



## Ascension Health Advocacy Environmental Assessment

### Health Status and Needs of the Poor: **Policy Update**

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## Introduction

This analysis, prepared for Ascension Health, updates an advocacy environmental assessment prepared in 1999 for the Daughters of Charity National Health System by the George Washington University Center for Health Services Research and Policy (CHSRP). In that assessment, researchers reported on the factors that influence health and access to health care, including poverty, insurance coverage, and community, environmental and behavioral risk factors. This Policy Update analyzes recent trends in the areas of family income and poverty status, health insurance coverage, and health care access and considers their implications for long term health advocacy on behalf of low income, medically underserved, and vulnerable populations.

The data presented in this analysis come from a variety of sources, including the U.S. Census Bureau, the National Center for Health Statistics of the CDC, and various federal agency data sources. In addition, special national statistical reports developed by the Henry J. Kaiser Family Foundation and related to women's health, the elderly poor, the uninsured, and immigrant health are also reviewed.

These data are as current as is possible in the case of large-scale statistical studies. At the same time, it is important to remember that in the year and a half since many of these statistics were collected, the U. S. economy has eroded significantly. Furthermore, the catastrophic events that recently have taken place can be expected to generate enormous health system needs -- not only among the survivors of the disaster and the families of the deceased, but also within entire communities affected by the disaster. No statistical data can capture these unfolding events in either a timely or complete fashion. As a result, the statistics presented in this Update if anything understate the magnitude of the challenge that confronts health care systems such as Ascension, that operate with service-related missions.

## Family Income and Poverty

CHSRP's earlier report underscored the powerful relationship between poverty and health status, health insurance coverage, and access to health care. Poverty remains a major issue in the U.S., particularly among children and minority Americans.

In 1999, 32.5 million persons, nearly 12 percent of all Americans, were poor. Although poverty rates fell significantly between 1994 and 1999, the 1999 figure was higher than comparable rates in the early 1970s, despite one of the strongest periods of sustained economic growth ever witnessed in the U.S. Although rates dropped for individuals of all ages, children remained the poorest Americans. In 1999, 16.9 percent of children were poor. Children were significantly poorer in 1999 than they were thirty years earlier in 1969, and 75% more likely than the elderly to be poor. **(Figure 1)** In addition to age, race and ethnicity remained strong predictors of poverty. In 1999, Black and Hispanic persons were three times more likely than white persons to be poor; although Black poverty

rates fell dramatically between 1959 and 1999, the Black/White poverty “gap” remained as great. **(Figure 2)** Hispanic poverty was higher in 1999 than in 1979.

Employment offers relatively limited protection against poverty for certain families. In 1999, 10.2 % of all families with at least one worker were poor, but the poverty rate jumped to 30.4% among families headed by a female householder who worked. **(Figure 3)** The increasing concentration of children in female-headed households over the past 40 years is a major factor underlying childhood poverty.

Poverty also varies significantly by state of residence. Over the 1997-1999 time period, a resident of New Mexico was three times more likely to be poor than one living in Maryland. **(Figure 4)**

Residence in a poor community, whatever the state, has a powerful effect on poverty status. Table 1 shows a 40% poverty rate among children who in 1999 lived in areas that were classified as poverty areas in 1989 (i.e., census tracts with a poverty rate of 20% or higher). Among children who in 1999 resided in any area of the nation in 1989, 17% were poor. Similarly, elderly persons who lived in areas designated as poverty areas in 1989 were twice as likely in 1999 to be poor.

**Table 1. Poverty Rate of Census Tract in 1989 and Poverty Status of Residents in 1999**

Persons	All Areas in 1989: Currently Below Poverty in 1999	Poverty Areas in 1989: Currently Below Poverty in 1999
Children under 18	16.9%	40%
Persons over 65	9.7%	19.0%

Source: U.S. Census Bureau (accessed Sept. 22, 2001)

Receipt of means-tested government assistance represents another way of thinking about poverty. Data from the Current Population Survey indicate that in 1999, 35 percent of all children lived in a household that received one or more forms of means tested benefits, a figure that declined to 26% when school lunch assistance was excluded, but that is considerably higher than the nominal poverty rate in 1999 of 16.9%. In the case of persons 65 and older, 16.5% lived in households in 1999 that received means tested benefits exclusive of school lunch assistance.<sup>1</sup> Estimates of individuals who received means tested benefits in 1999 (excluding school lunch assistance) rise to nearly three quarters of all children, and 43% of all persons over age 65, when only the poor are considered.<sup>2</sup>

<sup>1</sup> U.S. Census Bureau, Current Population Survey, Annual Demographic Survey (March Supplement) Table 3.

