Office of Managed Care, New York State Department of Health, unpublished data, July 1998). Overall, almost 20% of the sites reported that they turned away Medicaid managed care patients seeking out-of-network care "always or most of the time" (Table 3). HHC sites were least likely to report a policy of routinely turning away patients signed up with other plans, while FQHC sites stood out as most likely to reject such patients.

DISCUSSION

Findings from the New York City Ambulatory Care Provider Survey describe an extensive array of practices geared toward promoting access to primary care for low-income patients. However, in many clinics, accessibility for the uninsured may be limited in important ways. In many cases, the contingent nature of access-enabling services may mean that services are not always available when needed. Many sites do not make enabling services a formal part of a staff member's job, raising questions about how well and consistently these services are provided. For instance, an average of more than 1 in 3 patients at the surveyed sites did not speak English, yet fewer than half of the sites employed physicians or trained medical interpreters as the predominant means of communicating with non-English-speaking patients. Relying on untrained staff or family members for interpretation can lead to poor communication that compromises the quality of patient education and confidentiality. Traditionally, Medicaid or other payers do not directly reimburse enabling services. Under managed care, clinics may be freer to allocate resources to nonmedical enabling services, but such freedom is illusory with capitation payments typically well below fee-for-service reimbursements.

Our analysis also reveals considerable variability in the accessibility of services among clinics operating under different auspices. Sites sponsored by HHC provide the greatest access for the uninsured by nearly any measure. It is thus not surprising that HHC sites provide twice the proportion of self-pay visits as other sites.

Like HHC sites, sites sponsored by FQHCs show strong performance across nearly all of the measures of accessibility that we examined. But unlike the one-third share of visits at HHC sites, only about 1 in 6 visits at FQHC sites were by uninsured patients. Although FQHC sites provide a rich array of enabling services and offer considerable discounts to the uninsured, our data suggest that they make more efforts than the public clinics to "manage" their self-pay exposure by requiring up-front payment or turning away managed care patients seeking out-of-network care.

Clinic sites sponsored by voluntary hospitals are the most numerous facilities that serve as points of access to primary care for poor New Yorkers. However, these sites are among those least likely to invest in enabling services, provide access to physicians after

hours, or have evening or weekend sessions. They also offer smaller discounts to the lowest-income uninsured and are much less likely to offer prescriptions on a sliding fee basis. Consequently, the share of visits at these clinics made by uninsured patients is the lowest among the clinics we studied. Perhaps these facilities do not share as deep a sense of mission to serve the uninsured as public or FQHC sites, or perhaps their inpatient focus has meant that they have not emphasized primary care access. Nevertheless, the large number of such clinics means that these sites play an important role in serving low-income neighborhoods.

Like voluntary hospital clinics, freestanding facilities without FQHC designation provide a less rich mix of access-enhancing services than other sites. Nevertheless, the share of visits made by the uninsured at these sites is as large as at FQHC sites. This suggests that these sites are important sources of access for the uninsured, but that they may not have resources to provide extensive enabling services or to absorb the cost of serving large numbers of nonpaying patients.

The variation we found among the range of enabling services raises questions for further research. We do not know how patient characteristics differ across sites, whether enabling services affect patients' decisions about where to seek care, or whether those who face greater barriers to care seek out sites with resources to help them.

Our study did not address whether the services provided to the uninsured by primary care facilities in New York are sufficient to meet the demands for care or whether the enabling services are adequate given community need. Other studies have shown that, even with the extensive clinic infrastructure, serious access barriers persist for low-income New Yorkers. Certainly, high rates of avoidable hospitalizations and a persistent gap in use rates of ambulatory care among the uninsured suggest that there are significant unmet needs (D. DeLia, J. C. Cantor, E. Wojas, unpublished data, December 1998).[6]

The future ability of primary care facilities in New York to improve or even to sustain levels of service to the uninsured is in serious doubt. Demand for uncompensated or discounted care appears to be rising in New York as the number of uninsured has grown, putting added pressure on clinics.[7] At the same time, financial pressures on primary care providers are also rising. Mandatory Medicaid managed care, which is being phased in over the next several years in New York City, is likely to lead to lower reimbursements to clinics than they enjoyed under Medicaid fee-for-service. Also, subsidies from state and federal sources to support institutions serving a disproportionate share of low-income patients have been flat or declining in recent years. And the public hospital system, which carries an extraordinary burden of ambulatory care for the uninsured, has experienced a significant decline in paying patients, making cross-subsidizing nonpaying patients even more difficult. In this context, it is vital to closely monitor indicators of access to care among the uninsured as well as the level of service available through the safety net facilities. ■

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Contributors

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