Articles

California Physicians' Willingness to Care for the Poor

MIRIAM KOMAROMY, MD, *San Francisco, California;* NICOLE LURIE, MD, MSPH, *Minneapolis, Minnesota; and* ANDREW B. BINDMAN, MD, *San Francisco, California*

Although generalist physicians appear to be more likely than specialists to provide care for poor adult patients, they may still perceive financial and nonfinancial barriers to caring for these patients. We studied generalist physicians' attitudes toward caring for poor patients using focus groups and used the results to design a survey that tested the generalizability of the focus group findings. The focus groups included a total of 24 physicians in 4 California communities; the survey was administered to a random sample of 177 California general internists, family physicians, and general practitioners. The response rate was 70%. Of respondents, 77% accepted new patients with private insurance; 31% accepted new Medicaid patients, and 43% accepted new uninsured patients. Nonwhite physicians were more likely to care for uninsured and Medicaid patients than were white physicians. In addition to reimbursement, nonfinancial factors played an important role in physicians' decisions not to care for Medicaid or uninsured patients. The perception of an increased risk of being sued was cited by 57% of physicians as important in the decision not to care for Medicaid patients and by 49% for uninsured patients. Patient characteristics such as psychosocial problems, being ungrateful for care, and noncompliance were also important. Poor reimbursement was cited by 88% of physicians as an important reason not to care for Medicaid patients and by 77% for uninsured patients. Policy changes such as universal health insurance coverage and increasing the supply of generalist physicians may not adequately improve access to care unless accompanied by changes that address generalist physicians' financial and nonfinancial concerns about providing care for poor patients.

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Increasing the availability of health insurance coverage appears necessary but insufficient to improve access to care for poor patients. Studies of expanding Medicaid eligibility have been unable to show consistent improvements in access to care or in health outcomes.[1-3] Many health policy analysts have suggested that access to care can be improved by linking expansion of health insurance coverage with a shift in the delivery of care from specialist to generalist physicians.[4-6]

Indirect evidence suggests that generalist physicians are more likely than specialists to provide care for poor patients. Generalist physicians are more likely than specialists to practice in rural areas and inner cities,[7] their fees are lower, and they see more patients per hour than specialists.[8] They report that they devote a somewhat greater percentage of their practice to Medicaid patients than do specialists.[9]

It is unclear, however, whether these observed practice differences reflect physician attitudes that will guarantee improved access to care for poor patients if the physician workforce shifts from specialist to generalist. Analysts have concluded that successful reform will need to address nonfinancial as well as financial barriers to care.[10,11] Physicians' attitudes or beliefs may pose such nonfinancial barriers; for example, physicians might be reluctant to care for patients from a socioeconomic class or cultural background different from their own. A study of the willingness of family physicians to provide obstetric care for Medicaid patients suggested that the fear of being sued and the perception that Medicaid patients are noncompliant were both important factors in the decision to discontinue obstetric care for these patients.[12] A study of pediatricians found that broken appointments and "the type of patient" eligible for Medicaid were perceived as

From the Primary Care Research Center (Drs Komaromy and Bindman) and the Division of General Internal Medicine, San Francisco General Hospital Medical Center (Dr Bindman); the Division of General Internal Medicine (Dr Komaromy), the Institute for Health Policy Studies (Dr. Bindman), and the Department of Epidemiology and Biostatistics (Dr. Bindman), University of California, San Francisco, School of Medicine, and the Department of Medicine, Hennepin County Medical Center and University of Minnesota School of Medicine, and the Division of Health Services Research and Policy, University of Minnesota School of Public Health, Minneapolis (Dr Lurie).

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Reprint requests to Miriam Komaromy, MD, UCSF Box 1364, Primary Care Research Center, San Francisco General Hospital Medical Center, San Francisco, CA 94143-1364.

important problems with the Medicaid program.[13]

To learn more about generalist physicians' attitudes toward caring for low-income adult patients and the financial and nonfinancial factors that affect their attitudes, we conducted structured small-group interviews—focus groups—and a survey of generalist physicians in California. We studied whether physicians are willing to accept patients who lack private insurance into their practice, and how they decide whether to provide care for these patients.

