



# **FREE CLINICS IN MIAMI-DADE COUNTY: THEIR ROLE AS CORE SAFETY NET PROVIDERS**

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**&**

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## Executive Summary

This study, the first of its kind, tackles the essential issue of the role played by free health clinics in Miami-Dade County as a core safety net provider of the area. No previous study of this magnitude had been conducted in the county with respect to Free Clinics. The study is based on extensive research of Free Clinics in Miami-Dade County. It presents significant empirical evidence from the clinics and discusses significant data beyond the clinics. The clinics that participated in the study represent virtually all of the Free Clinics existing in the area.

The National Association of Free Clinics (NAFC) defines Free Clinics as “volunteer-based, safety net health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals who are predominately uninsured. Free Clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered Free Clinics, provided essential services are delivered regardless of the patient's ability to pay.”<sup>1</sup>

## Results

- Free Clinics are not just essential for the provision of health care services to a large number of uninsured and underinsured individuals and families in the county. They have other social functions that are vital not only to individuals and families, but also the neighborhoods and communities in which they operate.
- They offer, at no cost to the neediest patients, an array of health care services, including primary and specialized care. These services are offered either on-site or through extensive referral networks. Their services range from expensive treatments, to simple medical procedures, to preventative methods and education to reduce the spread of contagious diseases.
- Free Clinics in Miami-Dade County tend to offer an array of services related to family medicine. However, some clinics tend to focus on a specific population group and/or issues. For example, one focuses on patients who have been diagnosed with cancer, another focuses on children, women, and reproductive health, and one has a strong focus on the homeless and patients with HIV/AIDS.
- The rich cultural background of the clinics' personnel facilitates their medical and social role in a county in which approximately half of the population was born abroad, most of them in Latin America and the Caribbean.
- The Free Clinics in Miami-Dade County operate with very limited budgets while offering services that are several times the value of their budgets in terms of the “retail value”.
- The backgrounds of the directors and other executive personnel of the Free Clinics of the county vary. They range from certified physicians and professors from medical programs at a local college to individuals with no professional background in the medical fields, who nevertheless have a long history of volunteer community involvement, including leaders of religious organizations and entrepreneurs from different fields.
- Free Clinics are socially imbedded in their neighborhoods, communities and beyond through extensive networks that encompass multiple private and public organizations, entities, and individuals.
- Their social functions extend beyond solely providing medical attention in the narrow sense of the term. They perform educational functions, such as assisting the neighborhoods in improving literacy rates by coordinating educational programs for the patients. They provide health education and counsel to the community on sexual and reproductive behavior, nutrition, domestic violence and related issues. As a result of their functions, social awareness and understanding of individual habits and social-environmental factors associated with specific illnesses in the community is greatly

improved.

- Each clinic offers physical exams and medical treatment for a number of illnesses, while offering comfort and hope to those who would otherwise be in a hopeless situation given the compounding factors of poor health and a poor economic situation.
- Today some of the Free Clinics' fundamental functions are: 1) providing cost-effective quality care for economically disadvantaged, uninsured or inadequately uninsured patients, thereby reducing the burden on larger structures of the health care system, 2) educating the community concerning health issues and best practices in preventive care, and 3) providing a medical and social structure that is deeply embedded in the neighborhoods and communities at the grassroots level which can potentially be used to assist larger segments of the population in the event of pandemics or other catastrophic scenarios.
- Related to the role of Miami-Dade County as a gateway of immigration to America, (immigrants constitute approximately 50% of the total population of the county) immigrants are the vast majority of the patients of Free Clinics of the county.
- Free Clinics provide medical services not only in English, but in various foreign languages; mainly Spanish, Portuguese, Haitian Creole, and Urdu. Catholics, Baptists and Muslims are very active in the Free Clinics of the county as founders of clinics, health care providers, and volunteers.
- Barriers to access and health disparities in Miami-Dade County related to ethnicity, immigration status, income, type of employment and gender, are steep. Free Clinics play a significant role in diminishing the negative implications of such barriers.
- Concerning the impending reform in health care, the report adheres to the view that it is fundamentally a reform related to coverage. The main premises upon which the provision of health care are built on in our society will remain intact. Thus, millions of individuals are expected to continue "to fall through the cracks of the system."

## **Recommendation**

Conceptualized as "charter funding," this research report advances a policy proposal that aims to secure a recurrent stream of funding for Free Clinics of Miami-Dade County and beyond. Charter funds refers to a stable stream of funding for Free Clinics that is provided under a specific charter granted by the State Legislature, U.S. Congress or other public authority. This kind of funding would lead to a new funding model, which is necessary for the purposes of expanding or improving the services of existing clinics and even the creation of new ones. The charter funds could be provided directly to clinics, although some funds could also be provided to increase a Free Clinic fund created by umbrella organizations, such as a regional Free Clinic Association.

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**Foreword by:  
Marisel Losa, President and CEO, Health Council of South Florida, Inc.**

The study leading to this report was commissioned by the Health Council of South Florida, Inc. (HCSF) as part of the Health Council of South Florida's efforts to assist Free Clinics. By incubating the Florida Association of Free Clinics, the Council is focused on finding innovative strategies to many challenges faced by Free Clinics, primarily sustainability.

Prior to this study, no comprehensive analysis had been conducted regarding the role of Free Clinics in Miami-Dade County's health care safety net. This study intends to present stakeholders with pertinent information to help build sound policy recommendations that are in line with the areas intended to be affected. Findings will support a policy proposal that seeks a stable stream of government funding for Free Clinics. The HCSF is committed to advancing this and other policy initiatives designed to have a positive impact on the community.

It is expected that this report will provide valuable insight to local, state, and national leaders who are involved in finding ground-breaking solutions to expand access to quality care for the most vulnerable segments of the population. Given the wealth of information discussed and the insights offered by Dr. Cervantes-Rodríguez, this comprehensive study will serve as a foundation to be utilized by those who are committed to further assisting Free Clinics to achieve their goal of providing high quality care for underserved populations.

## Acknowledgements by the Author

This study could not have been possible without the support and involvement of Marisel Losa, President and CEO of the HCSF, and her understanding of the need for this kind of research. Ms. Losa’s support transcended the formality of her position. Her enthusiastic, intellectual engagement in every substantive discussion we had, her willingness to share her expertise and precious time, and her commitment to assist the free health clinics in Miami-Dade County are behind this study.

My gratitude also extends to other members of the HCSF who were directly involved in assisting me throughout the process. Vanessa Rodríguez, Manivone Douangdara and Robert Harris assisted in the compilation and provision of data, charts and maps. Ms. Rodríguez and Ms. Douangdara also assisted with the follow up related to the questionnaire applied to Free Clinics. I also thank Jack Goldberg for his help in the formatting and editing stages. Invaluable assistance was also provided by María Ortega, Volunteer Program Coordinator of the Health Department in Miami-Dade County, who together with Ms. Losa assisted me in identifying and classifying Free Clinics and other health care safety net providers in the county.

In addition, I would like to express my appreciation to the following directors and other personnel of the Free Clinics that participated in the study, offering their time, their willingness to share their experiences, and their collaboration with the survey:

Interviewed	Position	Organization
Giselle Bretones	Clinical Coordinator	Miami Rescue Mission Medical Clinic
Adriana Cora	Executive Vice President	The League Against Cancer
Ana Daily	Administrator	Good News Care Center
Rev. Michael Daily	Founder/ CEO	Good News Care Center
Sadrul Fasihi	Administrator	Universal Heritage Institute Medical Clinic
Annette Gibson, MSN, MED, RN	Vice President	Miami Rescue Mission Medical Clinic
Sister Edith Gonzalez	Vice President of Mission Services	Mercy Hospital
Peter Gutierrez, MD	Director	Miami Rescue Mission Medical Clinic
Betty Leguisamon	Supervisor	St. John Bosco Clinic
Robert Nery, MD	Medical Director	Good Samaritan Community Health,
Mariela Perez, MD	Physician	Open Door Health Center
Mary Pujols	Medical Center Director	The League Against Cancer
Cesar Scheker	Administrator	The League Against Cancer
Tina Scott, MD	Medical Director	South Miami Children’s Clinic
Nilda Soto, MD	Medical Director	Open Door Health Center
Ady Viera	Member of Board of Directors	The League Against Cancer

I would also like to express my deepest gratitude to other workers of the clinics for sharing their experiences.<sup>2</sup>

I am particularly grateful to Rev. Michael Daily, Founder/CEO of Good News Care Center and originator of the notion of Charter Clinic, as discussed here. His willingness to discuss the notion with me in great detail and share ideas made a significant difference in the shaping of the policy proposal included in this report.

I also conducted several interviews with local leaders of different organizations which have been very valuable for this report. Some of the interviews had been conducted prior to this study as part of my research interest in a broader project on safety net providers in Miami-Dade County. Others were conducted once I started this project which focuses on Free Clinics. The additional interviews that were useful for this report were granted by:<sup>3</sup>

<b>Interviewed</b>	<b>Position</b>	<b>Organization</b>
Boris Alvarez	Administrator	Dr. Rafael A. Penalver Clinic
Manuel Armada	Director of Research	Miami-Dade County Zoning and Planning Dept.
Bill Duquette	CEO	Homestead Hospital
Pedro Jose Greer, M.D.	Assistant Dean of Academic Affairs	Florida International University, College of Medicine
Daniella Levine, JD, MSW	Founder/ President/ CEO	Human Services Coalition
Cheryl Little, Esq.	Executive Director/ Co-founder	Florida Immigrant Advocacy Center
Maria Ortega	Volunteer Program Coordinator	Miami-Dade County Health Dept.
Lillian Rivera, R.N., M.S.N., Ph.D.	Public Administrator	Miami-Dade County Health Dept.
Brendaly Rodriguez, MA	Community Outreach Manager	Miami Field Center-Hispanic Community Health Study, University of Miami
Eneida Roldan, MD, MPH, MBA	President and CEO	Jackson Health System
Hiram A. Ruiz	Director of Refugee Services	State of Florida Dept. of Children and Family
Monica Russo	Founder / President	SEIU Healthcare Florida
Steven G. Ullmann, Ph.D.	Professor and Director, Programs in Health Sector Management and Policy	University of Miami

I would also like to thank the Center for Migration Studies (CMD) at Princeton University, and in particular its director Alejandro Portes, Ph.D. for the insights I acquired during my participation as a research associate in the study on Health and Immigration, hosted by the CMD. The interviews I conducted as part of that study were particularly useful as background information for some of the issues discussed in this report. Although this study is sponsored by the Health Council of South Florida, from a professional perspective, it constitutes a continuation of my research experience at Princeton.

## Introduction

### Objectives

The following interrelated objectives guided the study leading to this report:

1. To shed light on basic definitions related to health safety net providers, with a focus on Free Clinics as part of the core safety net providers.
2. To identify the Free Clinics in Miami-Dade County, their location, major characteristics, and their role as part of Miami-Dade County's health care safety net.
3. To examine the challenges that clinics face in light of current barriers to access and patterns of health disparities in the county as well as current socioeconomic conditions and a new environment characterized by policy debates in anticipation of changes in the health care system.
4. To increase awareness of the social impact of Free Clinics by researching and documenting their contribution to health improvement efforts and other social functions.
5. To substantiate and advance a policy proposal that is intended to support Free Clinics in maximizing their resources and assist in their sustainability and developmental efforts by securing recurring funding. In relation to these goals, the proposal also intends to support current efforts launched by the Health Council of South Florida to facilitate the potential replication of Free Clinic models.

### Methodology

This report offers fresh empirical evidence based on fieldwork and a wealth of information from various sources. The fieldwork encompassed eight (8) clinics in Miami-Dade County. Seven (7) of them operate from permanent facilities located in different areas of the county: they constitute almost the entire universe of Free Clinics that operate from permanent facilities in the county. In addition, a Free Clinic that operates from a mobile unit was also included to detect similarities and differences with respect to the others.

The following methodology was employed in generating and analyzing the data included in this study:

- The author conducted on-site semi-structured in-depth interviews with the directors, administrators, and other personnel of Free Clinics. In addition to interviews, visiting each facility provided the basis for observations and comparisons.
- A survey questionnaire of 28 questions was applied to all eight Free Clinics studied. The questions addressed the following issues: a) general characteristics of clinics such as founder(s), years established, operating budgets and service focus, operational infrastructures, and aspects of referral systems, b) general characteristics of the patients including number of patients served per year, chief patient health problems, and the predominant ethnic and immigrant groups among the patients served, and c) general characteristics of clinic staff such as whether they are full-time or part-time paid workers or volunteers, ethnic and immigration background, and the languages spoken, d) the social immersion (or social embeddedness) of Free Clinics in their communities and the county; partnerships with hospitals for the purposes of service delivery and/or partnerships with community organizations and other entities for various purposes, including additional services related to overall wellbeing. The questionnaires were completed by clinic directors or designated administrative personnel.
- Non-structured, in-depth interviews conducted with several local leaders of health care organizations, social services agencies, immigrant advocacy groups, and labor leaders, among others.<sup>4</sup>

Additional information was gathered and processed from scholarly reports, policy-oriented papers, and media articles. A portion of the information was provided by local entities, predominantly the Health Council of South Florida and the research section of Miami-Dade County Zoning and Planning Department.

**Part 1**  
**Health Care Safety Net**

## 1.1. The Health Care Safety Net

The health care safety net has been portrayed as encompassing “a broad patchwork of institutions, services, and financing mechanisms that vary considerably across the country and that aim to provide health care to underserved populations, including individuals who are uninsured or low-income.”<sup>5</sup> A report by the Institute of Medicine entitled *America’s Health Safety Net: Intact but Endangered*, further specifies the geographical differences and financial vulnerability of the health care safety net system:

This safety net system is neither uniformly available throughout the country nor financially secure. Rather it is a patchwork of institutions, clinics, and physicians’ offices, supported with a variety of financing options that vary dramatically from state to state and community to community. Its structure and strength likewise vary depending on the general political environment of a state or community, the number of uninsured people, and the types of health care institutions in the area. The safety net system has never been financially robust, but it has continued to survive.<sup>6</sup>

The Institute of Medicine defines core safety net providers as providers that have “two distinguishing characteristics:

1. either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
2. a substantial share of the patient mix are uninsured, Medicaid, or other vulnerable patients.”<sup>7</sup>

The institutional make up of the core health care safety net system prominently includes: public hospitals, Free Clinics and other clinics, private not-for-profit hospitals that serve a substantial number of patients who are underinsured or uninsured, community health centers (CHCs), and the local health departments.<sup>8</sup>

In addition, there are entities such as some social service agencies and other local agencies that do not provide medical services and are not part of the core health care safety net system, but they assist the medically underserved population in addressing their health care needs. They perform this function mainly through referrals or by assisting patients in “navigating the system.” They may also work in partnership with local clinics and health centers through subcontracting or using other modalities as a way to advance public health programs. The Miami-based Human Services Coalition is a good example, other organizations provide funding and so on.

### Hospitals

Although the institutional and social fabric of the health care safety net extends well beyond the public hospital, the general public tends to identify the public hospital as the facilitator of the health care safety net for the uninsured and the underinsured.

The ways in which hospitals function as safety net providers vary based on their specific mission and socially expected functions. Felland and her associates (2009) have noticed that public hospitals assume the safety net role “either by mission or default,” while religiously affiliated hospitals’ missions tend to include “to serve people regardless of their ability to pay for care” even though they may not focus on low-income groups.<sup>9</sup> They also notice that the emergency departments remain at the core of private for-profit hospitals’ safety net functions, although some may offer “a broader range of services to low-income people.”<sup>10</sup>

In the case of Miami-Dade County, the Jackson Health System plays a major role as a safety net provider. The Jackson System encompasses three hospitals: Jackson Memorial Hospital (centerpiece of the system), Jackson South Community Hospital, Jackson North Medical Center and several clinics, community centers and mobile health units. All Free Clinics of the county have either cooperation agreements with “the Jackson” or “el Jackson,” as it is usually called by the residents and providers, or

simply make arrangements to send patients to the emergency rooms if emergency care beyond the scope of the clinics is required.

The Jackson System which represents itself as “an academic health system with a public healthcare mission,”<sup>11</sup> is also known for its strategies to encourage preventive health care through cooperation agreements with Free Clinics and for providing medical training to students of medicine and nursing as these students provide services to some of the clinics. The Jackson Health System’s reputation as a major safety net provider stems from its long history of service to the population of Miami-Dade County, its multiple affiliations with strong academic programs, and the fact that residents of the county tend to identify it as the public hospital. The result is the widespread perception of accessibility regardless of income, at least in emergency situations. The system has grown since its origins as a few-bed hospital facility in the early 1900’s to the main employer of the county currently. It is deeply rooted in the communities that make up the county, mostly those located from the middle to the northern sections of the county, but not limited to them. Currently the Jackson System faces enormous financial challenges. Although the repercussions these challenges may have are hard to predict, it is safe to say that they may have a long-term impact on the clinics that operate under its umbrella. Jackson is also likely to change some dynamics pertaining to its functional links with other clinics as well.

There is a second major health care system in Miami-Dade County: the Baptist System. It is a private faith-based system that has been playing an increasing role in assisting local Free Clinics and other safety net providers. To a large extent it also functions as a safety net provider itself by treating the uninsured through emergency rooms, by providing volunteer physicians and services to Free Clinics in support of their efforts, and they also have charity care programs to assist the uninsured. In its mission it states: “Baptist Health is dedicated to providing high-quality, cost effective, compassionate services to all...including, as permitted by its resources, charity care to those in need.”<sup>12</sup> There are other hospitals in the county that also perform safety net functions, although those operating as part of the Jackson and the Baptist Systems stand apart because of a combination of factors that range from their resources to their multiple regular relationships with clinics and health centers in the county.

To the untrained eye, the difference between free health clinics and hospitals is more obvious than the difference between Free Clinics and other entities of the safety net, such as community health centers and retail clinics that sell medicines and services at discount rates. The following sections are meant to shed light on the specificity of Free Clinics compared to these other entities to further clarify their functions as part of the health care safety net.

## Health Centers

The health centers are known to be an umbrella group constituted by relatively small and typically underfinanced health organizations broadly defined as “community-based and patient-directed organizations that serve populations with limited access to health care.”<sup>13</sup> Patients seen at health centers tend to be “low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farmworkers, individuals and families experiencing homelessness, and those living in public housing.”<sup>14</sup>

The Department of Health and Human Services (DHHS) classifies the health centers into three subgroups:

- Grant-Supported Federally Qualified Health Centers (or the FQHCs),<sup>15</sup>
- Federally Qualified Health Center Look-Alikes<sup>16</sup>, and
- Outpatient health programs/facilities operated by tribal organizations<sup>17</sup>

The main entities that make up the first subgroup, the FQHCs, are:

- Community Health Centers which “serve a variety of underserved populations and areas.”