<sup>2</sup> Id.

## Health Insurance Coverage

In the U.S., access to health insurance among non-elderly persons depends on two principal factors: either access to employer-sponsored coverage or access to a source of public insurance in situations where no employer-coverage is available or the coverage that is available is unaffordable. In 2001, the average premium cost of family HMO coverage under employer-sponsored plans stood at \$6538, with 11% premium increases anticipated.<sup>3</sup>

Public sources of subsidized insurance are essential, because of the limitations of a voluntary employer-sponsored system, the absence of affordable coverage through the individual market, and the inadequacy of individual insurance, even when available, in the case of children and adults with serious and chronic health needs. Even when it is available, insurance coverage in the individual market, is prohibitively expensive: unlike employer-sponsored benefits, no tax subsidy is available to help purchasers in the individual market afford the cost of coverage.

In 1999, 42 million persons -- 18% of the non-elderly U.S. population -- were uninsured.<sup>4</sup> The large number and size of the uninsured non-elderly U.S. population is an unfortunate testament to the structural deficiencies in both the public and private health insurance systems for non-elderly persons. In 1999 42.1 million Americans had no health insurance, a slight decline from the previous several years but a rate nearly one-third higher than 1988 levels. **(Figure 5)**. Underlying these figures was an employment based system that despite an enormous surge in the economy, performed more poorly in 1999 from a health insurance point of view than it performed two decades before, as well as a declining system of public insurance coverage under Medicaid. Although the enactment of the State Children's Health Insurance Program (SCHIP) in 1997 reduced the number of uninsured children between 1998 and 1999 by a million, as of 1999, as of 1999, nearly 11 million children, and more than 30 million adults, were without coverage.<sup>5</sup>

Continuing historical trends, in the lack of insurance continues to be concentrated among children and adults in lower income working families. In 1999, over 80% of the uninsured were members of working families and 80% lived in families with incomes at or below 300% of the federal poverty level. **(Figure 6)**. Moreover, the absence of health insurance is not a short-term problem. In 2000, 60% of all adults without health insurance were uninsured for a period of 2 years or longer.<sup>6</sup>

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<sup>3</sup> Henry J. Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2001 Annual Survey (Menlo Park CA, 2001). Charts 4 and 5.

<sup>4</sup> Kaiser Commission on Medicaid and the Uninsured, the Uninsured: A Primer (Washington D.C. , 2001) p. 1.

<sup>5</sup> Id., p. 9.

<sup>6</sup> Id., p. 2.

The weaknesses of the employer-sponsored system stem from two basic problems. First, only about two in five low wage workers have access to any employer-sponsored benefits; 45% of all low wage workers are employed by firms that do not offer coverage at all. Conversely, 96% of all high wage workers have access to coverage. Second, another 13% of all low wage workers have access to coverage but decline it, primarily because of cost.<sup>7</sup> On average, in 1996 workers were responsible for 27% of their employer-sponsored family health insurance premium.<sup>8</sup> **(Figure 7)**. With the escalation in health insurance costs, this figure may rise still further.

Because Medicaid and SCHIP now make coverage possible for low income children, the uninsured are heavily skewed toward adults. In 1999 75% of uninsured persons were low income adults. Twenty two percent were low income adults with children. **(Figure 8)**. Poor adults with children represent an optional Medicaid coverage category, but as of 1999, 32 states failed to cover parents working full time for the minimum wage.<sup>9</sup> Because coverage of poor working parents is an option, the current economic setbacks represent a clear threat to the continuation of state policies, even as a recession leads to greater unemployment and loss of coverage.

Individuals who are not citizens are disproportionately likely to be without coverage. In 1999, over 50% of all non-citizens who were short term U.S. residents and more than 40% of non-citizens who were long-term U.S. residents (6+ years) were uninsured.<sup>10</sup> Eighteen percent of all uninsured persons were non-citizens, and two thirds of these (12% of the uninsured) were long-time U.S. residents. **(Figure 9)**.