Sample and Methods

We conducted focus groups with physicians and then used these findings to design a physician survey. Focus groups are a qualitative research method in which a small number of study subjects participate in structured group interviews.[14] The open-ended nature of the questions posed in the focus groups makes this a useful technique for understanding the range of physician attitudes and motivations.[15] Because it is difficult to generalize from focus group data, we conducted a survey of a random sample of primary care physicians in California to examine how broadly generalizable the focus group findings were. The study protocol was approved by the University of California, San Francisco, Human Subjects Committee.

We formed four focus groups with a total of 24 practicing generalist physicians. Letters of invitation were sent to the general internists and family and emergency physicians on the admitting staff of one hospital in each of four northern California communities. Participants were enrolled in the order in which they responded up to a total of seven per group. The hospitals were a semiurban public teaching hospital, an urban private teaching hospital, an urban private nonteaching hospital, and a rural private nonteaching hospital. Physicians were told only that we were studying physician decision making and were offered $100 to participate. Discussions were facilitated by two of us (M.K. and N.L.), who are general internists and have been trained in focus group facilitation. The groups each lasted 60 to 90 minutes. Among the 24 physicians, 22 were men; 13 were internists, 7 were family physicians, and 4 were emergency physicians.

Using a script of prepared questions, we asked physicians how patients' social and economic status influenced their clinical practice and decision making. We investigated how they decide whether to care for uninsured and Medicaid patients; and if they choose not to, we explored their reasons and strategies for avoiding these patients.

The sessions were audiotaped and transcribed. Patterns and trends of responses were established through a content analysis of the data that entailed systematic coding. Each investigator analyzed the content of the groups, and the analyses were compared and integrated.[16]

To ascertain the generalizability of the findings from the focus groups, we surveyed a random sample of 80 California general internists, 80 family physicians, and 80 general practitioners in active practice. Participants were chosen from the current roster of California physicians from the American Medical Association Physician Masterfile. The Masterfile includes physicians who are not members of the American Medical Association. Participants were initially mailed the survey in April 1993 and were informed that on receipt of their survey, their name would be entered into a drawing for one of two continuing medical education tuition vouchers worth $500. Within a month, nonresponders were sent a reminder postcard and a second copy of the survey. Physicians who still had not responded were contacted by telephone or by a visit to their office.[17] We attempted to verify the addresses of nonresponders through telephone information, an inquiry to the state licensing board, and finally with a postcard asking office staff to confirm whether the physician was actively practicing in California. Physicians were considered ineligible if we learned that they were not a general internist, general practitioner, or family physician currently practicing in California.

The survey was a written, closed-ended questionnaire developed from a review of the literature and from the focus group findings. Physicians were asked whether they were accepting new patients with different insurance types; if they were not, why not; the insurance status of patients in their practice; and factors in their practice setting that might influence their decision to accept patients with different types of insurance.

The survey was analyzed in two stages. Demographics and practice characteristics were compiled for all respondents. Physicians who said that they were accepting patients with private fee-for-service or managed care insurance were asked whether they were accepting new patients with Medicaid and with no insurance. Physicians who accepted Medicaid or uninsured patients, or both, were then compared with those who accepted neither, to see whether they differed with regard to physician demographics or practice setting (Fisher's exact test). Race was dichotomized into white (non-Hispanic) and nonwhite (plus Hispanic). Family physicians and general practitioners were combined for analysis because many physicians listed as general practitioners in the American Medical Association Masterfile identified themselves as family physicians on the survey. A logistic model designed to predict physician acceptance of Medicaid and uninsured patients was constructed using individual variables that were significant at the $P = .1$ level in the univariate analysis: physician race, practice location, and hospital type. Physicians' reasons for not accepting patients were examined separately for Medicaid and uninsured patients; because these were not mutually exclusive—physicians could accept both, one, or neither, for example—comparative statistical analysis was not done.

Because the survey results paralleled the attitudes we heard discussed in the focus groups, we have chosen to present them together using illustrative quotes from the focus groups to highlight the survey data.