- Migrant Health Centers (also known as Migrant/Community Health Center) which focus on “migrant and seasonal agricultural workers.”
- Healthcare for the Homeless Programs, which “reach out to homeless individuals and families and provide primary care and substance abuse services,” and
- Public Housing Primary Care Programs, which “serve residents of public housing and are located in or adjacent to the communities they serve.”<sup>18</sup>

Prestigious New York Times columnist Bob Herbert wrote a column which he entitled “Hard to Believe!”. What was hard to believe? In a nutshell, the key role that health centers throughout the country play in addressing primary care needs. The columnist was particularly impressed by the Federally Qualified Health Centers (FQHCs):

“What is impressive is how much sense these centers make. They are nonprofit and receive federal support, but they don’t require a ton of taxpayer dollars. By focusing intently on primary care and preventive services, they save a tremendous amount of money.”<sup>19</sup>

Providing access to health care in areas heavily populated by immigrants has been a major characteristic of Community Health Centers since their origins. Data from Miami-Dade County shows that over 60% of the population is Hispanic, and more than 50% of the patients of Federally Qualified Health Centers (which serve the majority of patients of community health centers in the area) are Hispanics.<sup>20</sup>

Florida’s foreign-born population constitutes approximately 19% of the total population. In Miami-Dade County the foreign-born population is approximately 50% of the total population (over four times the national rate of approximately 13%).<sup>21</sup> Thousands of the state and county migrants are low-paid service workers and farmworkers, hence the weight that immigrants as patients represent on the heart of the health care safety net providers. In addition, the undocumented migrants also have in the safety net system their only hope to receive sustained medical care for chronic, and even contagious, diseases beyond emergency situations.

The Migrant/Community Health Centers (MHCs) are an important safety net in the state. A report posted in 2006 indicates that “farmworkers are central to Florida’s \$6.2 billion dollar agricultural industry, second only to tourism in economic importance.”<sup>22</sup> An estimated 70,000 migrant and seasonal farmworkers received the services of the state MHCs that year.<sup>23</sup>

## Free Health Clinics

The National Association of Free Clinics defines Free Clinics as follows:

Free Clinics are volunteer-based, safety net health care organizations that provide a range of medical, dental, pharmacy, and/or behavioral health services to economically disadvantaged individuals who are predominately uninsured. Free Clinics are 501(c)(3) tax-exempt organizations, or operate as a program component or affiliate of a 501(c)(3) organization. Entities that otherwise meet the above definition, but charge a nominal fee to patients, may still be considered Free Clinics provided essential services are delivered regardless of the patient’s ability to pay.<sup>24</sup>

The origins of Free Clinics in the United States is associated with the health care needs of poor individuals and families in low-income urban areas. Thus, urban residents including people living in housing projects, played a key role in the emergence of this new form of health care delivery between the late 1960’s and early 1970’s and as an identifiable health care entity.<sup>25</sup>

Like the Community Health Centers, Free Clinics enhance access to health care among individuals and families who have no access to health care through insurance programs or have very limited access. However, there are major differences between CHC/FQHC programs and Free Clinics concerning

sources of funding, regulatory bodies and types of patients, among other features. Major differences between federally-funded health centers and Free Clinics stem from the fact that Free Clinics do not receive a stream of government funding to the entities that oversee them, and the number of volunteer workers is much higher in Free Clinics.

It should be noted that Free Clinics have gradually lost control over the charges for services for in-patient care through referrals. The interviews conducted for this study suggest that it has become increasingly difficult to guarantee in-hospital services at no cost to the patients for two basic reasons.

First, even in cases in which arrangements are made to have a hospital physician provide his or her services on a voluntary basis, the services of other physicians which may be required for the whole treatment cannot be guaranteed to be free. Second, since many physicians have joined health maintenance organizations, even in cases in which the physician is willing to provide the service on a free basis, the management group may offer resistance. In the end, many uninsured patients referred to hospitals by the clinics may receive a bill from the hospital and some efforts of collection made. Sending the bills helps hospitals and other providers to have proof of unpaid claims which they can submit for partial reimbursement from government funds.

Another characteristic of Free Clinics is that they tend to operate with very small budgets. This is possible to a great extent because they tend to be volunteer-based organizations. Forty four percent of the clinics nation-wide have an operating budget of less than \$100,000 and only 5% have an operating budget of over a million dollars. The most recent estimates point to 1,200 Free Clinics nation-wide, with an estimated 4 million patients and approximately 5 million volunteers working for Free Clinics. The estimated number for 2006 was 800 Free Clinics which served 3.5 million patients.<sup>26</sup>

According to Nicole D. Lamoureux, Executive Director of the National Association of Free Clinics, eighty percent of Free Clinic patients come from households in which at least one person works full time. She estimates that number of patients will double in 2009 because of the recession.<sup>27</sup> Many American workers cannot afford health insurance, hence many patients of Free Clinics are low-income workers who sometimes work two or more jobs, but do not have the means to pay for health insurance and whose economic assets place them as part of the financially disadvantaged population.

A common characteristic of Free Clinics is the lack of a stable stream of funding. Their funding sources vary depending on the abilities of their directors and administrators to raise funds, plan fundraising, the opportunities available at a given moment, and the willingness of donors to pledge funds.

Another characteristic of Free Clinics is their social immersion in the community, which results not only from the medical services they provide and their functional links with other organizations, but also their role in assisting patients and their families to improve their overall well-being through educational programs. For example, as society gains greater consciousness about the importance of eating healthier, exercising and other forms of preventive measures, Free Clinics have taken on the role of providing services that are specifically oriented to mold social behavior. Dieticians and nutrition experts teach classes to patients and other members of the community regarding how to prepare healthy meals. Some Free Clinics provide instruction and recreational activities to the patients and their children. Thus, their social services have expanded beyond the range of medical services they offer within the clinic.

Becoming part of a more comprehensive approach to health is a feature of Free Clinics nation-wide: "... because Free Clinics are 'the medical home' of millions of patients, the majority of these clinics already incorporate the 'broad and inclusive' mission of providing not just care and treatment, but health promotion and education to promote wellness and health maintenance in the community."<sup>28</sup>

Many Free Clinics nation-wide have strong functional links with faith-based organizations, including faith-based health care organizations or tend to be faith-based clinics. Free Clinics in Miami-Dade County also display this general characteristic. Catholic, Baptist and Muslim organizations have played a pivotal role in founding most of the Free Clinics that operate in the area and in assisting them financially, with volunteers and other in-kind services.

Even though Free Clinics share some common characteristics, a remarkable characteristic since their inception as an identifiable part of the health safety net has been their diversity:

A common adage among free health clinic staff and volunteers is that ‘if you have seen one free health clinic... you have seen one free health clinic.’ In other words, despite the presence of certain traits in some Free Clinics and the presence of some general patterns, no Free Clinics are exactly alike. Free health clinics exist in all kinds of communities with different circumstances: populations who have different health problems, with varying numbers of physicians, and other health care professionals willing to participate, with more or less access to funding sources, and with staff and volunteers with a wide range of personality types, leadership styles, and visions for the clinics. Therefore each Free Clinic is configured somewhat differently.<sup>29</sup>

While the patients of Free Clinics tend to be similar in terms of basic economic characteristics, the socio-demographics of Free Clinic patients may show some variations. The age and sex distribution of the patients may vary significantly depending on which segment of the population they target or the area where they operate. The patients may be different also in terms of their immigration background, citizenship status and the languages they speak.

The predominant medical conditions of the patients may vary depending on whether the clinics have a specific medical focus or not. For example, in the area of Miami-Dade County most clinics offer family medicine. However, there is one that focuses on patients diagnosed with cancer, another focuses on children and women, and one has a strong focus on the homeless and individuals with HIV/AIDS.

Although many free health clinics are affiliated with the National Association of Free Clinics (NAFC), many throughout the country are not. While some states have their own Free Clinic umbrella associations to which free health clinics can affiliate on a voluntary basis, most states do not have such a structure yet. Only recently has the State of Florida created a state-wide association.<sup>30</sup>

The material infrastructure, including building infrastructure, the size and appearance of the facilities, medical equipment available, and professional infrastructure (e.g. the presence of a full-time physician or not, number of nurses available on a permanent or voluntary rotating basis, type of specialists accepting referrals from the clinics, etc.) varies from clinic to clinic. The background of the directors and other executive personnel of Free Clinics, tends to vary also. For example, in the case of Miami-Dade County, they range from certified physicians and professors from medical programs at a local college to individuals with no professional background in the medical field yet a long history of volunteer service and community involvement, including leaders of religious organizations.

## **Differences Between Free Clinics and Retail Clinics or “Convenient Care Clinics”**

There are other clinics in our highly fragmented system of health care that emphasize low cost, but they tend to be for-profit and even in cases in which their prices for services and medicines are significantly lower than those found in the non-subsidized (“open market”), their services do not qualify as part of “grassroots medicine.” Retail clinics or “convenient care clinics” are a case in point.

“Convenient care clinics” are defined as “niche providers” that offer “a relatively limited set of services in a manner that is cost-effective, transparent and convenient, while maintaining a strong commitment to clinical quality.”<sup>31</sup> These clinics differ substantially from Free Clinics even though they also provide venues for low-income uninsured and underinsured populations to access basic primary health care services and medicines at low prices.

A fundamental characteristic of the retail clinics is their embeddedness in large-scale, for-profit market operations that distinguish them from “grassroots health care.” They are typically operated by for-profit organizations such as specialty clinic companies or hospitals which rent space in large retail stores, such as Wal-Mart, and pharmacy chains, and most of them accept insurance. Another substantial difference with respect to the free health clinics refers to the areas in which they tend to be located. Free Clinics tend to be located in areas where medically underserved populations constitute either the demographic majority or a very large segment of the total population. However, a recent study on retail

clinics shows that only a small fraction of the more than the 930 units studied were located in medically underserved areas.<sup>32</sup> Free Clinics tend to focus on underinsured patients with very low income, while both insured and uninsured people of different socioeconomic backgrounds use the retail clinics.

## **1.2. Safety Net Providers in Miami-Dade County**

Chart 1 shows a sample of the safety net providers in Miami-Dade County.<sup>33</sup> For analytical purposes they have been divided into: 1) those that are part of the public health system, 2) Federally Qualified Health Centers, 3) Free Clinics, and 4) mobile health units that offer some kind of health services. In everyday life, however, many of these entities are interrelated either through direct affiliation and multiple functional links or through some loose bureaucratic links. In addition, there are hospitals and other entities that perform safety net functions. They are not included in the chart because the chart is intended to reflect a comprehensive sample of the most established organizations and entities within each category. Special mention is needed for the Baptist Health System which plays a strategic role in supporting some of the Free Clinics of the county, in addition to performing some safety net functions. This issue is discussed later in this report.

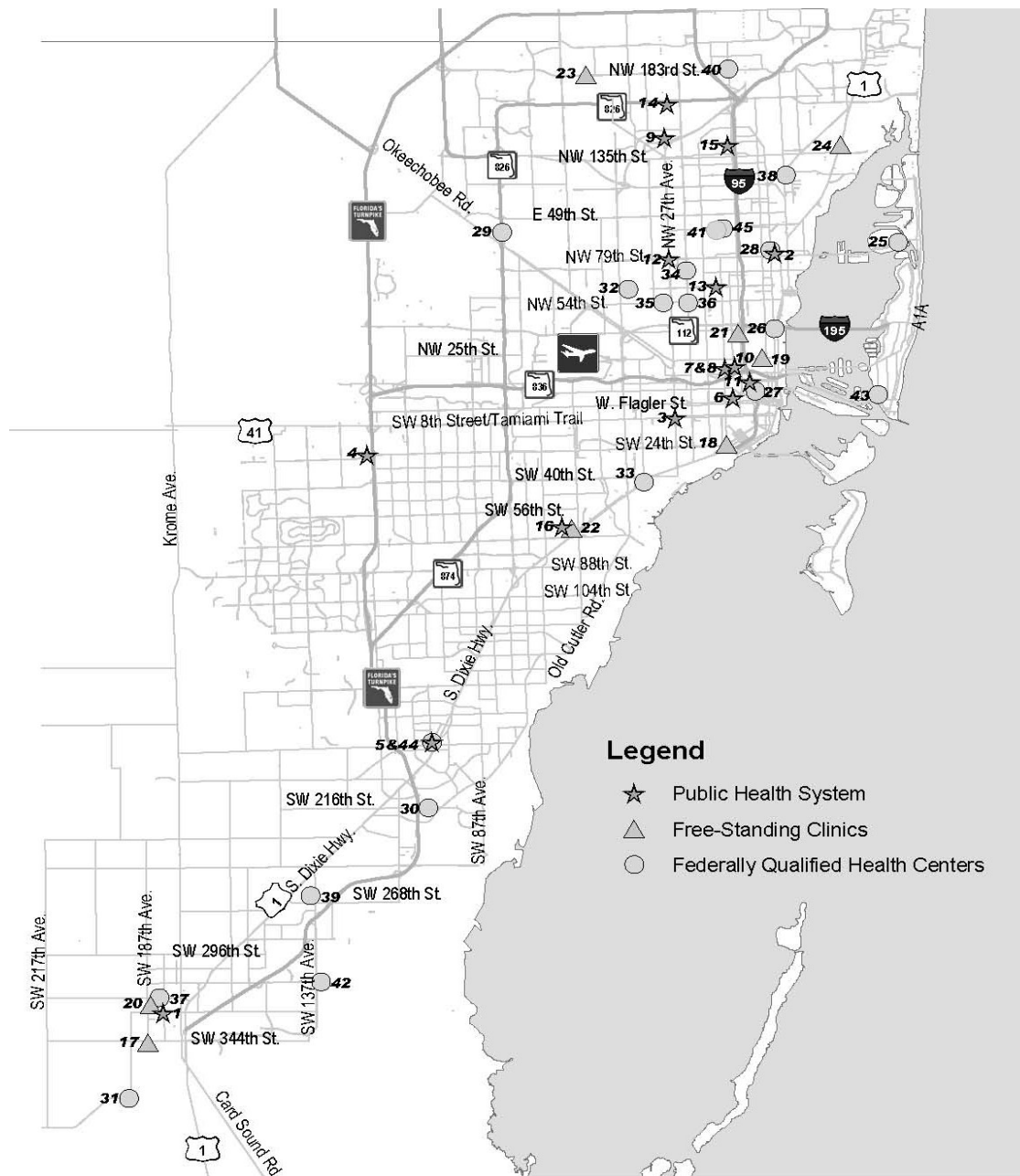
# CHART 1: COMPREHENSIVE SAMPLE OF THE SAFETY NET PROVIDERS IN MIAMI-DADE COUNTY

PUBLIC HEALTH SYSTEM	FREE CLINICS	MOBILE HEALTH UNITS
<p><b>Miami-Dade County Health Department</b></p> <ol style="list-style-type: none"> <li>Florida/Homestead Neighborhood Center</li> <li>Little Haiti Health Center</li> <li>Refugee Health Assessment Clinic</li> <li>West Dade Family Planning Clinic</li> <li>West Perrine Health Center</li> </ol>	<ol style="list-style-type: none"> <li>Good News Care Center<sup>2</sup></li> <li>The League Against Cancer<sup>2</sup></li> <li>Miami Rescue Mission Medical Clinic<sup>2</sup></li> <li>Open Doors Health Center<sup>2</sup></li> </ol>	<ol style="list-style-type: none"> <li>Borinquen Mobile Care Unit</li> <li>Care Resources HIV/AIDS</li> <li>Community Partnership for Homeless Dental Mobile Unit</li> <li>Empower U HIV/AIDS</li> <li>Good Samaritan Community Health, Inc.<sup>3</sup></li> <li>Jackson Health System Jackson Care-A-Van</li> <li>Jackson Health System Mobile Mammography Van</li> <li>Miami-Dade County Health Department Dental Van</li> <li>Miami-Dade County Health Department MoMmobile</li> <li>Miami Children's Hospital Health on Wheels</li> <li>North Miami Beach Medical Center, Inc. North Miami Beach Mobile Unit<sup>3</sup></li> <li>University of Miami Pediatrics</li> </ol>
<p><b>Jackson Health System</b></p> <ol style="list-style-type: none"> <li>Dr. Rafael A. Penalver Clinic<sup>1</sup></li> <li>Jackson Memorial Hospital</li> <li>Jackson Memorial Hospital Ambulatory Care Center</li> <li>Jackson North Specialty and Diagnostic Center</li> <li>Jackson Memorial Mental Health Center</li> <li>Jefferson Reaves, Sr. Health Center<sup>1</sup></li> <li>Juanita Mann Health Center</li> <li>Liberty City Health Services Center</li> <li>North Dade Health Center (Opa Locka)<sup>1</sup></li> <li>North Miami Health Center (Miami)</li> <li>Rosie Lee Wesley Health Center (Miami)</li> </ol>	<ol style="list-style-type: none"> <li>St. John Bosco Clinic<sup>2</sup></li> <li>South Miami Children's Clinic<sup>2</sup></li> <li>Universal Heritage Institute Medical Clinic<sup>3</sup></li> <li>North Miami Beach Medical Center, Inc. Urban Mercy Clinic<sup>3</sup></li> </ol>	
<b>FEDERALLY QUALIFIED HEALTH CENTERS</b>		
<ol style="list-style-type: none"> <li>Beverly Press Center (MBCHC)</li> <li>Borinquen Health Care Center<sup>1</sup></li> <li>Camillus Health Concern<sup>1</sup></li> <li>Center for Haitian Studies (MBCHC)</li> <li>Citrus Health Network</li> <li>Doris Ison Health Center (CHI)<sup>1</sup></li> <li>Everglades Health Center (CHI)<sup>1</sup></li> <li>Flamingo Medical Center (JTCCCH)</li> <li>Helen B. Bentley Family Health Center<sup>1</sup></li> <li>James E. Scott Center (JTCCCH)</li> <li>Jefferson Reaves Women's Residential (JTCCCH)</li> <li>Jessie Trice Center for Community Health (JTCCCH)<sup>1</sup></li> <li>Martin Luther King Jr. - Clinica Campesina (CHI)<sup>1</sup></li> <li>Miami Beach Community Health Center at North Miami (MBCHC)</li> <li>Naranja Health Center (CHI)<sup>1</sup></li> <li>Norland Family Health Center (JTCCCH)<sup>1</sup></li> <li>North Medical Center (JTCCCH)</li> <li>South Dade Health Center (CHI)<sup>1</sup></li> <li>Stanley C. Myers Center (MBCHC)</li> <li>West Perrine Health Center (CHI)<sup>1</sup></li> <li>Women's Center at NorthShore Hospital (JTCCCH)</li> </ol> <p><b>MBCHC: Miami Beach Community Health Center JTCCCH: Jessie Trice Center for Community Health CHI: Community Health of South Dade</b></p>		

1. Offer oral health services either as specialization or as part of the services provided; 2. Services offered at no cost (primary care, some specialty care through volunteer physicians); 3. Primary care offered at no cost to patients.