In light of the limitations of the employer-sponsored health insurance system for poorer families and those with limited or no attachment to the workforce, it is almost impossible to overstate the importance of Medicaid. In 1999, Medicaid insured more than 10% of the non-elderly U.S. population, covering nearly 20% of all children, and nearly 11 percent of women of prime child-bearing age. **(Figure 10)**. The link between employment and coverage also means that in 1999, individuals in fair to poor health were more likely to be completely uninsured or dependent on Medicaid. Medicaid is a source of health insurance coverage for non-citizens and naturalized U.S. citizens, but at only about half the frequency as among the general population, despite their greater poverty. In 1999, 10.6% of non-elderly U.S. native citizens were covered by Medicaid; in comparison, coverage for naturalized citizens, short term U.S. residents, and long term U.S. residents stood at approximately half that level. **(Figure 11)**.

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<sup>7</sup> Id.

<sup>8</sup> Employer Health Benefits, op. cit.. Figure 3 in Summary Chart Pack.

<sup>9</sup> Center on Budget and Policy Priorities, Washington D.C. .As of 2000, the following states extended coverage to parents working for the minimum wage: Maine, Vermont, Massachusetts, Connecticut, Rhode Island, the District of Columbia, Oregon, California, Washington State, Hawaii, Nevada, Alaska, Ohio, Minnesota, North Dakota, Michigan, Iowa, and Missouri.

<sup>10</sup> Kaiser Commission on Medicaid and the Uninsured, Health Insurance Coverage in America: An Update (Washington D.C., 2001).

Although Medicare offers virtually universal coverage of the elderly (as well as coverage for severely disabled persons with an insured work history), coverage is seriously limited in certain ways, most notably in the absence of prescription drug coverage. In 1998 27% of all Medicare beneficiaries lacked any prescription drug coverage, and half of all uninsured beneficiaries had family incomes below 175% of the federal poverty level. **(Figures 12 and 13).** One third of all beneficiaries derived their coverage from employer-sponsored plans; a significant fact given the potential for serious erosion in employer-sponsored retiree benefits in the face of leaps in the cost of coverage.

## **Health Status and Access to Health Care**

### Health Status

Classic measures of health status, reviewed in CHSRP's earlier report, continue to reveal serious disparities based on income, race and ethnicity. Maternal mortality among Black women occurred at 4 times the frequency as for white women in 1998 (16.1 deaths per 100,000 live births compared to 4.2 deaths).<sup>11</sup> Among minority Americans, preliminary death rates for all causes among minority Americans outpaced rates among white non-minority Americans, as did years of productive life lost.<sup>12</sup>

### Access to and Utilization of Health Services

Poverty and a lack of health insurance is associated with reduced access to health care. In 2000, persons without health insurance were three times as likely to report skipping a recommended medical test or treatment, two and a half times as likely to report failing to fill a prescription, over 5 times as likely to report postponing needed medical care and more than 6 times as likely to report failing to receive care for a serious condition. **(Figure 14).**

Recent data from the National Health Interview Survey suggest declines in access to key health services. Between 1997 and 1999, even as the proportion of children reporting no usual source of health care declined nationally among all races and incomes,<sup>13</sup> the proportion of children under age 6 reporting *no* health care visits to an office or clinic within the past 12 months grew significantly. Reduced utilization affected young children of all races and economic backgrounds as Table 2 shows, with the strongest effects among the poorest children, as well as Black children. Among adults, uninsured persons, members

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<sup>11</sup> DHHS, Health United States 2001 (Table 44).

<sup>12</sup> Id., Tables 36 and 35

<sup>13</sup> Id., Table 76.

of racial minority groups, and the poor were significantly more likely in 1999 to lack a usual source of health care.<sup>14</sup>

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<sup>14</sup> Id., Table 78.  
Ascension Health Environmental Assessment Update  
September, 2001

**Table 2. No Health Care Visits to an Office of Clinic within the Past 12 Months Among Children Under 18 Years of Age According to Selected Characteristics**