TABLE 1.—*Characteristics of Physicians Who Accept Medicaid or Uninsured Patients*

Physician Characteristic	No. Accepting Medicaid or Uninsured Patients/ No. in Category (%) n = 95	P Value
Race*		
White	30/56 (54)	
Nonwhite	30/39 (77)	.02
Hospital type†		
Nonpublic	39/67 (58)	
Public	19/24 (79)	.05
Practice location		
Urban	49/82 (60)	
Rural	11/13 (85)	.08
Sex		
Male	48/78 (62)	
Female	12/17 (71)	.34
Specialty		
General internist	28/46 (61)	
Family physician or general practitioner	32/49 (65)	.41
Training		
United States	40/65 (62)	
Foreign	20/30 (67)	.40
Years since graduation		
≤ 10	14/20 (70)	
> 10	46/75 (61)	.33

*Table excludes 29 physicians who were accepting no new patients.
†The numbers add up to less than 95 because of skipped answers.

Results

The survey was mailed to 240 physicians. Of these, 37 were found to be ineligible because they had retired, moved out of state, were in another specialty, or were deceased. In addition, we considered 26 physicians ineligible because five or more attempts to locate them through mail, telephone, and the physician licensing board were unsuccessful. We received responses from 124 of the 177 remaining physicians (70%). The respondents did not differ from the nonrespondents with respect to age, sex, specialty, or years in practice. Respondents were predominantly white (63%), male (78%), and trained at medical schools in the United States (73%). Of our respondents, 60% admitted patients primarily to private hospitals, 24% to public hospitals, and 9% to health maintenance organization hospitals.

Providing Care for Medicaid and Uninsured Patients

Of the 124 physician-respondents, 95 (77%) said they accept new patients with private insurance (fee-for-service or managed care); 31% accept new Medicaid patients, and 43% accept new uninsured patients who are unable to pay full fee. Physicians who said that they accept new uninsured or Medicaid patients also reported a significantly greater percentage of such patients in their practices ($P < .001$). These low rates of providing care for Medicaid and uninsured patients occur despite the fact that physicians in general rate the number who are willing to care for such patients in their area as inadequate. When asked about the adequacy of the supply of primary care physicians in their communities, 100 respondents (81%) reported that there were far too few or somewhat too few providing care to Medicaid patients, and 109 (88%) said the same was true for uninsured patients.

These findings reinforced focus group comments. One focus group physician remarked:

"I doubt very much whether there's any physicians taking new Medicaid patients in [our community]; and there probably hasn't been for many years."

Several physician characteristics were related to the acceptance of new Medicaid or uninsured patients (Table 1). In univariate analysis, nonwhite physicians and those who admit patients primarily to public hospitals were more likely than their counterparts to accept new Medicaid or uninsured patients. Rural physicians tended more than nonrural physicians to accept new Medicaid or uninsured patients. In a simultaneous logistic regression analysis, physician race (nonwhite) remained a significant predictor of accepting Medicaid and uninsured patients ($P = .05$). There continued to be a trend for rural physicians to do so ($P = .08$), although admitting to a public hospital was no longer a significant predictor ($P = .16$).

In the focus groups, physicians described several strategies to avoid caring for uninsured and Medicaid patients. Some physicians refused all patients without private insurance either in the hospital or as outpatients. Another strategy was to arrange for residents to provide outpatient care for these patients. Other physicians transferred all uninsured patients to public hospitals. A final strategy was to agree to care for uninsured and Medicaid patients as inpatients or in the emergency department, but not to provide follow-up outpatient care. This strategy was articulated thus:

"The best strategy—no, I'm sorry, MY *strategy—is I don't see them in my office."*

In some settings, on-call physicians are also expected to provide follow-up care for patients who are seen in the emergency department but not admitted. An emergency physician described the situation in one of the communities where she worked:

"We'd assign them to the family physician on call, and my understanding when I started there was that they were obligated, the staff, to see that patient once, but they didn't have to see them on an ongoing basis. . . . And what was happening was the office people were screening them. They'd call and they'd say what kind of insurance they had, and try to make an appointment to follow up. And if they told them they had Medicaid or were unfunded, the clerk said, 'Sorry, we can't see you.' Boom. And they never got any further than that."