Map 1 shows the location of the safety net providers represented in Chart 1 with the exception of the mobile units. The map shows that, as expected, most safety net providers are concentrated in the most populous areas of the county (from the upper-middle section to the northern part). It shows that only two free non-mobile clinics operate in the south and that they are very close to each other. Although there are other safety net providers in the area, based on data that is discussed below, the south may require at least an additional Free Clinic in the near future or the expansion of the capabilities of existing ones, including perhaps their operation through mobile units as well, to be able to reach more families. A similar conclusion may apply to the central area of the northern section of the county.

**Map 1**  
**Miami-Dade County: Safety-Net Providers\***  
 \*Does not include free mobile clinics



The network of supporters of the core safety net providers (see definition in Chapter 1), among which we find the free health clinics, extends well beyond health care providers to include a numerous and diverse group of private and public organizations and agencies that provide funding, in kind assistance, sustained cooperation, and other forms of support. This supporting network is vital for the survival and development of the safety net providers in Miami-Dade County.

**Part II**  
**Free Clinics in Miami-Dade County**

## 2.1. Introducing the Free Clinics of the County

The study leading to this report focused on 8 Free Clinics (almost the entire universe of the clinics of the county). Seven operate from permanent locations and one is a mobile clinic. The non-mobile Free Clinics are:

- The League Against Cancer (La Liga Contra El Cancer), founded in 1975.
- St. John Bosco Clinic (San Juan Bosco Clinic), founded in 1992.
- Good News Care Center, founded in 1996.
- Open Door Health Center, founded in 2001.
- South Miami Children's Clinic, founded in 2007.
- Universal Heritage Institute Medical Clinic, founded in 2008.
- Miami Rescue Mission Medical Clinic, founded in 2009.

In addition, Good Samaritan Community Health Inc., a mobile Free Clinic, was also included as part of the study to contrast the above-mentioned. It should be noted that the clinic Good Samaritan is a mobile unit in Miami-Dade County, but it has a permanent facility in Monroe County.

The saying that is typically used when people refer to Free Clinics: "If you have seen one Free Clinic; you have seen one Free Clinic," applies to those operating in Miami-Dade County. Certainly, the free health clinics of the county tend to be very different in many respects; from the motivations or rationales leading to their inauguration, to the backgrounds of the founders, backgrounds and characteristics of the directors, the physical structures from which they operate, their service focus, number of physicians providing on-site care, and the clinics' referral networks. Even the patients who tend to share some basic characteristics (such as being people of few economic means who are uninsured) vary in several respects.

The following summaries of the clinics included in this study illustrate some of their similarities and differences.<sup>34</sup>

***The League Against Cancer*** known locally as ***La Liga Contra el Cancer (La Liga)*** was founded in 1975. Its origins can be traced to a similar organization founded in Havana, Cuba which started treating cancer patients in 1925. The first waves of Cuban exiles to Miami starting in 1959 included many physicians, for whom inaugurating La Liga and volunteering for it was a way of honoring their country's long-term tradition of volunteer services and compassionate care in the medical field. The clinic focuses exclusively on patients who have been diagnosed with cancer.

Located in an area called The Roads in the City of Miami, La Liga operates from a building that is centrally located on Coral Way, close to Downtown Miami, and also close to Calle Ocho at the heart of Little Havana. It has a small waiting room and three examination rooms, in addition to a room in which chemotherapy is administered. Fifteen patients can be seen in that room simultaneously and several members of the medical staff provide their services and watch the patients as the treatment is administered. The clinic has several offices for the administrative staff. All the physicians, including Mr. Luis Villa, M.D., the President of the clinic and a renowned physician himself, are volunteers. Adriana Cora, the Executive Vice President is a volunteer as well. Ady Viera, a long-term volunteer at the clinic and other medical facilities in the area carries four pins on the lapel of her uniform; two were given to her because she was the President of Mercy Hospital Auxiliary in two terms, the others were given for the years of volunteer services. One of the pins reads 13,500 hours, when asked what motivated her devotion, she kindly said: God.

A walk-through of the clinic showed the human face of this venerable institution of Miami-Dade County. The patients had cancer and a difficult, if not desperate, economic situation. However, at least in one respect they were fortunate. They were treated with the most advanced technologies, by a group of physicians and other medical personnel who were well-trained, some even stellar in their profession, but who were also exceptional in their humane approach to patients who had only appreciation to offer in return.

The clinic has a strong corporatist flavor. Luis Villa, M.D. along with several professional and executive personnel are key players in the clinic; each one with a high-profile specific function to perform. For example, Adriana Cora, the Executive Vice-President, César Scheker, the Administrator, and Mary Pujols, the Director of the clinic, all have specific functions concerning day-to-day operations, from case management to outreach. The media, which was never mentioned in the interviews with the other Free Clinics as a fundraising vehicle, is a key fundraising vehicle for La Liga. Among the other Free Clinics there was only one director who commented on the media potential for fundraising and what was mentioned, was that the feature articles they have had in the media tended to attract people who want to send patients instead of donors. In sharp contrast, the media, particularly the telethon, has historically been a key fundraising vehicle for La Liga. Certainly, the clinic is famous to a large extent for its fundraising telethon, which typically features actors and actresses, singers, bands, and celebrities. The most recent one held in June 2009, yielded over \$4.5 million in pledges.

La Liga is a very prestigious institution in Miami-Dade County and beyond. That prestige is directly linked to the way it works and also its specialty. Given the devastating impact cancer has on many families and the high cost associated with the treatment of the illness, many individuals from different walks of life find it commendable to have such an institution devoted to provide free care to people from the lower echelons of the social pyramid.

La Liga has more than 300 volunteer physicians and a number of professionals in the medical field as frequent collaborators. In addition, it has cooperation agreements with local health care organizations, including Jackson Health System. It has a long list of sponsors starting with the State of Florida Department of Health, Miami-Dade County Department of Health, the Fundación Roca-Rubal, the Public Health Trust, and businesses with established brands, such as Sazón Goya / Goya Foods of Florida, Procter & Gamble, Winn-Dixie Supermarket Charities, and Ocean Bank, to mention a few. Many individuals contribute to the league with the amount they can: from five dollars to thousands depending on their resources. The clinic supports health fairs and participates in educational programs in partnership with several institutions, mainly to increase awareness about breast cancer. It also has programs to provide assistance to the children of patients and other family members in special circumstances. Despite the fact that La Liga has proven to be a stable institution, it is currently feeling the economic impact of the recession. According to the Administrator, donations have shrunk since the beginning of the recession which is true not only in the case of many individual donors but corporate donors as well.

**St. John Bosco Clinic** known locally as **San Juan Bosco Clinic (SJB Clinic)** was inaugurated in 1992 as a partnership between Mercy Hospital, the Catholic Hospital of Miami-Dade County, and the San Juan Bosco Parish. Since its inception, the clinic has been particularly effective in assisting uninsured immigrants with their medical needs. Today, it reports that approximately 85% of the patients are immigrants, mainly Hispanics from the areas of Little Havana and Allapattah, whom receive care at the clinic under the mantra “diferentes nacionalidades, diferentes culturas, pero las mismas necesidades” [“different national origins, different cultures, but the same needs”].<sup>35</sup> Sister Edith González, Vice President of Mission Integration at Mercy Hospital, oversees the clinic. She explained during the interview that the mission of assisting immigrants remains at the core of their efforts, although since the number of uninsured people from different backgrounds has dramatically increased, the clinic is approaching their needs as innovatively as possible.

Several prominent Cuban Americans have been recognized as influential people who raised funds and pulled the strings to make the dream of the clinic possible. Among them, Manolo de Jesús Reyes, a Mercy Hospital Executive, Father Emilio Vallina, a prominent religious leader, and Pedro José Greer Jr., M.D., known as “the doctor of the homeless” for his devotion to assist the homeless since the beginning of his career. Dr. Greer, who was recently awarded the highest civilian honor conferred by the U.S. government, the Presidential Medal of Freedom, continues to support the clinic as the Medical Director. The clinic is located in a renovated building that had previously hosted the San Juan Bosco Parish, in the area of Allapattah. It has three spacious examination rooms, several offices and a spacious waiting room. During the walk-through, Betty Leguisamon, the clinic’s Dominican-origin Supervisor, explained that they had recently installed a system of electronic medical records. The clinic also offers patient education, with a focus on prevention and treatment of diabetes. Staff and volunteers assist with

educational programs, including advanced nurse practitioner Maria Elena Torres, who plays a key role in the diabetes program.

SJB Clinic has cooperation agreements or fluid relationships with several organizations and several funding agencies have supported the clinic. Jackson Health System and academic institutions, such as Miller School of Medicine, University of Miami, which through the Mercy Foundation facilitates the participation of medical students in the clinic, are cases in point. Residents from the School of Medicine go an evening every week, and that evening is also used to offer specialty care on a rotating basis. Mercy Hospital of Miami and several organizations and private foundations have provided funding to assist SJB Clinic, among them: American Cancer Society, Susan G. Komen Breast Cancer Foundation, Florida Department of Health, American Heart Association, Allegany Franciscan Ministries, Deering Foundation, Dr. John T. MacDonald Foundation, Blue Foundation for a Healthy Florida and Jessie Ball Dupont Foundation, among others.

**Good News Care Center** is located in Florida City, close to agricultural areas in the southern parts of the county. It is one of two Free Clinics in the study located in a semi-rural area where anecdotal evidence suggests a large proportion of the population is currently uninsured or underinsured. Many of the residents of the area are immigrant workers, including farmworkers and so are the patients of the clinic.

The clinic founded in 1996 by Rev. Michael Daily, a local religious leader of the Baptist Church, is also a faith-based clinic owned in this case by Miami Baptist Association. The imprint of Rev. Daily's wife, Mrs. Ana Daily, a highly motivated immigrant from Brazil who works at the clinic full-time and is in charge of coordinating the day-to-day operations on-site, makes a difference in the way the clinic is run. The central role Mr. and Mrs. Daily play in running the clinic in its day-to-day operations confers a distinctive flavor to Good News when compared with other clinics that are run in a more corporatist style.

One of the volunteer physicians at Good News, Leslie Polland, M.D., has received the most recent "Volunteer Physician of the Year" award granted by the Miami-Dade County Health Department. In appreciation for the award, Dr. Polland mentioned something that other physicians and some of the directors of the clinics always emphasized in the interviews: their disposition to go beyond medical treatment, the importance of understanding the patient's emotional needs and his/her social and family contexts to be able to assist them: "I don't only help people with their health issues; I also help them with emotional issues. I've seen people that come into the center abused, with mental traumas and depression, and come out revitalized, not only physically but mentally."<sup>36</sup>

The clinic operates in a small bungalow on the grounds of the First Baptist Church. It has two examination rooms, a small eat-in kitchen where the workers tend to have their lunch, and a room full of medicines, which the clinic provides free of charge or at very low cost to the patients. The links of the clinic to the community are extensive, which to a large extent can be explained by Rev. Daily's commitment to the community. He can be seen in a nearby government office giving a donation of school supplies to be distributed to a long line of people with modest economic means who anxiously wait to receive the supplies, or coordinating a talk on how to "cook smart" and "eat smart" in a community center within an immigrant camp.

Free Clinics depend on a large number of individuals and institutions to operate, many of whom offer their time and efforts on a voluntary basis and Good News is no exception. However, from the observations from the fieldwork comes the conclusion that the personalities, professional background, religious background, and/or entrepreneurial spirit of the directors or main leaders of the clinics—who may adopt different titles: president, director, CEO, administrator, etc.—are key factors accounting for the direction the clinic takes in terms of services, and the extent and peculiarities of its social embeddedness.<sup>37</sup> In this case, the social embeddedness of the clinic attests to both the engaging entrepreneurial ways and the religious/social activism of its CEO, Rev. Daily, although the links of the clinic transcend Baptist religious organizations.

The organizations and groups related to Good News Care Center either as supporters of the clinic through grants and donations or as collaborators in different projects include: Miami Baptist Association, Baptist Health South Florida, University of Miami Mobile Pediatric Clinic, Sembrando Flores Community,

an agency that provides services to migrant farm laborers, and also functions as an official AIDS testing and referral site for the Miami-Dade County Health Department, Dade Community Foundation, a local private foundation that assists local clinics by matching multiple donor resources with appropriate non-profit agency projects, the Health Foundation of South Florida, a private philanthropic foundation which plays a key role as a major donor of several Free Clinics, Miami-Dade Health Action Network, Nova Southeastern University, Miami-Dade County Health Department, MUJER (an organization that supports women especially Latinas), North American Mission Board of the Southern Baptist Convention (NAMB), the Immigration and Refugee Program of Church World Service, and the Allegany Franciscan Foundation, among others.

**Open Door Health Center** was founded in 2001. The clinic is hosted in a large one-story building on a large piece of land with subsidized rent from Habitat for Humanity. It is in a semi-rural area of Homestead, in the southern-most region of the county, near the last exit of the Florida Turnpike on the way to the Florida Keys. It is also near Good News Care Center.

It has a spacious entrance with the registration desk on the right. The entrance leads to a long hall that leads to a private waiting room, staff offices, and other areas. In addition to the examination rooms, it has a well-equipped spacious kitchen where the patients and other members of the community take classes to improve their eating habits and their nutrition. It also has an entertaining room with musical instruments and several tables, which are used for educational and recreational activities that the clinic organizes for the patients, their families and friends.

During the visit to the clinic, Mariela Pérez, M.D., a full-time physician at Open Door, pointed to an agricultural area that is right across from the clinic. She mentioned that they are located right across from a large field where immigrant laborers work, which provides some comfort to the workers, many of them uninsured, who sense that they are not on their own if they have a medical emergency while working. Approximately 50% of the patients are immigrants, including many agricultural workers.

The long distance that separates the clinic from the most populous nuclei of the county, where most safety net providers are located, does not prevent it from having an extensive network of supporters and collaborators throughout the county and beyond. The social immersion of Open Door through multiple partnerships is due largely to the commitment of Nilda Soto, M.D., a physician by training, and Director of the clinic. She devotes her professional and social skills to serve individuals and families who have very limited economic means. During the interview with Dr. Soto, it was clear that her top priority is to provide high-quality medical services to the patients. She follows a motto that was explicitly brought to my attention by the directors of other clinics: the fact that it is free does not mean that it is low-quality. Dr. Soto's commitment to the clinic and quality care has facilitated access to an array of organizations and individuals from the most varied walks of life; from large medical organizations to various academic institutions, religious organizations and secular ones, private and public.

The organizations, individuals and groups related to Open Door either as collaborators in mutually beneficial projects or as supporters of the clinic through grants and donations include but are not limited to: The Miami-Dade County Human Services Coalition, the American Medical Association Foundation, the Avon Foundation Breast Care Fund, Baptist Health South Florida, Robert Wood Johnson Foundation, ASPIRA SOUTH, Miami-Dade County Health Department, University of Miami Miller School of Medicine, Health Foundation of South Florida, Dr. John T. MacDonald Foundation, Les & Sheri Biller Family Foundation, Community Volunteering Physicians from Baptist Health, Barry University, School of Graduate Medical Sciences, Miami-Dade AHEC, Inc, United Way of Miami-Dade, The Allstate Foundation, Peacock Foundation, Susan G. Komen For The Cure, Miami-Fort Lauderdale Affiliate, Baptist Health Outreach Program, El Buen Samaritano Nazarene Church, Florida International University, Health Council of South Florida, Inc., Homestead Baptist Church, Homestead Haitian Baptist Church, MUJER, San Juan Neumann's Catholic Church, South Florida Family Practice Group, U.S. Medical Supply, and We Care of South Dade.

**South Miami Children's Clinic.** Founded in 2007, the clinic is located in the city of South Miami, in a neighborhood with housing projects and relatively low value housing units, in which a large number of the residents are African American. The neighborhood is right across from the main campus of the University of Miami, which is located in the affluent area of Coral Gables. Just a street, 57<sup>th</sup> Avenue,

separates the neighborhood with housing projects, from the private university.

Wayne Brackin, the COO of Baptist Health System of South Florida, was the force behind the foundation of *South Miami Children's* in terms of initiative and ability to have the clinic inaugurated. Mr. Brackin, while bringing his own children to a nearby community center, the Bethel Gibson Community Center, noticed that there was a one-story building right on the grounds, very close to the housing projects that would need renovation but had potential to host a clinic. Aware of the need for a clinic in the area to assist the medical needs of children who live in precarious social conditions, the building in question eventually became the South Miami Children's Clinic. The renovation of the structure was funded by philanthropists Jim and Susan Carr and The Lennar Foundation. Thus, the clinic is on the grounds of the Bethel Gibson Community Center, and the building is owned by the City of South Miami which charges \$1 per year to the clinic for rent.

Tina Scott, M.D., a physician and Director of the clinic, explains that South Miami Children's Clinic offers many of the uninsured residents of the neighborhood a place where they can address specific needs concerning children and parents, in an environment that they find comfortable in terms of specialization and cultural sensitivity. The clinic also has a geographical focus that Free Clinics of the county usually do not have. The agreement with the City of South Miami, when the clinic opened, was that it would only see residents of South Miami who qualify for care. By focusing on children, the clinic deals with family medicine. Dr. Scott, a pediatrician by training, explains that it is hard to deal with the problems that children of the area confront without dealing with family issues, including the sexual behavior of the parents. Thus, she has developed a holistic approach to medicine that includes long hours of personalized counseling devoted to the most problematic cases. In some cases, she has even used her own time and resources to locate resources such as scholarships and boarding schools for college-age women who lack high school diplomas or can barely read or write.