Children	Under 18		Under 6	
	1997	1999	1997	1999
<b>All</b>	12.8	13.2	5.7	6.6
<b>White</b>	12.2	12.4	5.6	6.2
<b>Black</b>	13.8	14.7	5.2	7.7
<b>Hispanic</b>	19.5	20.6	10.5	10.0
<b>Poor</b>	17.6	19.2	7.3	12.1
<b>Near-poor</b>	16.9	17.3	7.4	8.2
<b>Not poor</b>	9.7	9.7	4.1	4.4
<b>White/Non-Hispanic, Poor</b>	14.3	13.4	5.7	*
<b>Black/Non-Hispanic/poor</b>	15.4	16.4	*	9.6
<b>Hispanic/poor</b>	23.5	26.2	11.5	17.2
<b>Insured</b>	10.2	**	4.4	**
<b>Insured/private</b>	10.4	**	4.4	**
<b>Insured/Medicaid</b>	9.3	**	4.5	**
<b>Uninsured</b>	29.2	**	14.7	**

Source: Health, U.S., 2001 (Table 75) (\* = statistically unreliable) (\*\* = data not yet available)

Dental care remained particularly problematic, with slight declines (from 72.7% to 72.6%) between 1997 and 1999 in the proportion of children ages 2-17 with no dental visit in the preceding 12 months.<sup>15</sup> Among the poorest children, serious declines in dental care occurred. In 1997 63.5% of all poor children ages 2-17 reported seeing a dentist in the preceding 12 months; by 1999, the proportion of children who reported seeing a dentist in the preceding 12 months had declined to 57.8%.<sup>16</sup> Among poor Hispanic children, in 1999, fewer than half (49.6%) reported seeing a dentist in the preceding 12 months, down from nearly 57% in 1997.<sup>17</sup>

### Medicaid and its Health Care Implications

Because Medicaid compensates for the limitations of private insurance, and because private insurance is closely tied to work status, persons enrolled in Medicaid are more likely to be in fair to poor health status than those who receive employer-sponsored coverage.<sup>18</sup> Two thirds of all persons who are unable to work and need assistance with

<sup>15</sup> Id., Table 80.

<sup>16</sup> Id., Table 80.

<sup>17</sup> Id.

<sup>18</sup> Dennis McCarty and Helen Levine, "Needs of People with Chronic and Disabling Conditions," Access to Health Care: Promises and Prospects for Low Income Americans (Lillie Blanton et. al., ed.) (Kaiser Family Foundation, Washington D.C., 1999).

self care have some form of public insurance.<sup>19</sup> As Table 2 suggests, Medicaid has an enormous impact on access to health care. At the same time, beneficiaries often face serious barriers to health services and are significantly more likely to use emergency departments for care.

The barriers faced by Medicaid beneficiaries become even more consequential when the health status of Medicaid beneficiaries is considered. Statistics on disabling conditions among Medicaid beneficiaries show extensive health problems, and a rate of significant health conditions that far surpasses the much smaller percentage of beneficiaries whose eligibility for Medicaid is based on disability status. In other words, the proportion of Medicaid beneficiaries whose coverage is related to their link to the Supplemental Security Income program (SSI) seriously understates the prevalence of disabling and activity limiting conditions among the Medicaid population. Indeed, among Medicaid-enrolled children with chronic or disabling conditions, only 15% entered Medicaid through an SSI-linked pathway; among adult beneficiaries with disabling and chronic conditions, only 52% have Medicaid coverage linked to SSI status. **(Figures 15 and 16)**. The most prevalent conditions among “special needs” Medicaid children and adults are pulmonary, psychiatric, nervous system, gastrointestinal and skeletal and corrective (in the case of children), and psychiatric, cardiovascular, skeletal and connective, pulmonary, nervous system, and gastrointestinal (in the case of adults).<sup>20</sup>

### Participation in Managed Care: Implications for Safety-Net Care and Uncompensated Care

Managed care arrangements have become the norm for both publicly and privately insured non-elderly Americans. In 2000, more than half of all Medicaid beneficiaries and the great majority of privately insured Americans were members of managed care plans. In the case of privately insured persons, managed care arrangements tend to be more loosely configured, with access to non-network providers permitted with higher cost-sharing. In the case of Medicaid however, managed care arrangements are strictly structured, with virtually no out-of-network coverage in the case of services covered under managed care contractual agreements. This means that out of network services and providers remain uncompensated, no matter how necessary, unless the state Medicaid agency continues to cover and pay for the services directly as a state plan benefit.