TABLE 2.—*Physicians' Reasons for Not Providing Care to Medicaid and Uninsured Patients*

Reason	Physicians Not Accepting Medicaid n = 58 No.	%	(95% CI)	Physicians Not Accepting Uninsured n = 43 No.	%	(95% CI)
Reimbursement						
Inadequate	51	88	(80-96)	33	77	(64-89)
Difficulty providing adequate care						
Burdensome paperwork	43	74	(63-85)	9	21	(9-33)
Difficulty obtaining specialty consultations	40	69	(57-81)	28	65	(51-79)
Difficulty obtaining tests	20	35	(22-47)	28	65	(51-79)
Perceived increased malpractice risk						
Increased risk of being sued	33	57	(44-70)	21	49	(34-63)
Patient characteristics						
Psychosocial problems	24	41	(29-54)	20	47	(31-61)
Ungrateful for care	21	36	(24-48)	13	30	(16-44)
Noncompliant	36	62	(50-75)	17	40	(25-54)

CI = confidence interval

Reasons for Avoiding Medicaid and Uninsured Patients

In both the focus groups and the survey, physicians' reasons for avoiding Medicaid and uninsured patients fell into four broad categories: inadequate reimbursement, difficulty providing adequate care, perception of increased malpractice risk, and patient characteristics (Table 2).

Reimbursement

When survey physicians were asked why they did not accept patients with Medicaid, 51 (88%) cited poor reimbursement. Among those not accepting uninsured patients, poor reimbursement was cited by 33 (77%) (Table 2). This finding corroborated focus group data. For example, a physician said:

"I don't take any new Medicaid patients, and my colleagues are all doing the same thing now . . . and it is mostly for financial reasons. Our reimbursement goes down, our census goes up, and you find yourself working harder and not making ends meet the way you have."

Difficulty Providing Adequate Care

Survey physicians reported that difficulty in providing adequate care for Medicaid and uninsured patients influenced their decision not to provide care for these patients (Table 2). Burdensome paperwork and difficulty obtaining specialty consultations were important reasons for avoiding Medicaid patients, whereas difficulty obtaining specialty consultations and diagnostic tests were important reasons for avoiding uninsured patients.

In the focus groups, physicians described their frustration at trying to obtain needed services for their patients who lack private insurance.

"The problem of the unfunded patient is really very, very difficult for the private physician. . . . I would be more than happy to treat these people, but if they need referral, or if they need lab work, or if they need x-rays . . . these people will either tell you that they don't have the money to pay for it [or] they don't want to pay for it, and you're forced . . . into practicing poor medicine."

A physician at another hospital remarked:

"I do feel bad when the Medicaid patients that I am taking care of . . . need to see a specialist. It's hard to find somebody else who will take them."

Survey physicians who reported that their hospital had a policy against admitting uninsured patients were less likely than those whose hospital had no such policy to accept uninsured patients into their practice ($P < .01$). Two focus group physicians discussed the influence of their hospital's admission policy:

First physician: *"I wouldn't admit anyone who had no insurance."*

Second physician: *"The hospital won't take them, unless they're too unstable."*

First physician: *"No, they couldn't get in the door, anyway."*

Increased Malpractice Risk

The perception that they were more likely to be sued was cited as an important reason for avoiding poor patients by 33 of the physicians who did not accept Medicaid (57%) and 21 of those who did not accept uninsured patients (49%; Table 2).

In the focus groups, physicians expressed three areas of concern about increased malpractice risk. Many thought that Medicaid patients were actually more likely to bring lawsuits against physicians than were other patients.

"Your risk of being sued for malpractice is greater. [Medicaid patients] have multiple problems you don't know anything about."

Some physicians were aware that studies have shown that this is not the case,[18,19] but thought that the presence of any substantial risk of being sued was unacceptable when providing care to patients who are not privately uninsured.

"I understand that you're actually less likely to be sued by [Medicaid patients]; but you can be sued by them and always really resent it when you're taking care of somebody for essentially nothing and you get nailed."

Others thought they were particularly vulnerable to being sued because difficulty obtaining tests and consultations for poor patients caused them to provide substandard medical care.

Patient Characteristics

In the survey, psychosocial problems and patient noncompliance were cited as important reasons for avoiding both Medicaid and uninsured patients (Table 2). This echoed attitudes expressed in the focus groups. One physician said:

"They are more difficult to take care of . . . they have lots of social and medical problems, they are more

difficult in terms of compliance, they have drug habits, things like that."

In addition, 36% of survey physicians felt that Medicaid patients were ungrateful for care. A focus group physician described caring for Medicaid patients:

"You just don't get the positive feedback and reward for trying to make these people well, because they can sabotage and destroy things; usually not deliberately, but they just. . . . They're hard to work with. They're hard to help. And you get tired."