South Miami Children's Clinic has three spacious examination rooms and a waiting room tastefully decorated. In the words of Dr. Scott: "The vision of the South Miami Children's Clinic was to create a clinic that would not only cater to the underserved but be aesthetically pleasing to the patients and everyone. This meant nice furniture, colorful kid-friendly décor, and state of the art equipment."<sup>38</sup> She explains that thanks to a donation from a medical records company, the clinic was given the hardware and software that was necessary to keep electronic medical records.

Even though the clinic opened recently, it has developed important collaborative agreements with other organizations. For example, Strong Women Strong Girls— an organization funded by Americorps that provides mentoring for girls— mentors girls in 3<sup>rd</sup> through 5<sup>th</sup> grade at the clinic, Vaccines for Children— which provides free vaccines to patients who are uninsured, underinsured, and other groups, is collaborating with the clinic as well. The clinic also has an agreement with Jack and Jill of America, South Miami Chapter, led to the funding of a reading program that the clinic offers to improve literacy, MedAppz, an online medical record company provides free electronic medical records to the clinic, and South Miami Hospital and Baptist Children's Hospital also provide in-kind donations.

***Universal Heritage Institute Medical Clinic*** was founded in the northern-most part of the county in 2008, by immigrants from Pakistan who are mostly professionals and/or business owners. Thirty physicians and nurses providing their services to the patients of the clinics, most of them on a voluntary basis, are Pakistani. The clinic operates from a shopping strip in Carol City. The would-be founders realized that the area lacked a medical facility for a segment of the population who was medically underserved. In addition, a clinic run by Pakistani professionals would also benefit a segment of the population in the area that has specific immigrant characteristics, such as speaking Urdu (a language spoken in Pakistan and India) as their mother tongue and coming from religious and cultural backgrounds in general that are familiar to the Pakistani physicians. Sixty percent of the clinic's patients are immigrants, most of them Asians, however patients also include Hispanics and other groups.

The clinic is affiliated with The Universal Heritage Institute, Inc. a non-profit organization founded in 1989, that is introduced by its members as "a Muslim community outreach organization engaged primarily in interfaith and intercultural dialogue, media relations and activities that promote friendship, tolerance and understanding among and with the diverse members of South Florida's community."<sup>39</sup> Members of the Universal Heritage Institute regard the clinic (Universal Heritage Institute Medical Clinic)

as “the most ambitious out-reach project to date... a free primary care clinic to serve our less fortunate, uninsured and indigent neighbors.”<sup>40</sup>

There have been several faith-based clinics throughout the history of Miami-Dade County, including the ones that operate currently. However, this is perhaps the first Free Clinic inaugurated by members of the Muslim community in the area. The umbrella organization out of which the clinic sprang specifies: “The clinic is funded primarily by contributions and the volunteer efforts of South Florida Muslims and friends and we welcome all donors and volunteers to lend a helping hand.”<sup>41</sup> Since the clinic has been operating for barely a year, Mr. Sadrul Fasihi, the Clinic Coordinator explains, it does not have much community immersion yet. They are currently developing outreach programs extend their links into the community and are seeking advice from local organizations, including the Health Council of South Florida.

***Miami Rescue Mission Medical Clinic*** was founded in 2009, through a partnership of Miami Rescue Mission, Miami Dade College Medical Center Campus, Miami-Dade Area Health Education Center (AHEC) Program, and MDC Center for Community Involvement. The Boston Scientific Foundation and the Michael Capponi Group were the main donors. Peter Gutierrez, M.D., physician by training and Annette Gibson, a professor at Miami Dade College, were instrumental in the inauguration of the clinic.

The clinic is located in the area of Overtown, an economically depressed area of the city close to Downtown Miami. The area has a relatively high concentration of housing projects and other publicly subsidized housing. The clinic focuses on the homeless, and families and residents of the area, including those who have substance abuse problems and HIV. The residents of the community are predominantly African Americans, so most patients tend to be African Americans, Hispanics constitute the second major group. The clinic provides on-site practice to physician assistant students from Miami Dade College and medical students from Ross University in Dominica. The clinic is staffed mainly by PA-CS from the School of Health Sciences at Miami Dade College.

Although the clinic is new, one of the organizations from which it sprang, Miami Rescue Mission, which has the following motto on their website: “reaching out to the least, the last and the lost of our community to inspire hope with human compassion and the love of God,”<sup>42</sup> has been functioning in Miami since 1922 and focuses on providing social services, food and shelter to the homeless, among other economically marginalized groups. They have already established cooperation agreements with other entities, such as Meridian Laboratories.

## **2.2. The Social Immersion of Free Clinics**

As seen before, complex functional links and social networks tend to link the Free Clinics of Miami-Dade County with other institutions and health care organizations, groups and individuals. This is a characteristic shared by most of the clinics studied. Arguably, the community rooting of the Free Clinics in Miami-Dade County results from the synergy of two complementary forces.

First, Free Clinics increasingly provide services that are based on a more sophisticated understanding of health that includes health as overall well-being. The World Health Organization’s definition of health as overall well-being and not merely absence of disease— “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”<sup>43</sup> —has been around for several decades. However, it was only relatively recently that this notion has become more popular among people of different walks of life. The importance of good nutrition, exercising, stress reduction and similar strategies to improve an individual’s well-being are being emphasized by both health care providers and the media more systematically. This social environment has led to the involvement of Free Clinics in different programs concerning preventive health that go beyond medical treatment. In the case of Miami-Dade County, the clinics offer an array of programs from which the patients and their families can benefit. Clinic programs can include recreational and educational activities for the patients and their families, such as classes covering nutrition and dieting, or guidance to keep a family environment safe from violence, programs to improve the literacy, sexual education, programs to eliminate addictions, mentorship of the youth, or even assisting immigrants and their families mitigate the psychological hardships associated with their transition, among others. Thus, while providing primary care, and while opening the doors for specialty care, and even highly specialized care as in the case of one of the clinics

studied, the clinics of the county also perform vital social functions in the communities in which they are immersed.

Second, the medical and economic viability of Free Clinics depends greatly on the ability of their executive personnel to attract collaborators, develop programs, get funding and similar activities. All this also requires a skillful immersion in the community through the forging of extensive and durable social networks and functional links. Thus, both the provision of health care services and other services following the most modern vision of what health and preventive care entail, and the specific ways in which Free Clinics operate institutionally, including the specific ways in which they tend to access funds, services, medicines, etc., presupposes the social embeddedness of the Free Clinics of Miami-Dade County, within and beyond the neighborhoods from which they operate.

### **2.3. Characteristics of Free Clinics of the County in a Comparative Perspective**

Tables Q-1 to Q-6 offer summaries of the results generated from a questionnaire applied to the Free Clinics that participated in the study. Table Q-1 displays the years in which they were founded, who the founders were and their budgets by range.

The following characteristics are worth highlighting:

- Most clinics have been functioning for less than a decade. Only one Free Clinic has survived since the 1970's and two have been open since the 1990's. This pattern may indicate that Free Clinics do not tend to last many years. Interviews with officials from the Health Department and other entities corroborated that some clinics of the county have closed their doors throughout the years. Furthermore, these interviews and the interviews at the Free Clinics suggest that some of the ones currently operating are facing financial constraints that may be jeopardizing their economic viability (an issue that is dealt with in greater detail below). Four out of the eight clinics studied opened between 2007 and 2009. This has been the result of several factors, many of which preceded the current recession; from immigration trends, to the worsening of the economic situation for many individuals and families in the county, and other factors. The recession may have functioned as incentive to finally open them but inaugurating a Free Clinic is a process that often takes years of planning.
- The longer the period of time functioning, the larger the budgets. The clinic with the highest operating budget (over \$5 million) is The League Against Cancer, which has been opened since 1975. The clinics that opened between 2007 and 2009 have the lowest operating budgets (less than \$500,000), while those that opened between the early 1990's and the year 2000 have budgets that range between \$500,000 and \$1 million. This pattern makes sense because the chances of getting more funding pledged from various entities or individuals increases as the clinic becomes known and develops a reputation for its services, and as the owners and other people in management get to know the donors and develop effective networks. The clinics that are not able to develop this synergy may be forced to close before a decade.
- Another observation shown in Table Q-1 is the diversity of Free Clinics in terms of who the founders were. In the cases of La Liga and Open Door, they had multiple founders and no clear-cut faith-based affiliation. However, La Liga shares with Universal Heritage Institute Medical Clinic (UHIMC) the characteristic of having been founded mainly by several immigrant professionals and entrepreneurs from the same group (Cubans and Pakistanis respectively), even though UHIMC sprang out of a faith-based organization which is not the case of La Liga.

In some cases they can be described as faith-based clinics due to their close institutional links with a particular religious organization, in other cases the links with religion are looser or the religious organizations do not tend to be so influential from the institutional perspective. For example, the links between SJB Clinic and the San Juan Bosco Parish and the Order of Malta, between Good News Care Center and the Baptist Church, between Universal Heritage Institute Medical Clinic and Universal Heritage Institute Inc., and between Good Samaritan Health Clinic and the Kendall Brazilian Church, to which the director of Good Samaritan, Robert Neri is affiliated as Pastor, indicate that these are

faith-based clinics. The Catholic Church may be influential in La Liga if only because Catholicism may be the predominant faith among the physicians and other volunteers with a Cuban Catholic background. However, La Liga is not a faith-based clinic. The Baptist religious system has played a key role as supporter of Open Door and South Miami Children’s Clinic, however, these are not faith-based clinics either. It should be noted, however, that in all the clinics included in this study, religion plays a role in inducing voluntarism and a charitable approach to service.

**Table Q-1. Free Clinics in Miami-Dade County: General Characteristics**

<b>Name of Clinic</b>	<b>Year Founded</b>	<b>Founded by</b>	<b>Operating Budget</b>
The League Against Cancer	1975	Individuals and physicians from the community	Over \$5,000,000
St. John Bosco Clinic	1992	Mercy Hospital and San Juan Bosco Church*	Between \$500,000 and \$1,000,000
Good News Care Center	1996	Rev. Michael Daily through Miami Baptist Association	Between \$500,000 and \$1,000,000
Open Door Health Center	2001	Multiple groups Non-profit Baptist Health South Florida Health Foundation of South Florida Faith groups, academia (including Miami-Dade AHEC), volunteers	Between \$500,000 and \$1,000,000
South Miami Children's Clinic	2007	Mr. D. Wayne Brackin (COO Baptist Health South Florida System)	Less than \$500,000
Good Samaritan Health Clinic**	2007	Kendall Brazilian Church	Less than \$500,000
Universal Heritage Institute Medical Clinic (UHIMC)	2008	Pakistani professionals and other community members	Less than \$500,000
Miami Rescue Mission Medical Clinic	2009	Private foundation, private social services/ human organization, private donor, corporate foundation.	Less than \$500,000

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\*See main text for the names of people who played a key role during n the foundation of the clinic. \*\*Mobile clinic

Table Q-2 provides information about the days and hours of operation for each clinic. Most clinics open 5 days a week. One opens 6 days (Open Door Health Center), and one just two days (UHIMC). Not all the clinics use all this time to see patients, sometimes the clinics close one day or half day and use that time to catch up with the paperwork and other administrative issues. However, for the most part Free Clinics of the county guarantee services to the patients throughout the week.

**Table Q-2 Free Clinics in Miami-Dade County: Days Opened\***

Clinic	Days and Times Opened
The League Against Cancer	Monday to Friday - 9:00 am to 5:00 pm
St. John Bosco Clinic	Monday to Friday - 8:00 am to 4:30 pm
Good News Care Center	Tuesday to Friday - 8:30 am to 5:00 pm Saturday - 8:30 am to 2:00 pm
Open Door Health Center	Monday - 9:00 am to 8:00 pm Tuesday to Friday - 9:00 am to 5:00 pm Saturday - 8:00 am to 12:00 pm
South Miami Children's Clinic	Monday, Tuesday, Thursday and Friday - 9:00 am to 3:00 pm Wednesday - 3:00 pm to 7:00 pm
Good Samaritan Health Clinic**	Tuesday and Friday - 10:00 am to 4:00 pm Tuesday and Friday - 4:00 pm to 10:00 pm
Universal Heritage Institute Medical Clinic	Friday - 3:00 pm to 6:00 pm Saturday - 10:00 am to 2:00 pm
Miami Rescue Mission Medical Clinic	Monday to Friday - 9:00 am to 5:00 pm

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\* Not in all cases the hours coincide with the hours of direct service to patients. Sometimes clinics use a day or session to administrative work. Lunch time is included. \*\* Mobile services.

Table Q-3 refers to specialization of the clinics and the specialties they consider to be the most difficult in terms of referrals.

- Only one clinic is highly specialized in terms of medical treatment, in this case cancer treatment. And only two clinics, Miami Rescue Clinic and Miami Children's Clinic tend to target certain groups. The first focuses on the homeless and substance abuse patients; the second on children and to a large extent their parents, particularly their mothers since many of them are single parents. The other clinics tend to provide both primary care and specialty care to both children and adults without a particular focus, either medically or in terms of demographics. The number and types of specialties available on-site vary significantly across clinics.
- Urologists are the most difficult to find as volunteers for specialty care in Free Clinics. Three out of seven clinics mentioned having trouble finding urologists and one mentioned difficulties with exams related to urology. Gynecology is the second most difficult specialty cited in terms of referrals and then other specialties show a high variation from clinic to clinic.
- The interviews combined with the survey showed that although several conditions were mentioned by various clinics, arterial hypertension and other conditions typically related to heart diseases, in addition to diabetes and respiratory and pulmonary problems are among the chief medical conditions of the patients in the county's Free Clinics.

**Table Q-3. Free Clinics in Miami-Dade County: Selected Medical Characteristics**

Clinic	Service focus	Most difficult specialty for referrals
The League Against Cancer	Cancer care services provided on-site include mammograms, occult blood tests, PAP Smears, prostate screening, chemotherapy, radiotherapy, among others). (more than 300 volunteer physicians see patients at their offices).	In-house urologist to provide prostate screening
St. John Bosco Clinic	Family medicine. Some specialty care provided by on-site volunteer physicians (e.g. gynecology)	Pulmonologist function test, renal mass protocol with contrast.
Good News Care Center	Primary care. Some secondary care provided in the clinic by on-site volunteers: cardiology, ophthalmology, gastroenterology, and dermatology. (more than 70 volunteer physicians see patients at their offices).	Urology, gynecology rheumatology and neurology
Open Door Health Center	Primary care. Some secondary care provided in the clinic by on-site volunteers (rheumatology, nephrology, dermatology and podiatry) (more than 135 volunteer physicians and other non-MD medical volunteers see patients at their offices).	Orthopedics, anesthesiology, oncology, gynecology
South Miami Children's Clinic	Primary care (general medical problems, immunizations, school and sports physicals). Some specialty care (gynecology).	Neurology, gastroenterology orthopedics, infectious disease
Good Samaritan Health Clinic	Family medicine, primary care only. No specialty care provided on-site, just through referrals.	Orthopedics
Universal Heritage Institute Medical Clinic	Family medicine, primary care only No specialty care provided on-site, just through referrals.	Gastroenterology, urology
Miami Rescue Mission Medical Clinic	Primary Care (physicals, labs, chronic and acute health care management.	Psychiatry

Table Q-4 shows information about the patients.

- Concerning the average number of patients seen each year, The League Against Cancer shows 1,200. However, given the high level of specialization of this clinic, this number cannot be compared to the others shown in the table. In the case of this clinic, they accept an average of 200 new patients each year. However, most of these patients tend to keep their charts running for a number of years, estimated to be five years for remission purposes.
- Good News Care Center and Open Door Health Center reportedly see 3,500 and 3,000 patients on average per year which places them first among the other clinics in terms of number of patients seen, followed by SJB which sees an average of 1,000 patients per year.

Some clinics reported an increase in the number of visits. The most significant increase was reported by Open Door Health Center. In 2008, the number of visits (which include new patients and repeat visits) was 12,665. Yet between January and August of 2009, the number of visits was almost 16,000 (15,991).

- The clinics that opened more recently have a lower average of patients per year. This is in part due to the fact that they are relatively new in their areas. Yet the fact that two of them target specific segments of the population, and one of these focuses on a specific city within the county, arguably impacts the number of patients in these cases. As expected, the clinic that opens only two days per week had the lowest number of patients.
- In six out of the eight clinics included in the table, immigrants constitute 50% or more of the total number of patients; as high as 94% in the case of the League Against Cancer followed by SJB with 85% and Good News with 70%. In these clinics most of the patients are Hispanics.
- Cubans are named among the main groups in all the clinics. Salvadorans, Hondurans, and Nicaraguans are mentioned in three clinics each, and Haitians are among the main groups seen in the two clinics located in the agricultural areas of the south.<sup>44</sup> Brazilian immigrants tend to be mentioned in the two clinics where either the director or a top management person is of Brazilian origin.
- The only clinic that has a high percentage of immigrant patients that are not from Latin America or the Caribbean is Universal Heritage Institute Medical Clinic, in which immigrants constitute 60% of the patients, yet they are mostly from Asia; more specifically Pakistanis and Indians.
- Only in the two clinics located in neighborhoods with a high concentration of African Americans, the percentage of immigrants is much lower (1% in the case of South Miami Children's Hospital). Miami Rescue Mission estimates that 30% of its patients are immigrants although the clinic has been opened for less than a year and it is hard to make an estimate in terms of annual average.

**Table Q-4. Free Clinics in Miami-Dade County: Number of Patients and Selected Characteristics**

Clinic	The League Against Cancer	St. John Bosco Clinic	Good News Care Center	Open Door Health Center
Average no. of patients per year*	1,200**	1,000	3,500	3,000
Main ethnicity of the patients***	Hispanic	Hispanic	Hispanic	Hispanic
Immigrant patients (%)	94%	85%	70%	50%
Main national origins of immigrant Patients	Cubans, Nicaraguans, Salvadorans, Colombians, Venezuelans, Hondurans	Cubans, Nicaraguans, Ecuadorans, Salvadorans, Hondurans, Guatemalans Dominicans	Mexicans, Cubans, Brazilians, Colombians, Haitians, Guatemalans	Mexicans, Salvadorans, Haitians, Cubans
Clinic	South Miami Children's Clinic	Universal Heritage Institute Medical Center	Miami Rescue Mission Clinic	Good Samaritan Health Clinic
Average no. of patients per year	856	420	218	1,200
Main ethnicity of the patients***	African American	Asian	African Americans and Hispanics	Hispanic
Immigrant patients (%)	1%	60%	30%	90%
Main national origins of immigrant patients	Colombians, Peruvians, Ecuadorians, Cubans, Venezuelans	Indians and Pakistanis	--	Mexicans, Cubans, Nicaraguans, Brazilians, Hondurans

\*Refers to unduplicated patients. \*\* See main text for the specificity of this clinic. \*\*\* Hispanics include various racial classifications.