The growth of managed care among publicly insured patients has significant implications for safety net providers, as well as for access to other sources of uncompensated care. In its 2000 study, the Institute of Medicine identified the loss of revenues from the health system generally as a key factor in the overall decline in the availability of uncompensated care.<sup>21</sup> For in-network providers, safety net and otherwise,

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<sup>19</sup> Id.

<sup>20</sup> Center for Health Care Strategies, *The Faces of Medicaid* (Princeton, N.J., 2000) p. 14.

<sup>21</sup> IOM, *America's Health Care Safety Net: Intact but Endangered* (NAS Press, Washington D.C., 2000)

managed care has resulted in deep discounts for covered services, and as noted, a virtual cessation of insurance payments for services furnished on an out-of-network basis. Data from the federally funded community health centers program, which collects information on revenues in relation to costs, show that health centers experience significant losses under both their publicly and privately sponsored managed care contracts.<sup>22</sup> There is no reason to believe that other safety net and community providers are immune from payment discounting, nor is there evidence that even well-structured incentive payments allow public or private providers to recoup the losses experienced by deep discounts.

The loss of revenues (both as a general consequence of a more competitive health system and more specifically as a result of managed care) also appears to have had a significant impact on the provision of uncompensated care by private physicians. A recent study from the Center for Health Systems Change, which tracks changes in the health care system across the nation, shows continued erosion in the provision of uncompensated care among private physicians; between 1997 and 1999, the proportion of physicians reporting uncompensated care services decreased from 76% to 72%.<sup>23</sup> The study reported widespread declines among all classes of physicians and all forms of practice arrangements. Declines were evident even among physicians reporting less than 60% of practice revenues derived from managed care, suggesting that more than simply managed care discounting was at work.

As physicians move away from privately owned practices and into employment arrangements charity care declines, because rates of charity care in employment based arrangement historically has been significantly lower. At the same time, however, the rate of charity care declined in privately owned practices as well. Time constraints, an overall loss of revenues, and changes in practice style all have had a substantial impact, not only on the proportion of physicians reporting any charity care, but also on the amount of charity care furnished by physicians during a month.

## **Discussion**

The statistics presented in this Update demonstrate a continued elevated poverty rate, particularly among children and households headed by women, sustained elevated rates of persons without health insurance, and large numbers of Medicare beneficiaries without adequate sources of coverage for prescribed drugs. Persons who are low income and without health insurance feel the effects of the lack of health insurance in reduced utilization of services and more limited access to care.

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<sup>22</sup> Uniform Data Set; calculations by CHSRP for the Bureau of Primary Health Care (July, 2001).

<sup>23</sup> Marie Reed, Peter Cunningham, and Jeffrey Stoddard, Physicians Pulling Back from Charity Care (Issue Brief #42) (CSHSC, Washington D.C., August, 2001)

Furthermore, there are at least some indications that access has worsened in recent years, as measured by elevated use of emergency room care declines in the proportion of children who use any health services in a year, and declines in dental care use. Eroding pediatric health care, dental care, and emergency room utilization statistics may be particularly sensitive indicators of an overall decline in health care access among populations already at risk for inadequate health care. The strains on the health care system as it attempts to respond to these developments is evident; safety net providers report significant jumps in provision of care to the uninsured, concomitant financial losses from insurers, both public and private, and the provision of charity care declines.

It is important to stress the point made in the Introduction: as current as they may be, these statistics portray a picture of American health care before the recent economic downturn and the catastrophic events that will inevitably worsen Americans' overall well-being. As the economy degenerates, poverty rates can be expected to climb, the rate of persons without health insurance can be expected to grow, and the strains on the safety net to ensure access to even basic health services, increase.

Even at the height of economic prosperity, only 18 states made health coverage available under Medicaid to low income working parents. The enactment of SCHIP and relatively rapid implementation by states has placed a coverage safety net under children, but early evidence suggests that enrollment declines sharply after the first year, not because children's economic circumstances improve, but because state procedures for continuing enrollment without a break do not work well.

While many states have reported prescribed drug programs for Medicare beneficiaries, research by CHSRP suggests that only a small proportion actually subsidize the cost of prescriptions for low income beneficiaries. In many states the program consists solely of a discount card, which is helpful but obviously inadequate to place prescribed pharmaceuticals within financial reach of poorer persons.

