

Free Clinics

A Personal Journey

More than 46 million Americans have no health insurance, and the number is steadily growing. To meet the health care needs of the uninsured, a safety net has evolved of public health clinics, federally qualified health centers, emergency departments, and hospital outpatient clinics. In the article *Free Clinics in the United States: A Nationwide Survey*, the first comprehensive assessment of free clinics in 40 years, Darnell demonstrates that free clinics are an important but marginalized contributor to the safety net. With a national plan to expand health insurance passed by Congress and signed by President Barack Obama, some may mistakenly think that free clinics will no longer be needed. However, it is clear that the health care expansion will not cover all of the uninsured and will take several years to put into practice. Free clinics will be there to catch those who fall through these gaps.

While the study by Darnell provides an excellent assessment of free clinics in the United States, hard to capture in a quantitative study is the individuality of free clinics; just as no 2 patients, even 2 with the same disease, are the same, no 2 free clinics are exactly the same. Part of why there is so much diversity is that each free clinic starts in a different way. To better understand the development and purpose of free clinics, we tell the story of our free clinic, the San Francisco Free Clinic.

Twenty years ago, we were 2 young family physicians just out of residency starting a private practice in San Francisco. Despite not knowing how to run a business or even submit a bill, we were surprisingly successful. In just 3 years we had paid for an outfitted clinic, our staff was well paid, and we were taking home some money ourselves. But 1 thing bothered us. We could not afford to accept Medicare or Medicaid patients, and it was painful asking the many patients with no insurance to pay cash. At the time, nearly 1 in 5 San Franciscans were uninsured. Yet the city had more physicians per capita than most locales. Something seemed wrong. A large number of physicians were competing for patients with insurance, while a large number of patients were uninsured and had trouble finding physicians to care for them.

This led to a brainstorm. Would it not be better to practice in the population that needed us most? We would only see patients with no insurance and repaint the shingle to read *Free Clinic*. We soon discovered, however, that there was so much to do. We would have to be a nonprofit organization or no one could donate money. That meant finding a board of directors. And where would the money come from? Did we really want to trade hospital rounds for writing complex government grants? How would our patients undergo laboratory studies, x-rays, or a specialty consult? Which hospital would accept our admissions? Would all our patients be homeless? Would we pay ourselves, and if so, how much?

They say that wisdom comes from asking the question, not from being certain of the answer. One by one we found solutions. In that process, we stumbled onto a project so simple and satisfying that it has been the gift of a lifetime, not only for us but also for the community who became a part of it.

Regarding a board of directors, the head of a large foundation gave us great advice. "Find heavy hitters for your board, not talkers. Their job is to raise money." We formed a small board of sympathetic folk who worked in finance and banking, and included a couple of physicians for good measure.

In considering government grants, it became apparent that we did not want public money at all. The applications are long and complex, and much of each dollar is spent in reporting requirements. Private foundations are simpler by far. We could write these ourselves and avoid hiring grant-writing professionals.

Our enthusiasm came down a notch with our first grant application. We were told that new nonprofit organizations are numerous and most quickly fold. We had to show a base of support—not 2 or 3 people but a population who support our project. Where would we find a base of support? Then we remembered; we were already connected to a group, our local medical society, the San Francisco Medical Society.

We wrote a letter to every physician in our membership book. The outpouring of help was tremendous, not only from physicians but also from imaging centers and hospitals. We went back to the foundation with our newfound wealth, and after receiving the first grant, others followed.

The clinic became a wonderful example of how the medical community, private charities, and business foundations can come together to help people with no health insurance. The structure of the clinic is unique. No bills are generated, and we do not apply for complex government grants. This eliminates the need for administrative staff and assures that everyone at the clinic is involved in patient care. All staff are paid, which gives us the stability of a private practice. More than 100 specialists donate 1 or 2 consults per month in their office, and imaging centers and hospitals each perform a small number of x-rays, computed tomographic scans, and magnetic resonance imagings. For admissions, we are blessed by one of the finest county hospitals in the world. Our golden rule is 2-fold: have many people give only a little bit each, and never allow complexity to enter the project. No provider has dropped out in 16 years. When we tally the value of donated time and supplies, we can honestly tell funders that every real dollar is stretched 3-fold by the medical community. Furthermore, 100% of donations go directly to patient care. Funders are fond of these principles, and they tend to repeat gifts year after year.

The clinic is a happy place. The staff feels good about helping those in need, and we appreciate the freedom to focus on patients. The specialists seem pleased to donate expertise and funders know their money is well used. Most important, patients say "thank you." And who are the patients? They are neighbors, families, students, the self-employed, small business folk, or people who recently lost their jobs. They are people we know and see everyday.

As Darnell suggests, many free clinics will integrate into the funding and billing network that will come with extending insurance coverage while others will remain the safety net for those excluded from federal reform efforts. Until we have true universal coverage, clinics will be needed where the uninsured can receive the care that all people deserve.

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