Thus, Free Clinics of Miami-Dade County constitute an important health safety net for immigrants of different national origins. This is in sync with the fact that approximately 50% of the county's population is foreign-born. The clinics request proof of income to provide services and also proof of residence in the county (usually for a term of 12 months), and in at least two cases some proof indicating they live in a specific city or area within the county. These requirements guarantee that the limited resources they have are used only by people who really need them and live in the county (or a given area). No clinic indicated that proof of immigration status is required, although some questions or conversations when the clinics assist the immigrants in navigating the system may raise some red flags. Some clinics are very sensitive to the needs of the undocumented population.

Even though these two basic conditions (proof of income and proof of residence in the county) may seem easy to meet, they become barriers to access for many immigrants and others who procure their livelihoods through "off the books" types of activities or move from place to place in search of jobs. Furthermore, when the clinics that accept some type of insurance have to handle applications for federally-funded means-tested programs that require proof of alimony, sometimes this becomes an issue for single mothers who do not have contact with, or ways to contact the father of their child. Even in cases in which she can contact him, he works in the informal economy and can only provide money on an irregular basis and without documentation.

Certainly, approximately 50% of the population of Miami-Dade County is immigrant, and a significant part of the total population is made up of second or third generation immigrants. Hispanic immigrants who are poor constitute a significant percentage of the Free Clinic patients in the county. African-Americans constitute the second most numerous group. Given the predominant presence of Hispanic immigrants and doctors in most of the clinics, lacking familiarization with the patients' culture and language tends to affect more Non-Hispanic patients than Hispanic patients on average, although some differences among Hispanics also makes issues of cultural competency challenging from the perspective of the providers.

Referring to the predominantly African American neighborhood where her clinic is located, the director of South Miami Children's Clinic explains: "Poverty, fatherlessness, HIV, teenage pregnancies and illiteracy are just a few of the problems plaguing this community. The clinic has become an avenue to address the medical, social and economic problems facing these families and is instrumental in providing resources."<sup>45</sup> These are problems that affect all ethnic groups to one extent or another, yet it has been extensively documented that certain segments of the African-American and the Hispanic populations are more vulnerable than other groups.

In contrast with other core safety net providers, Free Clinics do not request proof of citizenship or length of residency in the country, if they are non-citizens, in order to qualify for certain federally or state-funded means-tested programs. However, it was argued by some directors of clinics that they want to identify whether the patients qualify for federal or state insurance programs to use their limited resources for those who really need them. In addition, under certain circumstances they see insured or partially insured patients. Thus, their functions involve identifying whether the patients qualify for specific programs. However, the Free Clinics' work is guided by a service approach that does not emphasize health care as entitlement related to solid economic position, work status, or immigration status. This approach emphasizes health care as a right; a human right and the right of the economically marginal in need of care regardless of any other consideration.

Yet the principle of health care as a right can only be exercised so far. For example, once the undocumented immigrant requires a blood test from a hospital, the hospital requires a Social Security number and there is only so much the providers can do or are willing to do to circumvent these rules to run a test that may save a life. Once again the charisma, conviction and commitment of the directors and administrators of the Free Clinics and the commitment of the cooperating providers to save the life of a human being above any other consideration more often than not will play a role in the fate of the patients.

Table Q-5 shows information about some general characteristics of the clinic's personnel.

- The number of physicians providing on-site care on a regular basis varies significantly across clinics which may be related to factors as dissimilar as the geographical location of the clinic or its specialty or the types of cooperation agreements they have with other entities.
- In the clinics studied, the doctors tend to be mostly immigrants. With the exception of the clinic owned and operated by Pakistanis and the mobile clinic operated by a single doctor from Brazil, Cuban doctors are mentioned as providers in all the clinics with immigrant physicians.
- Free Clinics tend to provide medical services in at least two languages and often administrative services can be provided in three or more languages because the administrative personnel tend to have different immigration backgrounds.

One of the main advantages of Free Clinics for a population of patients that tends to be predominantly immigrant, is the familiarity of the doctors and other personnel with their mother tongue and aspects of their culture. Since most patients and most doctors are Hispanics, linguistic barriers tend to be almost null in the Free Clinics of Miami-Dade County at least for the most numerous group of immigrants.

**Table Q-5. Free Clinics in Miami-Dade County, General Characteristics of the Staff**

	Doctors providing on-site primary and specialty care on regular basis	Doctors who are Immigrants	National Origin	Linguistic Abilities of Permanent Staff*
The League Against Cancer	6	100%	Cuban, Dominican	English, Spanish (this refers to on-site services)
St. John Bosco Clinic	39	75%	Cuban, Nicaraguan, Ecuadoran, Chilean, Iranian, Lebanese, Indian	English, Spanish
Good News Care Center	10	40%	Cuban, Colombian, Brazilian, Indian	English, Spanish, Portuguese Haitian Creole
Open Door Health Center	17	15%	Several national origins	English, Spanish, Haitian Creole
South Miami Children's Clinic	3	0	n/a	English, Spanish
Good Samaritan Health Clinic	1	100%	Brazilian	English, Spanish, Portuguese
Universal Heritage Institute Medical Center	35	100%	Pakistani	English, Urdu, Spanish
Miami Rescue Mission Clinic	1	100%	Cuban	English, Spanish

\* Refers to both medical and administrative staff.

Table Q-6 offers the statements of the respondents concerning the main challenges the clinics face.

- Insufficient funding in general, lack of funding for specific projects, or lack of funding with continuity, came up as the main challenges that Free Clinics face regardless of the year in which they were founded, whether they are specialized or not and the size of their budgets.
- Enlisting volunteer physicians in addition to funding was mentioned as a major challenge in one case. The complexity of certain medical/social issues was cited in one case as a major challenge, in addition to lack of funding for specific projects.

**Table Q-6. Free Clinics in Miami-Dade County: General Characteristics**

Name of Clinic	Year	Main Challenges
The League Against Cancer	1975	Insufficient funds
St. John Bosco Clinic	1992	Insufficient funds
Good News Care Center	1996	Enlisting volunteer physicians. Insufficient funds for all budgeted needs
Open Door Health Center	2001	Funding with continuity
South Miami Children's Clinic	2007	Large number of patients with STI's in the neighborhood. How to assist patients in changing attitudes and behavior concerning lifestyles Insufficient funding for certain projects
Good Samaritan Health Clinic	2007	Shortage of healthcare providers. Insufficient funds to increase the salary of the staff and hire some of the voluntary workers and to be able to pay for additional health care providers
Universal Heritage Institute Medical Clinic	2008	Not enough funds available to add four more days (Monday to Thursday).
Miami Rescue Mission Clinic	2009	Getting more funds for the supplies

**PART III**  
**Barriers to Access and Health Disparities**  
**in Miami-Dade County**

### 3.1. Barriers and Disparities

#### The Uninsured Population

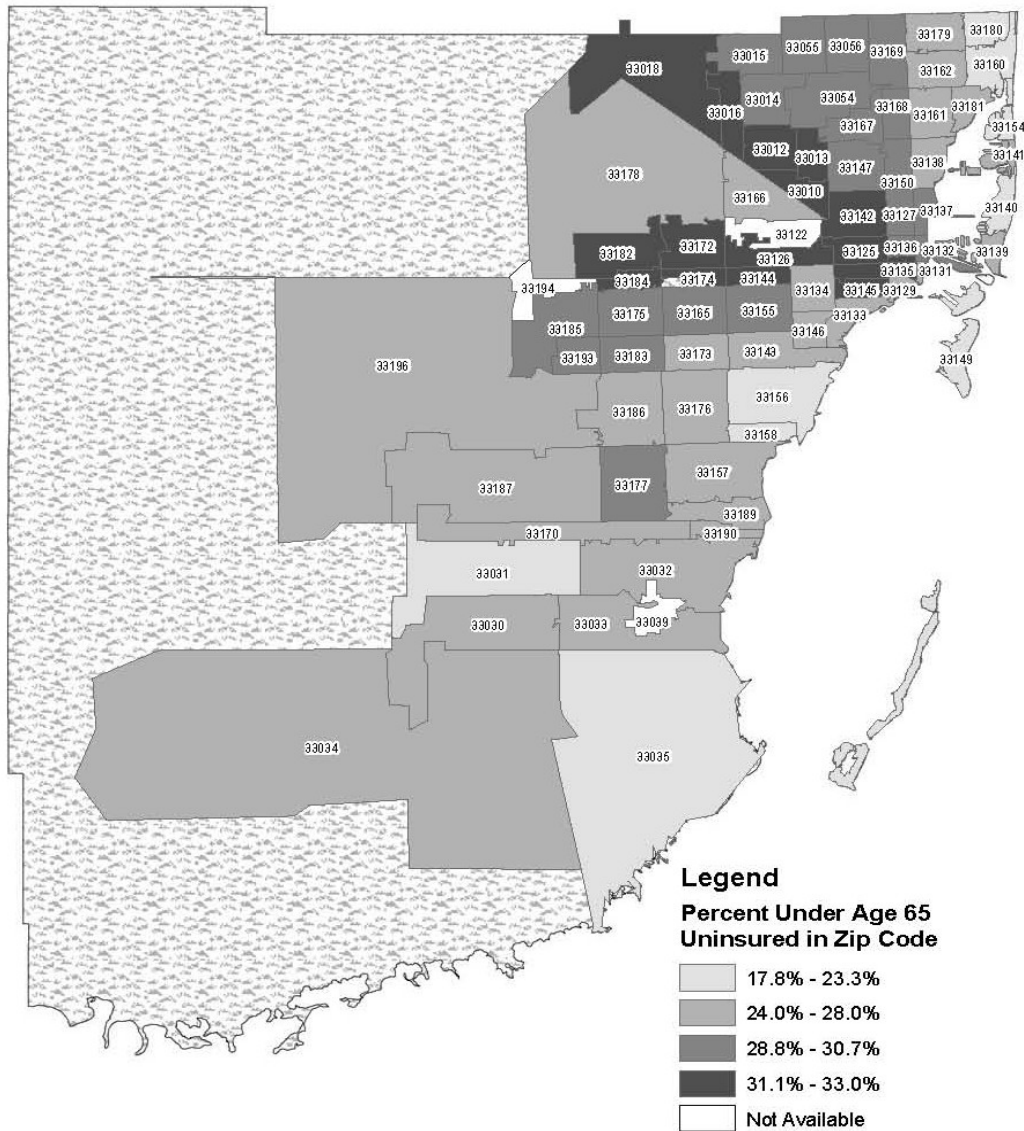
The key role played by Free Clinics is best understood if we take into consideration the precarious access that hundreds of thousands of residents have to health care and existing health disparities. In 2005, 65% of the population of Miami-Dade County was classified as medically underserved.<sup>46</sup>

By medically underserved it is understood “those that face multiple and compounding barriers to primary care, including lack of insurance and financial difficulty, language and culture, transportation as well as lack of physicians present or willing to treat them.”<sup>47</sup> According to the same source that same year, 49% of the population was classified as medically disenfranchised. The term “medically disenfranchised” refers to “people at great risk for being unable to establish a medical or health care home to provide them patient-centered, regular and continuous primary care because of a shortage of primary care physicians where they live.”<sup>48</sup>

Map 2 shows the percentage of uninsured people by zip code in Miami-Dade County for 2004. The rate of the uninsured population under age 65 was above 26% in most of the zip codes of the county. The northern section, which has the highest population density, has the highest number of zip codes with uninsured populations under age 65 and higher rates of uninsured population (more than 28% and up to 33%). In the entire county, only 6 zip codes had the lowest ranges in the rates of uninsured persons, although they still ranged between 18.8% and 20.6%.

Recent data on the uninsured population and other indicators pertaining to access to health care services which are discussed below, and the fact that the recession has hit hard in Miami-Dade County (the unemployment rate jumped from 4.7% in January, 2008 to 11.7% in August, 2009,<sup>49</sup> one indicator directly linked to access to health care), makes it safe to argue that if a similar map could be drawn for this year,<sup>50</sup> the uninsured rates would be higher in more zip codes, if not in all of them, and the highest would be well beyond 33%.

## Map 2 Miami-Dade County: Percent Under Age 65 Uninsured by Zip Code 2004



Source:  
 Zip Code Estimates of People Without Health Insurance from The 2004 Florida Health Insurance Studies,  
 Prepared by: The Department of Health Services Research, Management and Policy, University of Florida,  
 Under Contract to: The Agency for Health Care Administration, August 2005

Table 1 shows the percentage of individuals between 18 and 64 years of age with and without insurance for Miami-Dade County, some cities of the county, Florida and the United States, for the year 2008. The rate of uninsured people is much higher in Florida (27.42%) than at the national level (19.85%), and it is even higher in Miami-Dade County, where 36.64% of the population between ages 18 and 64 are uninsured. In absolute terms, this represents over half a million people in the 18-64 age bracket without insurance.

In some cities of the county the percentage of uninsured is much higher. For example, 53% of the residents of Hialeah age 18 to 64 are uninsured, and it is 45.8% for the City of Miami (see Table 1). Again, these estimates may not reflect the impact of the recession on the rates of the uninsured, but the rates are high nonetheless.

**Table 1. Population 18 to 64 years with Health Insurance and without Insurance (United States, Florida, Miami-Dade County and selected cities), 2008**

	Population		%	%	
	18 to 64	With health insurance		Without health insurance	
<b>United States</b>	187,579,233	150,353,431	80.15	37,225,802	19.85
<b>Florida</b>	10,894,707	7,906,963	72.58	2,987,744	27.42
<b>Miami-Dade County</b>	1,460,631	925,412	63.36	535,219	36.64
<b>Hialeah City</b>	127,426	59,790	46.92	67,636	53.08
<b>City of Miami</b>	212,633	115,218	54.19	97,415	45.81

Source: Prepared by the author based on U.S. Census Bureau, 2008 American Community Survey (different tabulations), data released on September 2009.

### Immigrants and Natives: Gaps Concerning Access

Table 2 offers a summary of some socio-demographic characteristics of the county's population based on the most recent estimates from the Bureau of the Census. They can be summarized as follows:

- The population of Miami-Dade County is 2,398,245 million.
- About 50% (49.9%) of the population was not born in the United States.
- The foreign-born population (FBP) is divided almost equally concerning naturalization: 50.32% has acquired citizenship through naturalization while 49.38% does not have citizenship.
- Almost 26% of the FBP entered the country between 2000 and 2008.
- 92.90% of the FBP was born in Latin America or the Caribbean, 3.20% in Europe and 2.80% in Asia.
- 1.4 million, or 62.40% of the population is Hispanic (of any race), 17.70% is classified as Black Non-Hispanic and 17.64% as White Non-Hispanic.
- Non-Hispanic Blacks and Whites make up 35% of the total population.
- The most numerous group, Cubans, constitute 59% of the Hispanic group (although not reflected in the table, it constitutes 33% of the population of the county).
- South Americans and Central Americans constitute 16.90% and 15.15% respectively of the Hispanic population and Puerto Ricans 5%.

**Table 2. Miami-Dade County: Population Characteristics, 2008**

	Total	%
Population	2,398,245	100
Native	1,202,633	50.15
Foreign-born population (FBP)	1,195,612	49.85
Naturalized	605,211	50.32
Not a U.S. citizen	590,401	49.38
Entered 2000 or later	309,340	25.9
Entered before 2000	886,272	74.1
Latin America	-	92.9
Europe	-	3.2
Asia	-	2.8
Other*	-	1.2
Major Ethnic Groups		
Hispanic**	1,496,595	62.4
Cuban	791,913	52.90
South Americans	253,357	16.93
Central Americans	226,737	15.15
Black Non-Hispanic	424,434	17.70
White Non-Hispanic	423,146	17.64

Source: Prepared by the author based on U.S. Census Bureau, 2008, American Community Survey (different tables).

\*Refers to Africa, Northern America and Oceania \*\*Refers to Hispanic of any race.

In the county, Hispanics have the highest percentage of uninsured population (30.7%), followed by Blacks (19.1%) and Non-Hispanic Whites (10.8%).<sup>51</sup> The significant gap between the White population and other groups, points to important disparities that have been studied in relation to social/medical factors. These factors stem from historical patterns of inequality that reflect in gaps of access to health care and the quality of the services received. In the particular case of the gaps observed between Hispanics and the two other major groups (Blacks and Whites), immigration-related barriers to access also play a role. The fact that half of the county's population is immigrant and half of the immigrants are not naturalized (which disqualify them for some publicly-funded means-tested programs depending on year of arrival), and the fact that many immigrants are low-income workers whose employers do not provide access to health insurance, place an important segment of the population in a vulnerable situation concerning access to health care.

## Barriers to Access: Legislation

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), signed under the Clinton administration in 1996, had a strong impact on immigrants' access to public health insurance. It denied access to Medicaid benefits and other means-tested federal benefits for immigrants who were not naturalized and had arrived after August 22, 1996. While there is greater flexibility concerning emergency situations and in some cases concerning Medicaid (provided that the other eligibility requirements are met), this law created barriers for both documented and undocumented immigrants to access public health benefits. It has been argued that PRWORA "fundamentally altered the legal structure for providing Medicaid and other public benefits to immigrants, while maintaining the federal entitlement to health insurance under Medicaid for all citizens."<sup>52</sup> In 1997, and subsequent years, the U.S. Congress revised the criteria; for example, it made elderly and disabled immigrants eligible to apply for Social Security, Medicaid and food stamp benefits, while immigrant children remained eligible for food stamps. However, the revisions introduced since then have excluded thousands of immigrants between the ages of 18 and 64, the age group where the vast majority of immigrants are found.<sup>53</sup>

In addition to PRWORA, Title V of the Illegal Immigration and Immigrant Responsibility Act (IRIRRA), which was enacted in 1996 also, further restricted immigrants' access to social services, including health care services. IRIRRA introduced important modifications to the existing law concerning immigrant eligibility for government funded programs, which applied not only to undocumented immigrants but also to "green card holders" or (legally admitted) permanent residents.

Furthermore, the laws enacted in 1996, also brought about a subjective element that has had an indirect impact on the disposition of immigrants to procure health care services provided through public funds, and consequently, their access to such services. In a study conducted in 1998, it was highlighted that the new "policies created confusion about eligibility and appeared to lead even eligible immigrants to believe that they should avoid public programs"<sup>54</sup> In 2005, almost a decade after the passage of the legislation, it was reported that "even in states that have attempted to continue public insurance for immigrants, lack of awareness of eligibility for these programs remains a problem."<sup>55</sup> Core safety net providers of the county are particularly affected by these issues given the fact that many residents are immigrants, and they are not familiar with the intricacies of the health care system in the United States.