Another physician in the same group disagreed:

"I have a handful of Medicaid patients in my practice, and they're very appreciative. They're appreciative overall of what they get, and they recognize that there are major limitations to what I can do for them."

Discussion

Nearly half the physicians we surveyed said they provide care for Medicaid or uninsured patients despite many financial and nonfinancial issues that make this difficult. Yet most thought that the supply of physicians who care for uninsured and Medicaid patients in their community was inadequate. We have identified a number of financial and nonfinancial factors that discourage physicians from caring for these patients. Efforts to reform health care would need to address these factors to increase the availability of health care for the poor.

Inadequate reimbursement is the reason physicians cited most commonly for choosing not to care for Medicaid and uninsured patients. Generalist physicians cannot be expected to assume responsibility for large numbers of poor patients if their reimbursement does not meet or only marginally exceeds their operating costs. Although health care reform efforts offering universal insurance coverage would improve financial access to health care, they might not eradicate financial barriers. Just as existing Medicaid programs have often been unsuccessful in providing the poor with financial access to care, a low-cost plan under a managed competition style health care reform plan might provide reimbursement that physicians would regard as inadequate compared with the reimbursement they receive for other patients. Rules that ensure that health plans cannot refuse coverage to patients may not deter physicians who function as independent providers from excluding patients because of inadequate reimbursement. If large differentials in reimbursement exist between health plans, or if some Americans continue to be insured by low-reimbursing Medicaid programs, poor patients are likely to face continued financial barriers to care even if comprehensive health care reform occurs in the future. Patients' Medicaid status or membership in another low-paying health plan could also stigmatize them as undesirable to some physicians for nonfinancial reasons and allow physicians to avoid them.

Three categories of nonfinancial issues played an important role in physicians' decisions not to care for Medicaid and uninsured patients: difficulty providing adequate care, fear of increased malpractice risk, and perceived patient characteristics.

Physicians identified several ways in which they had difficulty providing adequate care for poor patients. Burdensome paperwork, in addition to adding to the cost of care, was seen as a substantial diversion from patient care. Physicians were frustrated by difficulty obtaining diagnostic tests and specialty consultations and felt unable to provide care consistent with community standards. These findings are consistent with a recent study that found that when poor patients are admitted to hospital, they are more likely than others to receive substandard care.[20] Both patients and physicians suffer when substandard care is provided, and some physicians simply opt not to care for these patients rather than face this alternative. Even with health care reform that provided universal financial coverage, these problems would persist, and generalist physicians would not be able to solve these problems on their own. Specialists must be willing to accept appropriate referrals to help ensure that poor patients receive adequate care. Adequate reimbursement, coverage of laboratory tests and outpatient services, tort reform, and the elimination of burdensome paperwork are also needed.

Physicians were deterred from caring for poor patients by undesirable personal characteristics that they attributed to these patients. Addressing physicians' attitudes toward personal characteristics of poor patients is a challenging problem. Medical schools can attempt to recruit applicants who have a sense of responsibility toward the care of poor and underserved groups.[21,22] Our finding that nonwhite physicians are more likely than others to care for Medicaid and uninsured patients suggests that recruiting greater numbers of nonwhite physicians could be important for overcoming nonfinancial access barriers. Medical training sites can be relocated to high-need rural and inner-city areas to help accustom physicians to the goal of meeting the needs of a community.[22-24] The clinical curriculum can be restructured to focus more on skills needed to deal effectively with patients' social and psychological problems.[25] When better prepared, physicians may come to view these problems as challenging rather than undesirable. Finally, generalist physicians cannot carry the burden of medical, psychiatric, and social services for these patients; ready access to mental health and social services is critical to improving health care for poor patients.

Our study is limited by our reliance on physician self-report. Focus groups are useful for revealing attitudes and motivations, but they may present an overly negative picture of physician attitudes because group consensus may be swayed by extreme opinions. On the other hand, physicians are known to overestimate the amount of care they provide to low-income patients when they are asked in a survey format.[26] We used the combination of focus groups and a written survey to try to capture a balanced picture of generalist physicians' attitudes.

Even health care reform that provides universal coverage and increases the proportion of generalist physicians might not adequately improve access to care unless these are accompanied by changes that address generalist physicians' financial and nonfinancial concerns about providing care for poor patients.

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