It is not possible to accurately gauge the effects of the downturn in the economy on state health initiatives. Anecdotal evidence suggests that states are considering freezing SCHIP enrollment,<sup>24</sup> reducing or eliminating expansions recently adopted for adults and working families, and making other reductions in services. While tobacco revenues continue to flow into states, the National Conference of State Legislatures reports that only a fraction of all revenues received are spent on the provision of health services. Tobacco expenditures on health care may rise as the economic erosion increases the demand for publicly funded care, but at this point, it is difficult to anticipate future directions.

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<sup>24</sup> This is possible in states that did not enact SCHIP as a Medicaid expansion but rather adopted a separately administered program that does not operate as an individual entitlement. Sara Rosenbaum and Barbara Smith, *State SCHIP Design and the Right to Coverage* (SCHIP Policy Studies Project, Policy Brief #1) (GWUMC/SPHHS/CHSRP, March, 2001)  
Ascension Health Environmental Assessment Update  
September, 2001

In addition to changes at the state level, the federal government's decisions will have an enormous impact on the availability of funds to support care for lower income and medically vulnerable Americans. Funds earmarked under the FY 2002 federal budget for public insurance expansions and a prescribed drug program for Medicare beneficiaries appear to have disappeared in the face of a declining economic outlook, although the catastrophe in New York, as well as the eroding economy generally, may cause the President and Congress to devise broadly structured economic stimulus relief that could include funds for the expansion of health insurance and health care programs for the poor, such as the Community Access Program (CAP) and increased funding for other safety net programs.

At the same time, the United States Department of Health and Human Services has begun to move aggressively against states that used Medicaid "upper payment limit" flexibility to claim far greater levels of federal Medicaid contributions than they are entitled to receive under the nominal statutory formula. At risk as the federal government clamps down on "UPL scams" are not only county and city public facilities (whose eroding care capabilities will in turn strain the rest of the system) but also safety net providers whose own DSH payments have been financed in whole or in part through these financing arrangements.

Simultaneously with its efforts to reduce these "UPL" practices, HHS also has notified states of the availability of special demonstration authority under 1115 of the Social Security Act to expand coverage to lower income persons ineligible for even expanded Medicaid coverage (i.e., adults without children who are not disabled). This special initiative, known as Health Insurance Flexibility and Accountability (HIFA),<sup>25</sup> would permit a state to adopt on a time-specific, demonstration basis, limited insurance plans for low income residents otherwise ineligible for coverage. However, because HIFA requires demonstrations to be budget neutral, states would effectively have to eliminate DSH payments, reduce payments to other providers, and reduce or eliminate coverage for optional eligibility groups (who by and large are persons with disabilities) in order to take advantage of this flexibility.

The question in the face of growing need and declining revenues is how to maintain a mission of service. The answer is not an easy one. As a threshold matter, it is evident that the remaining health care safety net must pull together as one, without dissension and with maximum cooperation. In this regard, the CAP program offers an important opportunity for all safety net providers in a community, regardless of type or ownership, to collaborate in shared care arrangements and pooled resources. Even in the absence of CAP, community initiatives among safety net providers to share services and resources will be essential

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<sup>25</sup> [www.hhs.gov/cms](http://www.hhs.gov/cms) (Accessed September, 2001)

Second, it is essential that states that already have done so maintain their commitment to at least those Medicaid and SCHIP expansions that have been enacted, as well as other investments in the safety net. This means renewed attention to the use of special revenues, such as revenues from the nationwide tobacco settlement, that heretofore have by and large been diverted into other uses.

Third, physicians who perform charitable care must be “incentivized” to remain part of the safety net. The erosion in charity care is steady and significant, and it is impossible in the face of need on the magnitude of what may be coming in the U.S. to achieve even the semblance of a safety net under all communities without physician participation. Because Ascension Health works with so many physicians who furnish charity care, it might consider a structured evaluation that is in effect the mirror image of that carried out by the Center for Studying Health Systems Change. Why do these physicians do what they do? What makes their participation in charitable efforts possible? What might be means for strengthening the involvement of physicians in charity care? In a time of declining sources of uncompensated care, it is essential to understand why those physicians who do furnish care practice as they do, and to help local health systems develop programs that will reward continued charitable activities.