Table 3 shows the absolute numbers and percentages of the uninsured population by nativity, citizenship and duration of residence for the foreign-born population. The table covers both the total population of the United States and the Hispanic population for the year 2008. It shows that:

- The foreign-born population has much higher rates of uninsured individuals than the native population. This is true for the total population of the country and its Hispanic segment.
- 15.37% of the total U.S. population was uninsured in the year 2008. However, the rate of uninsured people was 12.86% for natives and 33.48% for foreign-born populations.
- The above gap between native and foreign-born people can be observed among Hispanics, although the percentages of uninsured people are much higher: 30.66% for all Hispanics, 19.82% for Hispanics that were born in the United States and 48.86% for foreign-born Hispanics.
- Another major gap is found within the foreign-born population between those who have acquired citizenship and those who are not naturalized. Eighteen percent (18.4%) of the foreign-born population of the United States who had acquired citizenship through naturalization were uninsured in 2008; the percentage was 44.71% for foreign-born individuals who were non-citizens.
- The above mentioned gap is also found among Hispanics, again, their rates being higher than those found for the total population. Almost 27 percent (26.9%) of foreign-born Hispanics who were naturalized citizens were uninsured while the percentage was 57.86 for Hispanics who were non-citizens.

- Length of residency in the United States plays an important role as a predictor for rates of uninsured populations. The longer they stay, the lower the percentage of uninsured people. This has to do with many factors, among which are barriers imposed by legislation that limit access to publicly funded programs in the case of legal immigrants depending on the length of their stay. The impact of duration of U.S. residency has on the uninsured rates is more clear-cut among naturalized immigrants. Non-naturalized immigrants also experience a reduction in the number of uninsured people as they accumulate years of residency in the U.S. However, non-citizens have higher rates of uninsured people than the naturalized immigrants in all brackets indicating duration of residency. In addition Hispanic immigrants tend to keep higher levels of uninsured than the national averages in all intervals of duration.

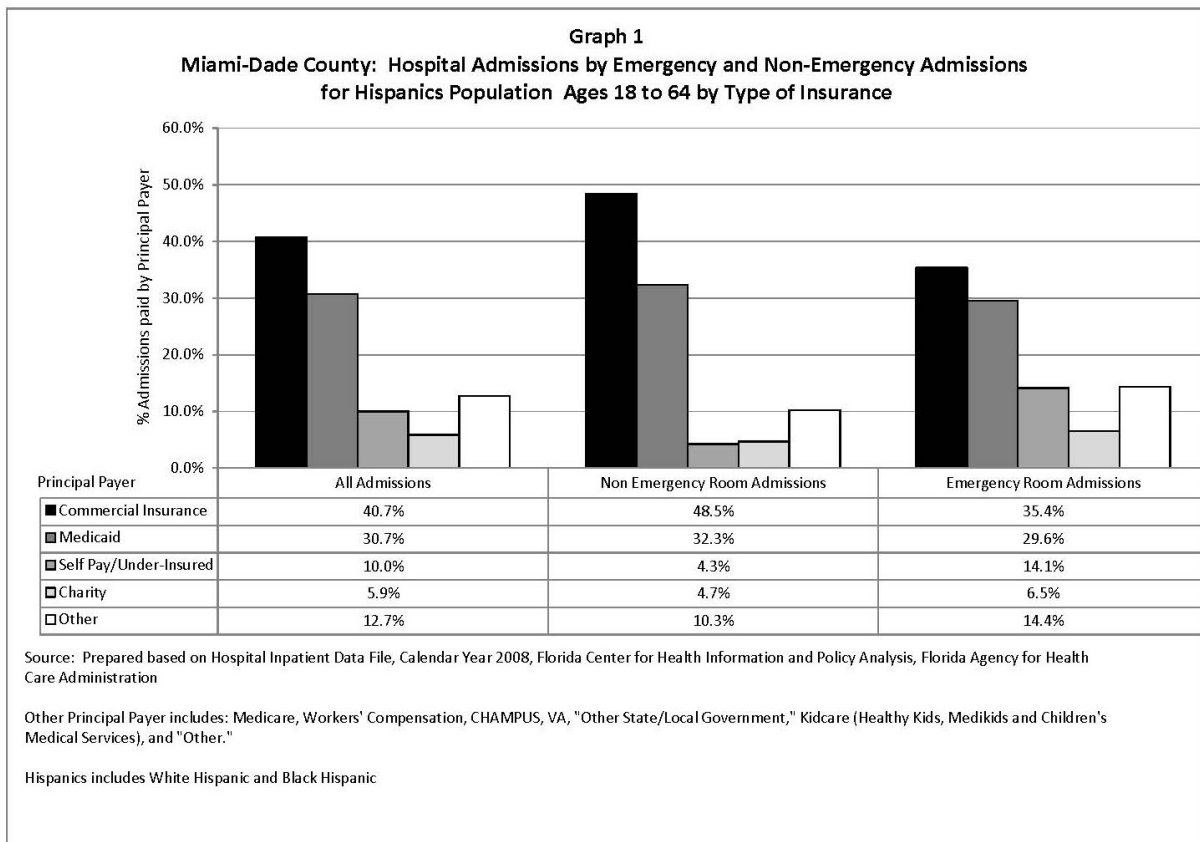
**Table 3. Health Insurance Coverage Status by Nativity, Citizenship, and Duration of Residence (Total and Hispanic), 2008**

U.S. Total Population	Total	Uninsured	%	Hispanics	Total	Uninsured	%
			Uninsured				Uninsured
Total	301,483	46,340	15.37	Total	47,485	14,558	30.66
Native Total	264,733	34,036	12.86	Native Total	29,771	5,901	19.82
Foreign born Total	36,750	12,304	33.48	Foreign born Total	17,715	8,656	48.86
Duration of U.S. Residency				Duration of U.S. Residency			
less than 10 years	12,899	5,744	44.53	less than 10 years	6,422	4,071	63.39
10 to 19 years	10,043	3,719	37.03	10 to 19 years	5,246	2,679	51.07
20 to 29 years	6,846	1,875	27.39	20 to 29 years	3,333	1,286	38.58
30 to 39 years	3,731	698	18.71	30 to 39 years	1,656	468	28.26
40 years or more	3,231	267	8.26	40 years or more	1,057	152	14.38
Naturalized citizen Total	15,475	2,792	18.04	Naturalized citizen Total	5,158	1,391	26.97
Duration of U.S. Residency				Duration of U.S. Residency			
less than 10 years	1,655	390	23.56	less than 10 years	516	172	33.33
10 to 19 years	4,072	888	21.81	10 to 19 years	1,219	386	31.67
20 to 29 years	4,238	899	21.21	20 to 29 years	1,495	472	31.57
30 to 39 years	2,812	421	14.97	30 to 39 years	1,075	253	23.53
40 years or more	2,699	194	7.19	40 years or more	854	107	12.53
Not a citizen Total	21,274	9,511	44.71	Not a citizen Total	12,557	7,266	57.86
less than 10 years	11,245	5,354	47.61	less than 10 years	5,906	3,899	66.02
10 to 19 years	5,971	2,831	47.41	10 to 19 years	4,027	2,293	56.94
20 to 29 years	2,608	977	37.46	20 to 29 years	1,839	814	44.26
30 to 39 years	918	278	30.28	30 to 39 years	581	216	37.18
40 years or more	532	73	13.72	40 years or more	203	45	22.17

Source: Prepared by the author based on U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement.

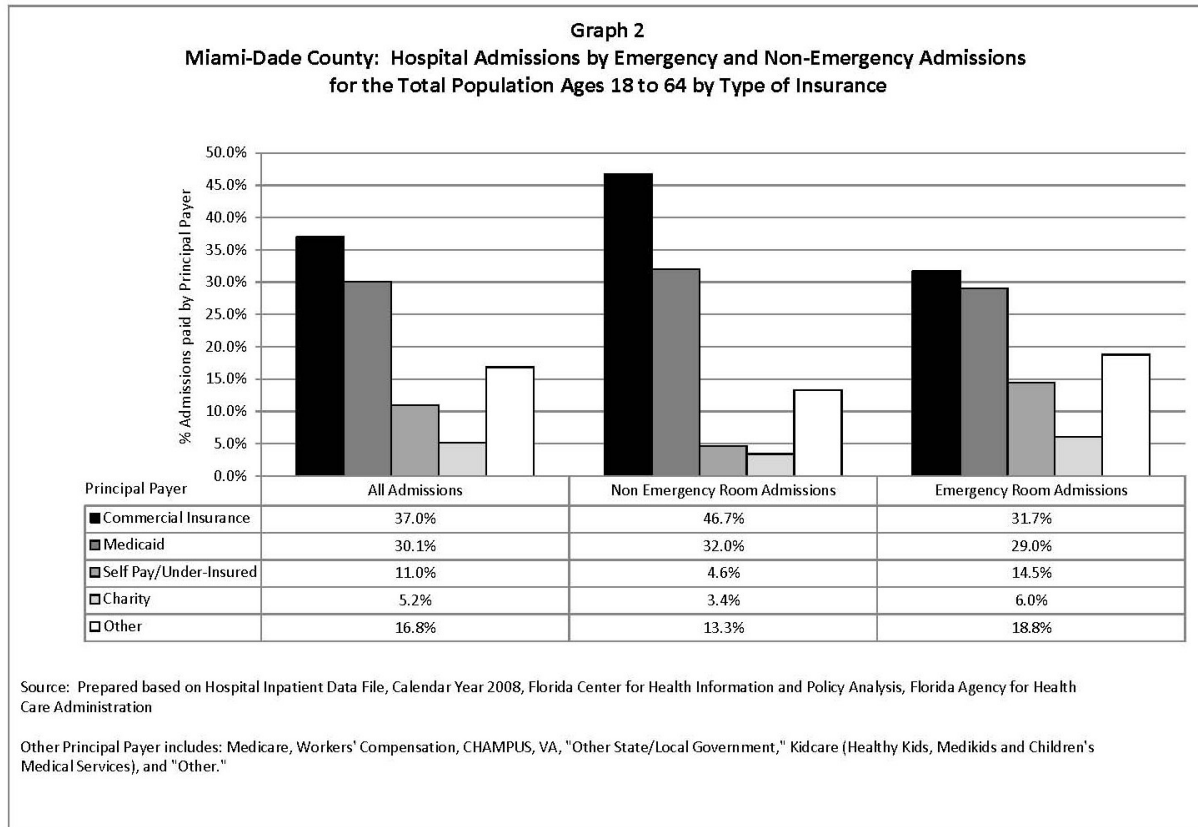
## Uninsured and Emergency Room Admissions by Ethnicity

Graph 1 shows hospital admissions in Miami-Dade County by emergency and non-emergency admissions and insurance types for the Hispanic population in 2008. Slightly over 80% of non-emergency room admissions were patients who either had commercial insurance or were insured through Medicaid. The percentage of patients with those types of insurance experience a significant reduction (65%) in the case of emergency room admissions. Conversely, 35% of patients admitted via emergency room either did not have insurance or were assisted through charity funds or classified under the residual category “other.” The category in question refers to several types of sponsored programs such as Medicare, Worker’s Compensation, the Veterans Administration, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and Kidcare programs, among others. In sharp contrast, it can be seen that 65% of Hispanic patients who were admitted through emergency room services either did not have insurance or had Medicaid. Fourteen percent of Hispanic patients admitted in emergency rooms lacked insurance or were underinsured while only 4.3% of the Hispanic patients admitted through non-emergency services were in the same situation concerning insurance. These figures are consistent with a national trend, widely discussed by experts in public health according to which, not having insurance or being inadequately insured delays the visit to the doctor and many people in that situation tend to go when there is no option other than to rush to the emergency room.



Graph 2 shows hospital admissions by types of insurance and types of admissions for the entire population of Miami-Dade County for the same year (2008). A similar pattern can be observed concerning the relationship between lack of insurance or adequate insurance and emergency room admissions. A difference found with respect to the data for Hispanics, is the percentage of patients classified under the residual group “other” is much higher for the total population than its Hispanic segment. The same source employed for the table shows that the percentage of patients using sponsored programs is much higher among the group classified as “Blacks” than the Hispanic “other”

group.<sup>56</sup> This may be indicative of lack of access to such programs by many Hispanics, many of whom need supplemental programs, but cannot access them due to barriers related to immigration or citizenship status.



## Gaps Based on Income, Type of Work, Gender and Ethnicity

Income, employment type, and other class-related barriers to health care play a role in shaping health inequalities. For example, a study by the Urban Institute (*Low-Wage Workers with Children Face Difficulties Gaining Ground*) sheds light on how labor-related barriers play a key role in access to health care and health disparities for both women and men. The vulnerability of low-income workers (both men and women) has been summarized as follows:

“Low-wage workers are less likely to work full time and year round than other workers, which limits their access to benefits and other supports.”

“Employer-Sponsored Health Insurance (ESI) is a relatively rare benefit among low-income working families. In families without ESI, children are twice as likely—and parents almost three times as likely—to be uninsured than those who are offered ESI.”<sup>57</sup>

However, women and men also face different barriers concerning access to health care, and these barriers also shape health inequalities. According to a study conducted by the Commonwealth Fund, more than 50% of women “reported problems accessing needed care because of cost and 45 percent of women accrued medical debt or reported problems with medical bills”; “seven out of 10 women were either uninsured or underinsured, reported medical bill or debt problems, or experienced a cost-related problem accessing needed care.”<sup>58</sup> The study also shows significant gaps between men and women concerning their respective risks concerning coverage, medical bill or access problems. Rising costs of health services and insurance premiums are cited as major factors placing women in a difficult position concerning access to services.<sup>59</sup> Although women with lower incomes felt the heaviest burden related to increasing costs, the gender gap was not specific to a particular income group:

“Differences between men and women who reported problems accessing needed care persisted across all income groups... Sixty-five percent of women with incomes between \$20,000 and \$39,999 experienced access problems because of cost, which is almost as high as the rate reported by women with low incomes...Men with moderate incomes fared only somewhat better than their female peers, with 52 percent reporting cost-related access problems. Women with higher incomes also reported higher rates of access problems than their male counterparts: 34 percent of women with income of \$60,000 or more reported cost related problems getting needed care, compared with 23 percent of men.”<sup>60</sup>

There is a consensus that the gender gap in access to health care is related to gender gaps with respect to income. Since women tend to have lower wages than men performing similar functions, their share of expenses associated to health insurance tends to be higher. In addition, women of child-bearing age tend to spend more money in health care than men regardless of income.<sup>61</sup>

In addition to the fact that women’s access to health care services is worse than men’s, gaps based on ethnicity are also found among women. Data from the Office of Women’s Health of the U.S. Department of Health and Human Services shows that Florida ranked 45th among the 50 states in the 2005–2007 period with respect to women’s health insurance coverage. Thirty three percent (33%) of Florida’s women lacked insurance coverage between 2005 and 2007. Yet the break down by ethnicity shows that almost 40% of Hispanic women lacked coverage. The percentages were 31.7% and 22.7% for Native American-Indian-Alaskan and Black women respectively, and 16.8% for White women.<sup>62</sup> Based on the data discussed earlier, arguably the gap between Hispanic women and other groups may be due to the fact that many Hispanic women are immigrants, and more specifically non-naturalized immigrants face additional barriers concerning access. The gap concerning access between White women and women in groups usually classified as “people of color” is dramatic.

Barriers to accessing health care services affect not only women but their children, particularly the newly born. Data about women’s uninsured rates from the Pregnancy Risk Assessment shows that 46% of the women giving birth in 2003 in the State of Florida were uninsured prior to pregnancy. In addition, “61% of Hispanic women, and 59% of Black women reported being uninsured prior to pregnancy compared to a third of White women.”<sup>63</sup> The infant mortality rate helps us capture how the mothers’ lack of access impacts the newly born. The infant mortality rate (IMR)—which is understood to be one of the most important indicators of the county’s health because of its relationship with maternal health, quality and barriers to health care, and factors such as educational level, socioeconomic conditions, and public health—also reflects deep inequalities across groups both nationally and in Miami-Dade County.

Nation-wide, the infant mortality rate for Non-Hispanic Black women was 13.63 infant deaths per 1,000 live births in 2005, while the rate was 5.76 for Non-Hispanic White women: “the IMR of Non-Hispanic Black women (13.63 infant deaths per 1,000 live births) was 2.4 times the rate for Non-Hispanic White women (5.76).”<sup>64</sup> Important disparities are found within groups, which are frequently driven by income, education and other characteristics directly linked to social class.

Health care disparities are even more complicated since some important gaps also exist among people from the same ethnicity, albeit from different national or regional origins. In the case of Miami-Dade County, the low level of infant mortality among Cubans pushes down the rate for Hispanics, which was 3.5 for 2006, according to a report on health disparities prepared by the Health Council of South Florida in 2008 (*Racial and Ethnic Health Disparities in Miami-Dade County*).<sup>65</sup> In general by 2006, the segment of the population classified as Black had the highest IMR 10.6, while the segment classified as White had an IMR of 4.2. The lowest level was found among Hispanics (3.5).<sup>66</sup>

Based on a study that included data from 2002 to 2006, a report by the Health Council of South Florida shows that the IMR among Blacks in Miami-Dade County is “on average 2.5 times that of Whites, and 3 times the rate of Hispanics.” The report further clarifies that “low birth weight infants account for only 7.9% of all births, but represent 66% of all infant deaths.”<sup>67</sup>

A study that focuses on women in Miami-Dade County, *Portrait of Women’s Economic Security in Greater Miami*, documents the challenges faced by women in Miami-Dade County who face economic insecurity.<sup>68</sup> It highlights that “86% of single female headed families live below self-sufficiency, and only 46.4% of all women who work earn enough to be self-sufficient.” It also shows that 17% of women work

“in low-wage occupations where the hourly median wage is under 10 dollars, compared with 12% of men.” Furthermore, “67% of working women are employed in occupations with a median wage below the overall median (\$13.64 per hour), compared with 53% of men.”<sup>69</sup>

The obstacles they face in the labor market, the study emphasizes, leaves thousands of women in the county vulnerable concerning their ability to address their health care needs. The report, published in 2009, indicated that 25% of Miami-Dade County’s women over the age of 18 have no health care coverage, while only “51% of women working full-time in MDC have health care coverage from their employer, compared to the national average of 66%.” In addition, many working women cannot afford to pay for child care.<sup>70</sup> The link between underemployment and access to health care by women is also noticed: “Nearly 20% of women who work are underemployed. Increasingly, employers are hiring part-time workers (less than 35 hours per week),” which allows them to bypass the payment of benefits including health insurance.<sup>71</sup> Another issue to bear in mind is that, due to the inadequacy of the criteria employed to measure poverty and other indicators, upon which decisions on means-tested programs are based, many women in Miami-Dade County who are living “below the self-sufficiency standard” are often left out of those government-sponsored assistance programs.<sup>72</sup>

In fact, guaranteeing insurance to the clinics’ own employees was mentioned as one of the challenges faced by the clinics in Miami-Dade County. A director of a Free Clinic of the area refers to this tension as follows:

“We have two physicians, a nutritionist, four nurse assistants, etc. We also contract services such as accounting, data entry, grant proposal writers, among others. You need personnel and resources to provide forty hours per week of services which includes case management, the referrals to the physician’s offices, admissions, in-house treatment of the patients for a variety of ailments. Each employee has several functions. Each one has a great responsibility. However, we cannot pay the salaries people get in other sectors. From last year to this year we have to pay 17% more for the same insurance coverage for our personnel. This is a very high percentage of the clinic’s budget. And it has become harder and harder to get funding.”<sup>73</sup>

Some of the clinics studied provided insurance to their full-time employees but could not afford programs that would cover their family members. In addition, others were trying to make arrangements with hospitals with which they had strong collaboration agreements, in order to put their employees under their insurance plan.

### 3.2. Free Clinics, the Recession and Prospective Reforms in the Health System

The severe recession in which the country is still immersed, has coincided with a renewed nation-wide attempt to introduce reforms in some aspects of the health care system. A cornerstone of the reforms refers to the transformation of the ways in which people pay for access to health care services.

There are great expectations that the reform will lead to greater access for millions of people who currently face severe economic barriers that have left them inadequately insured or without insurance. However, there is also great uncertainty concerning the actual extent to which the population will have access to health services, and the availability of medical personnel should the reform bring millions of currently uninsured individuals to the examination rooms. In addition, the scenario according to which, millions of people will be either uninsured or inadequately insured in the decades to come has not been discarded.

It has been emphasized by free health clinic directors and associations at the local and national level, that Free Clinics constitute the biggest omission in the various drafts of the health reform bill. Such an omission can be attributed to lack of knowledge about what they do and the belief that they will be redundant entities after the bill is passed, if some kind of universal coverage is guaranteed:

“The conscious decision to shut out Free Clinics from the debate may be due to lack of awareness about them and the services they provide or an unstated belief that [their] services will no longer be necessary if the reform is passed.”<sup>74</sup>

While bringing pharmaceutical companies to the negotiating table has been a top priority in Washington, the free health clinics have not been called to the table. Jason Baiden, Executive Director of the North Carolina Association of Free Clinics refers to this paradox unambiguously:

“This is a national issue... We have no seat at the table. If they are talking about helping the under- and uninsured, you think they'd want to talk to those who deal solely with that population.”<sup>75</sup>

During the interviews, some of the personnel at the Free Clinics were concerned that Free Clinics had been left out of the bill. Those who went deeper into the topic agreed that even if the reform leads to the expected reduction of uninsured, many individuals in Miami-Dade County will be either uninsured or insufficiently insured for either long periods of time or shorter periods when, nevertheless, they may need health care the most.

José Greer Jr., M.D., mentioned that the reform would be "a reform in coverage," not a reform of the way medicine is practiced, nor will it imply dramatic changes in the behavior of physicians and/or patients, and therefore it will not be a comprehensive reform of the system. Many people, he emphasized, will continue to fall through the cracks of the system.<sup>76</sup> There is consensus that the undocumented immigrants would be a particularly vulnerable segment of the population, but they are not the only ones that would need the services of free health clinics in a post-reform era.

A report on the socioeconomic conditions of Miami-Dade County shows that in 2006, median household value was 7.5 times median household income. The “affordability gap” (the difference between median household value and median household income) led to a situation in which “a household would be left with \$834 to pay for all other expenses” (including health care related ones).<sup>77</sup> That situation, which was defined as “untenable” in the report is expected to have worsened since. Despite the periods of economic bonanza that were experienced locally between 1989 and 2005, Miami-Dade County had not improved the poverty rate toward the end of that period. The poverty rate (measured as the percentage of persons with incomes below the poverty level) was 17.9% in 1989, and 17.8% in 2005.<sup>78</sup> Even before the recession, the estimates by several local agencies placed the number of uninsured people in the county at 600,000, which indicates that many residents of Miami-Dade County were having a hard time paying for health insurance even when the county enjoyed a much better economic situation.

A recent study on suburban poverty of five communities—Boston, Cleveland, Indianapolis, Miami, and Seattle—highlights that poverty rates have been increasing in suburban areas since 1990, and that by 2005, these areas accounted for more than half of all poor people living in major metropolitan areas.<sup>79</sup> The study calls attention to the worsening of economic conditions in these areas, including suburban areas of Miami, and the availability of safety nets there:

“Although suburban poverty has increased in the past decade, the availability of health care services for low-income and uninsured people in the suburbs has not kept pace.... low-income people living in suburban areas face significant challenges accessing care because of inadequate transportation, language barriers and lack of awareness of health care options. Low-income people often rely on suburban hospital emergency departments (EDs) and urban safety net hospitals and health centers. Some urban providers are feeling the strain of caring for increasing numbers of patients from both the city and the suburbs. Both urban and suburban providers are attempting to redirect patients to more appropriate care near where they live by expanding primary care capacity, improving access to specialists, reducing transportation challenges, and generating revenues to support safety net services.”<sup>80</sup>

The above study also argues that the bureaucratic requirements for the designation of safety nets as federally qualified health centers is a tedious, relatively long process, that is not guaranteed to succeed even in places where the pockets of poverty have grown. Furthermore, it indicates that some technicalities may lead to the conclusion that “there is not enough need” in the area whereas “everyday life needs” show the opposite.<sup>81</sup>

The study suggests that given such obstacles, it is not a bad idea to replicate models that are more flexible, such as the clinics. It is widely known that one advantage of free health clinics is that they can be developed without much institutional constraints, through private efforts and through the combination of private and public efforts. However, this advantage works in tandem with a major disadvantage: Free Clinics do not tend to have a source of continuous financial support, and therefore their life expectancy can be short compared to community health centers and other federally funded health safety nets.

The master paradox faced by the free health clinics of Miami-Dade County and throughout the nation is that, while the number of patients has dramatically increased since the beginning of the recession, the sources of funding have shrunk. Some of the directors of Free Clinics that were interviewed for this study observed that this trend was affecting them directly.

**Part IV**  
**Conclusion and Policy Implications**

## 4.1. Free Health Clinics: Strategic Yet Neglected

According to the National Association of Free Clinics (NAFC), currently “there is no state or federal support for Free Clinics”, despite the fact that they are estimated to serve about 4 million patients per year “through the dedication of thousands of volunteers.”<sup>82</sup> The NAFC projects the number of patients seeking the services provided by Free Clinics to double this year. The cumulative effect of a prolonged recession in which the recovery of the labor market has to be achieved, makes such an estimate highly credible.

In Miami-Dade County, the larger portion of Free Clinic directors interviewed, expressed an increased pressure to serve a greater number of patients with decreased resources. Many stated multiple reasons which include a significant decrease in private donations, grant funding and corporate contributions. The uncertainty of funding and sustainability surfaced as the primary concern for directors when questioned about the main challenges with which they are faced.

This study argues that the development of existing Free Clinics and the creation of new ones is an urgent necessity in Miami-Dade County. This conclusion is supported by the following evidence, which has been discussed in this report:

- Negative effects of the crisis on the local labor market, which is expected to affect many individuals and families in the community for a relatively long period.
- Persistence of trends that have been unfolding prior to the recession, some for a decade, including an increase in suburban poverty, the relative stagnation of the poverty level in the county, and more recently, an increase in the housing affordability gap.
- An increase in the number of individuals and families who rely on Free Clinics as their only viable means to access quality preventive care, primary care in general, and specialty care.

In addition, a consensus surfaced during the interviews with Free Clinic directors and experts familiar with Free Clinics: No matter what the final outcome of health care reform may be in terms of health insurance coverage, Free Clinics will continue to play a key role among the core health care safety net providers for years to come. Even if the number of insured individuals grows exponentially, the argument goes, millions of individuals will remain vulnerable enough to “fall through the cracks” of the system. In fact, it is predicted that 17 million citizens and residents would still be without insurance by 2019.<sup>83</sup>

The above two trends are projected to be experienced with particular strength in Miami-Dade County, associated with underlying economic trends and the socioeconomic characteristics of its population, which has been discussed in great detail in this report.

Another concern arising from the interviews is that, proposed health care reform while very relevant, will still be relatively modest, and therefore, it is not appropriate to refer to the expected restructuring as a “comprehensive” health care reform. It was emphasized that it would be “a reform in coverage,” yet many people will still remain vulnerable concerning access to health care in relation to their income and overall economic situation and certain characteristics.

The main philosophical premise upon which access to health care has been built in our society will remain intact. Health care will continue to be seen not as a human right but an entitlement largely linked to the economic means of the individual. The bill which is currently being debated in Washington is expected to enhance the dignity of U.S. citizens and residents by providing greater access to health care and by leveraging their power as individuals vis-à-vis market intermediaries. Yet that is a far cry with respect to the understanding of health care as a human right.

Health care services will continue to be bought and sold as a commodity through an exchange system: “Under the health care proposals, the government would create a marketplace, or exchange, where consumers would be able to compare and shop for insurance plans that meet new government specifications.”<sup>84</sup> The government, which has gradually increased its role in the health care system in

the last decades, may help boost the purchasing power of the individual through a government program or certain regulatory mechanisms, but this does not convey the understanding of health care as a human right, nor the implementation of practices associated with such understanding. Thus, millions of individuals are expected to continue "to fall through the cracks of the system."

## **The Strategic Role of the Clinics**

An issue that should remain in sight, is that all the expertise (medical, managerial, tradition of servicing the community) accumulated in Free Clinics and the extensive networking that ties the Free Clinics with other organizations in the community—which have been documented in this report for the case of Miami-Dade County—are ready to be used in the case of a crisis (such as those related to pandemics or externally induced catastrophic scenarios).

Thus, in the immediate future, Free Clinics will continue to perform at least three of their basic functions:

- Providing cost-effective quality care with respect for the dignity of the economically disadvantaged, uninsured patients, thereby reducing the burden on larger structures of the health care system.
- Serve as instruments to educate the community concerning health issues and best practices in preventive care.
- Provide a medical and social structure that is deeply embedded in the community at the grassroots level, which potentially can be used to cover larger segments of the population in the event of pandemics or other catastrophic scenarios.

Free Clinics in Miami-Dade County function with very low operating budgets while offering services that are several times the value of their budgets in terms of "retail" value. For example, Good News Care Center with an operating budget of less than \$1,000,000 annually, provided services for 22,000 patient visits and/or facilitated services through referrals, an estimated value of \$10 million in 2008.<sup>85</sup> Additionally, the League Against Cancer, a highly specialized Free Clinic with focus on services for financially disadvantaged patients diagnosed with cancer, has a budget of \$ 4.5 million currently, and is expected to provide services in excess of \$11 million this year. According to the administrator, the organization is able to provide these oncology services "due to favorable contract agreements with local hospitals/clinics and the in-kind support from our volunteers."<sup>86</sup> Cost-effective quality care is a common denominator, regardless of the specificities of the clinics.

The role of Free Clinics in alleviating the burden on local hospital emergency departments should not be underestimated. In 2008, 64.2% of the admissions to county hospitals were via the emergency department. The percentage of emergency admissions was high among Hispanics, and even higher among Black Hispanics.

Free Clinics provide preventive care through screening, and provide medical homes for patients with chronic diseases such as diabetes, arterial hypertension, rheumatologic problems, and thyroid dysfunction, among others. Although there is no "hard data" showing the role Free Clinics play in reducing emergency room utilization, anecdotal evidence from the interviews strongly indicates that Free Clinics are contributing to a reduction in emergency room visits by providing preventive care to thousands of individuals and a medical home to thousands of families in the county. At least one of the clinics studied has an agreement with a local hospital, which involves assisting the hospital with follow-up treatments for patients who have used emergency room services and are referred to the clinic for the continuation of treatment.

It is important to understand the interrelated functions of Free Clinics: their medical function, and their social function. The role of Free Clinics has expanded as new paradigms concerning health care, prevention and overall well-being increasingly affect the ways people think and act concerning their health.

In this context, Free Clinics in Miami-Dade County offer the services of dietitians, nutritionists, among other experts who introduce healthy cooking and eating habits to the patients and their families. Free Clinics also provide recreational activities and educational programs for children and other members of the families. For example, Open Door Health Center in Homestead has a well-equipped kitchen where patients attend classes focused on healthy cooking and eating habits. It also has a spacious room with music equipment for organized family recreational activities. Some clinics that have limited space use other facilities to provide such services to patients of the clinic and members of the community.

Often these kinds of services are provided in several languages for different groups of immigrant patients, from Spanish to Haitian Creole or Portuguese, to mention a few. The staff tends to be culturally diverse and in many cases bilingual and/or multilingual.

In addition to English, one can hear Spanish, Haitian Creole, Portuguese, Urdu, and other languages as one moves from clinic to clinic in the county. The cultural diversity of the clinics' personnel facilitates their social role in a county where approximately 50% of the population was not born in the United States and over 60% of the population is Hispanic.

Given the functions of Free Clinics in our society, it is reasonable to anticipate that as the U.S. health care system evolves into new forms in the future, Free Clinics will evolve with the system in innovative ways that will strengthen their roles in our communities. Yet this transformation will not take place spontaneously, innovation requires commitment and action.

This is a crucial moment for the Free Clinics of Miami-Dade County and the state of Florida. Stakeholders have a unique opportunity to collectively think and act innovatively to effectively support sustainability and even expansion. The policy proposal presented in this report is based on this consideration.

## **4.2. Charter Clinics**

The immediate antecedent of the concept of charter funds or charter funding, as developed here, is the notion of "Charter Clinic." As originally conceived by Rev. Michael Daily, "the notion of 'Charter Clinic' borrows from the Charter School operating system in which these schools earn their revenue from the state by being paid a predetermined amount for each student they enroll."<sup>87</sup> He further explains:

Private investors own the Charter Schools, but they serve regular public school system students who attend the schools for free. The school owners assume all responsibility for the building and overhead, and they hire their own teachers and staff. The teachers must be state certified and the students must take all tests required by the state.

Analogous to this, we [owners of Free Clinics] own and operate our clinics and hire our own staff, enlist licensed physicians, and create our own collaborative networks for caring for our patients. All of our patients are literally referred to us by the State Department of Health through the Volunteer Provider Program for Sovereign Immunity, and the persons who screen them for eligibility are volunteers designated as "110 Representatives" by the Department of Health. Sovereign Immunity mandates that the patients receive care at no charge.<sup>88</sup>

The analogy led to the following proposition to the state legislature: to habilitate a dollar amount that would grant sustained financial assistance to Free Clinics based on "a predetermined value per patient that is enrolled with an active patient chart." The tentative amount did not exceed \$500 per patient per fiscal year. The clinics receiving such funds would be called "Charter Clinics."<sup>89</sup>

Thus, "Charter Clinics" would be Free Clinics that would continue to have the main attributes most Free Clinics share currently: being "the medical home" for a number of patients, and have "a combination of paid and volunteer staff and providers, and collaborative relationships with hospitals, physicians representing various specialty services, and other significant organizations." In addition, they would have formal links of collaboration with local, regional and national Free Clinic associations. The main

difference would be that they would have funding “in the form of a predetermined value per patient that is enrolled with an active patient chart.”<sup>90</sup>

The study leading to this report reveals that there is a consensus among the directors of Free Clinics in Miami-Dade County, that lack of a sustained stream of funding represents a major challenge if not the main challenge they currently face. During the conversations with the clinic directors, they emphasized that their ability to provide services depends to a large extent on grants and donations, which tend to be one-time awards. Fundraising efforts aimed at securing a combination of grants is what usually allows them to complete the year’s budget.

The lack of a stable stream of funding is placing a heavy burden on the Free Clinics and constrains their ability to admit as many patients as the current situation is generating. Ultimately, it jeopardizes the very existence of some Free Clinics.

Although the funding problems have become more acute with the crisis, even before the crisis, lack of a stable stream of funding had placed many Free Clinics at risk, and some local clinics have closed. Perhaps the best indicator suggesting a peak in the demand for free medical services by financially disadvantaged groups is, three of the seven Free Clinic facilities (non-mobile Free Clinics) that currently operate in the area of Miami-Dade County opened between 2007 and 2009.

Recognition of this funding limitation makes the basic idea of securing a stable stream of funding from the state legislature reasonable, given the role that Free Clinics play as a core health care safety net provider and their financial vulnerability.

The notion of “Charter Clinic” led to the drafting of a bill by Representative Juan Carlos Zapata from the Florida House of Representatives. The bill, drafted in January 2007, was called “The Charter Clinic Proposal.” What follows is a summary of the bill’s main aspects that are worth highlighting for the purpose of this report:

It required the Department of Health to implement the “Florida Charter Clinic Pilot Project within the Primary Care for Children and Families Challenge Grant Program.”

The pilot project was intended to be implemented in three areas of the state. The bill also authorized “the Department of Health to fund competitive grants to be awarded to Charter Clinics that provide free or low-cost primary care services.”<sup>91</sup>

It amended Section 381.103 of the Florida Statutes and included the following provisions, among others:

“To the extent feasible, the department [of Health and Human Services] may:

- (1) Assist the pilot projects in development and implementation of their community programs by acting as the granting agency and contracting with the pilot projects.
- (2) Facilitate the integration of the pilot projects with ongoing departmental programs, so that duplication of services is avoided and synergy between the programs enhanced.
- (3) Develop educational and outreach programs for health care providers and communities that increase awareness of health care needs for low-income persons living in urban and rural communities.
- (4) Assist the pilot projects in obtaining free or low cost health care services designed to prevent disease and promote primary health care in urban and rural low-income communities.
- (5) Facilitate cooperation between affected communities, appropriate agencies, volunteer or Free Clinics and ongoing initiatives, such as Front Porch Florida.

The bill also proposed an evaluation of three Charter Clinic pilot projects to be created by the Office of Program Policy Analysis and Government Accountability. The core of the evaluation was proposed as

“assessments of reduced emergency room care in the community, consumer education, healthy behavior indicators, coordination of care, community resource referrals, patient outcome.” In addition, the bill included the appropriation of \$1 million dollars from the General Revenue Fund to the Department of Health for implementation of the provisions of the bill.<sup>92</sup>

The bill did not pass in the legislature. However, it created an important precedence concerning the recognition of Free Clinics as key providers of free or low-cost care services for the indigent segments of the population. Free Clinics are a key piece in the overall strategy of preventing disease and promoting primary care in the State of Florida, and the bill acknowledged this fact. It also implied recognition that every dollar invested in the improvement of existing Free Clinics was a dollar well invested.

## **Some Caveats**

The notion of “Charter Clinic” is attractive as an analogy that evokes the concept of “Charter School”, and can be used for the purpose of this proposal and initiatives derived from it. However, it should be emphasized that the most important distinctions that would exist between “Charter Schools” and Free Clinics receiving a stream of funds from the state legislature (whether they are called “Charter Clinics” or not) are as follows:

First, it is well-established that the concept of “Charter Schools” presupposes that the school is not authorized to function until it receives a charter, “a statutorily defined performance contract” which binds the school in question to state authority in various respects. In contrast, Free Clinics are private entities that do not need a charter to operate. They are either working already or they can be formed without a charter associated with a public authority.

Second, in contrast with the public school system, Free Clinics do not have taxing power. Thus, identifying the sources of revenue from which economic assistance will be derived may not be as straightforward a process as in the case of “Charter Schools.” Nor are the funds provided through public authorities on a sustained basis expected to be the main source of funding for Free Clinics.

Third, even though some of the specifics of operation of “Charter School “ may apply in the case of Free Clinics receiving a sustained stream of public funding, the concept of “Charter School” evokes an institutional charter; the creation of a new type of entity in relation to existing ones in the public school system. This proposal does not advocate for an institutional charter but a funding charter.

## **4.3. Charter Funds**

Charter funds refer to a stable stream of funding for Free Clinics that is provided under a specific charter granted by the State Legislature, U.S. Congress or other public authority. This kind of funding would lead to a new funding model, which is necessary for the purposes of expanding or improving the services of existing clinics and even the creation of new ones. The charter funds could be provided directly to clinics, although some funds could also be provided to increase a Free Clinic fund, created by umbrella organizations, such as a regional Free Clinic association.

In this proposal we do not intend to specify how the funding would be structured. We recommend that legislature put a structure in place for assisting with the sustainability of existent clinics and their gradual development. Their eventual contribution to a Free Clinic fund is also recommended.

We recommend the development of a formula that would allow clinics to receive a stable stream of funding from one or various public authorities, proportional to the number of patients, accounting for the complexity of the care they provide and the costs associated with these services, and other considerations to be determined in future negotiations between legislative bodies and Free Clinics or organizations representing the Free Clinics.

Building upon the notion of “Charter Clinic” and based on the results of this study, we anticipate that the model of Free Clinics financed through charter funding will have the following characteristics:

- Charter funds would not guarantee the main source of funding to the clinics.<sup>93</sup> However, they are expected to provide the most stable stream of funds for the clinics receiving charter funds.
- Free Clinics receiving charter funds are also expected to be funded through:
  - \* Private funds: Refers to direct donations or funds that are allocated based on clinic-specific types of agreements with private organizations or donors. This modality does not necessarily lead to a stable stream of funds.
  - \* Categorical public funds: Refers to public funds allocated to a clinic or a group of clinics by a public authority for a specific project and/or for the provision of services to a target population. This modality does not lead to a stable stream of funds.
  - \* Other funding modalities: Refers to funds allocated to a clinic or a group of clinics through modalities not contemplated under “private funding” or “categorical funding.” These modalities do not necessarily lead to a stable stream of funds.
- Free Clinics funded through charter funds will continue to be private entities that would receive a regular stream of public funds from the state, federal government and/or other public authority.
- Charter funding could be granted by a public authority either through the direct assignation of funds or through a formula including “matching funds.” An advantage related to having separate streams of state charter funds and federal charter funds is that the clinics may opt for either state charter funds or federal charter funds based on their requirements and other considerations.
- This proposal contemplates that charter funds will be allocated to Free Clinics through cycles (e.g. for two years at a time), and will be subject to reauthorization of the charter at the end of each cycle, based on state-wide or federal rules and standards. The rules for the creation and managing of charter funding shall depend on authorizing legislation.
- This proposal contemplates the possible adjudication of charter funds based on the number of patients with an active medical chart during the funding cycle. It also contemplates that regulatory mechanisms will be developed to continue placing professionalism and quality of service above any other consideration.
- The clinics to be partially funded by public funds through charter funds will be accountable for quality of service, among other standards associated with but not limited to The Volunteer Health Care Provider Program, which resulted from the “Access to Health Care Act,” enacted by the Florida Legislature in 1992.<sup>94</sup>
- The proposal contemplates the future development of quality assurance procedures by the corresponding entities to monitor the quality of health services of Free Clinics, and their meeting of other requirements that are contemplated by the funding charter.
- The chartering supervising agencies may be local or state agencies designated to supervise the clinics (partially) funded through charter funds.
- The proposal contemplates the granting of waivers to clinics funded through charter funds for cases in which the private principles of operation of Charter Clinics contradict state laws, regulations, and procedural requirements applied to other publicly funded health care entities.
- The basic right that all individual clinics currently enjoy in determining the patients who deserve to be treated in their facilities should not be jeopardized by the clinic’s inclusion in the charter, once the general parameters concerning socioeconomic status have been set.

## Potential Use of Charter Funds

Charter funds should assist the sustainability and further development of existing clinics by assisting in covering expenses related to:

- Providing comprehensive primary care for uninsured individuals and assuring access to care for vulnerable populations
- Providing preventive health, chronic disease management and education
- Maximize existing network capacity. This includes the formation of functional alliances between and among Free Clinics, between Free Clinics and other health care organizations for the purpose of sharing resources, and expanding their services and continuing to secure the quality of their services
- The modernization of Free Clinics' databases in order to show the number of patients, the services they use, patient follow ups and service outcomes, the Free Clinics' relationships with hospital services utilization, including but not limited to emergency services. The databases should also allow the sharing of data across health care organizations when considered appropriate.
- Improving the income and access to health insurance of salaried personnel
- Maximizing liability protection
- Supporting flexible approaches to the expansion of services such as furnishing existing clinics with a mobile unit when deemed necessary and cost-effective
- Supporting efforts to improve and/or expand educational programs launched by Free Clinics and the community awareness of existing services

### 4.4. Funds from “The Stimulus Package”

This study has documented the economic hardships experienced by Free Clinics since the beginning of the recession. The American Recovery and Reinvestment Act of 2009 (Recovery Act), signed into law by President Obama on February 17th, 2009, or “The Stimulus Package” (as this policy initiative is also known) contemplates the transfer of funds to health organizations in need of economic assistance to recover from the recession. However, the Free Clinics of Miami-Dade County have not benefited from these funds.

Most of the directors and administrators of Free Clinics mentioned that it has become harder for them to reconcile their increase in operation costs and shrinking donations. This situation affects well-established clinics as well as new ones, the patients, and the dedicated personnel that work in the Free Clinics.

This report recommends the transferring of funds through the stimulus package to the Free Clinics in Miami-Dade County. This recommendation is based on the combination of the following factors:

- The severe impact that the current crises is having on Miami-Dade County's clinics, and particularly the growth in the number of people who have lost their jobs and/or insurance and have experienced downward economic mobility, who are now seeking the services of Free Clinics
- The extreme financial stress that Free Clinics face currently
- The role that these clinics play in the core health care safety net, precisely because of their

focus on individuals and families that are uninsured

While the charter funding model proposed here is based on a long-term perspective, funds from the American Recovery and Reinvestment Act (ARRA) may be more readily available for immediate purposes. In other words, these two streams of funds are not meant to be substitutes, but complementary in attaining financial sustainability and strengthening of Free Clinics.

## Notes

- <sup>1</sup> Definition provided by the NAFC. Available at: [http://www.freeclinics.us/what\\_freeclinic.php](http://www.freeclinics.us/what_freeclinic.php)
- <sup>2</sup> Ms. Marisel Losa, MHA was present in three of these interviews when I first interviewed them. In two cases I conducted additional interviews with other staff from the clinics. The report is based on my notes.
- <sup>3</sup> Ms. Marisel Losa was present in two of these interviews. The report is based on my notes.
- <sup>4</sup> It should be noted that persons participating in the interviews are not necessarily familiar with or endorse the policy recommendation of this study.
- <sup>5</sup> Kaiser Family Foundation, "Health Care Safety Net" 2008, Available at: [http://www.kaiseredu.org/topics\\_im.asp?id=965&imID=1&parentID=71](http://www.kaiseredu.org/topics_im.asp?id=965&imID=1&parentID=71), summary based on National Academy of Sciences, Institute of Medicine, "America's Health Care Safety Net: Intact but Endangered" 2001
- <sup>6</sup> National Academy of Sciences, Institute of Medicine, "America's Health Safety Net: Intact but Endangered" 2000, Available at: <http://www.iom.edu/~media/Files/Report%20Files/2000/Americas-Health-Care-Safety-Net/Insurance%20Safety%20Net%202000%20%20report%20brief.ashx>
- <sup>7</sup> Ibid.p.1
- <sup>8</sup> This summary combines elements from Kaiser Family Foundation, 2008 and National Academy of Sciences, Institute of Medicine, 2000
- <sup>9</sup> Felland, L. E., Lauer, J., Cunningham, P. J., "Suburban Poverty and the Health Care Safety Net", Center for Studying Health System Change, Research Brief No. 13, July 2009, Available at: [http://www.kaiseredu.org/topics\\_im.asp?id=965&imID=1&parentID=71](http://www.kaiseredu.org/topics_im.asp?id=965&imID=1&parentID=71)
- <sup>10</sup> Ibid. p. 2
- <sup>11</sup> Jackson Health System, "Mission and Vision", Available at: <http://www.jhsmiami.org/body.cfm?id=143>
- <sup>12</sup> Baptist Health of South Florida, "The Crisis of the Uninsured.", Community Benefit Report 2003, Available at: <http://www.baptisthealth.net/en/patient-visitor/Documents/resource/25075401Winter2003ResourceCrisis%20of%20the%20Uninsured.pdf>
- <sup>13</sup> U.S. Department of Health and Human Services, n.d. (DHHS, n.d.), "What is a Health Center?", Available at: <http://bphc.hrsa.gov/about>
- <sup>14</sup> Ibid.
- <sup>15</sup> They are defined as "public and private non-profit health care organizations that meet certain criteria under the Medicare and Medicaid Programs (respectively, Sections 1861(aa)(4) and 1905(l)(2)(B) of the Social Security Act and receive funds under the Health Center Program (Section 330 of the Public Health Service Act)" (DHHS, n.d.)
- <sup>16</sup> They are "health centers that have been identified by HRSA and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330". (DHHS, n.d.)
- <sup>17</sup> Operated (under the Indian Self-Determination Act, P.L. 96-638) or Urban Indian Organizations (under the Indian Health Care Improvement Act, P.L. 94-437)" (DHHS, n.d.)
- <sup>18</sup> DHHS, n.d.
- <sup>19</sup> Herbert, B., "Hard to Believe", New York Times, August 15, 2009.

<sup>20</sup> The information on FQHCs was provided by Health Choice Network via email sent on September 24, 2009.

<sup>21</sup> Social and Economic Development Council and Miami-Dade County Department of Planning and Zoning (Planning Research Section), "An Overview of the Socio-Economic Conditions of Miami-Dade County." Miami-Dade County: Department of Planning and Zoning 2007, Available at: <http://www.miamidade.gov/planzone/pdf/Overview%20of%20the%20Socio-Economic.pdf>

<sup>22</sup> Data from the Florida Association of Community Health Centers, Available at: <http://www.fachc.org/migrant-overview.php>

<sup>23</sup> Ibid.

<sup>24</sup> National Association of Free Clinics, "What is a Free Clinic?", Available at: [http://www.freeclinics.us/what\\_freeclinic.php](http://www.freeclinics.us/what_freeclinic.php)

<sup>25</sup> The historical insights on Free Clinics presented in this paper are based on: Schwartz, J., "First National Survey of Free Medical Clinics 1967-69", *American Journal of Nursing*, Vol. 86, No. 9 (September 1971), 775-801; Amenta, M., "Free Clinics Change the Scene.", *American Journal of Nursing*, Vol. 74, No. 2 (February 1974), 284-288; Weiss, G., "Grassroots Medicine: The Story of America's Free Health Clinics", Lanham, Maryland: Rowman & Littlefield Publishers, 2006

<sup>26</sup> For recent estimates, see Nicole Lamoureux, presentation delivered at the National Health Collaborative Board of Directors Meeting of August 13, 2009, Available at: [http://www.nationalehealth.org/uploadedFiles/Home/Events/Board\\_of\\_Directors\\_Meetings/August\\_13,\\_2009/8-13-09%20board%20meeting%20transcript%20final.pdf](http://www.nationalehealth.org/uploadedFiles/Home/Events/Board_of_Directors_Meetings/August_13,_2009/8-13-09%20board%20meeting%20transcript%20final.pdf) and Nicole Lamoureux, cited by Fadel, L., "Amid Noisy Health Care Debate, Free Clinics Struggle to Keep up.", *McClatchy Newspapers* (September 6, 2009). For the estimate pertaining to 2006, see Weiss (2006).

<sup>27</sup> Cited by Fadel, L., "Amid Noisy Health Care Debate, Free Clinics Struggle to Keep up.", *McClatchy Newspapers*, September 6, 2009.

<sup>28</sup> Letter from Bonnie A. Beavers, former Executive Director, National Association of Free Clinics, to the Citizens Health Care Working Group, August 28, 2006, Available at: <http://govinfo.library.unt.edu/chc/recommendations/orgs/nafc.pdf>

<sup>29</sup> Weiss (2006), 2.

<sup>30</sup> The Health Council of South Florida has sponsored the creation of an umbrella organization for the free health clinics in Florida.

<sup>31</sup> Tine Hansen-Turton, Executive Director of the Convenient Care Association, cited in Vesely, R., "Where are the retail clinics?", *ModernHealthcare.com* (June 2009), Available at: <http://www.modernhealthcare.com/article/20090601/SUB/90529995>

<sup>32</sup> Pollack, C. E., Armstrong, K., "The Geographic Accessibility of Retail Clinics for Underserved Populations.", *Archives of Internal Medicine*. Vol. 169 Issue 10: 945-949 (May 2009).

<sup>33</sup> Ms. Marisel Losa, from the Health Council of South Florida and María Ortega, from Miami-Dade County Health Department, assisted in the identification of the entities shown in Chart 1.

<sup>34</sup> The summaries include only the clinics that operate from permanent facilities.

<sup>35</sup> Father Emilio Vallina, a renowned religious leader in Miami, quote from Joaquim Utset. "Padre Vallina: 50 Años de Vida Ejemplar en el Apostolado del Servicio y la Oración", *El Nuevo Herald*, May 24, 2002, Available at: <http://www.latinamericanstudies.org/exile/vallina.htm>

<sup>36</sup> Leslie Polland, M.D. from Good News Care Center Named “Volunteer Physician of the Year 2008”, Available at: [http://www.goodnewscarecenter.org/news\\_2.php](http://www.goodnewscarecenter.org/news_2.php)

<sup>37</sup> The term “entrepreneurial spirit” is not employed here in its limited economic connotation but in a broad sociological connotation as the propensity of the individual to find and introduce innovations and her or his readiness to determine courses of action when confronted with obstacles or when opportunities are available.

<sup>38</sup> Email exchange with Rev Michael Daily, Director of Good News Care Center, October 28, 2009.

<sup>39</sup> Statement from Universal Heritage Institute Medical Clinic, Available at: <http://universalheritage.org/>

<sup>40</sup> Ibid.

<sup>41</sup> Ibid.

<sup>42</sup> Available at: <http://rescuemissionmedicalclinic.com/>

<sup>43</sup> World Health Organization, “Men Aging and Health: Achieving Health Across the Life Span.”, Paper Series, 01WHO/NMH/NPH 01.2, 2001, 10., Available at: <http://universalheritage.org> see also The World Health Organization, “A Report of the First Ten Years.”, Geneva, Switzerland: WHO, 1968).

<sup>44</sup> The fact that the clinics closer to the populated urban areas did not mention Haitians among the main groups may be at least partially explained by the fact that Haitians have other safety net providers focused in this particular group in the densely populated urban areas of the county where they tend to settle in larger numbers.

<sup>45</sup> Email from Tina Scott, M.D. Director of South Miami Children's Clinic, October 28, 2009.

<sup>46</sup> National Association of Community Health Centers and The Robert Graham Center, “Underserved and Medically Disenfranchised Populations by U.S. County, 2005.”, (March 2007), Available at: <http://www.nachc.com/client/documents/All%20US%20counties%20and%20MD%20populations%202005.pdf>.

<sup>47</sup> National Association of Community Health Centers and The Robert Graham Center, “Access Denied: A Look at America's Medically Disenfranchised.” (2007), Available at: [http://www.graham-center.org/PreBuilt/Access\\_Denied.pdf](http://www.graham-center.org/PreBuilt/Access_Denied.pdf)

<sup>48</sup> Ibid. p. 7

<sup>49</sup> Florida Agency for Workforce Innovation, Office of Workforce Information Services, Labor Market Statistics, Local Area Unemployment Statistics Program. Data provided by the Research and Planning Division, Miami-Dade County Zoning and Planning Department (October 2009).

<sup>50</sup> To our best knowledge there is no comparable data available yet.

<sup>51</sup> U.S. Census Bureau, 2008 Current Population Survey.

<sup>52</sup> Bauwer, T., “Welfare Reform and the Perinatal Health of Immigrants: First Year Case Study, Finding and Analysis from California, New York, Texas and Florida”, The Research Foundation of the State University of New York, 1999, Available at: <http://www.nyam.org/initiatives/docs/sunyexecsummary.pdf> ; see also Kaiser Commission on Medicaid and the Uninsured, “Medicaid and SCHIP Eligibility for Immigrants.” April 2006, Available at: <http://www.kff.org/medicaid/upload/7492.pdf> ; Guttmacher Institute, The Guttmacher Report on Public Policy (May 2003), Volume 6, Number 2.

<sup>53</sup> Fix, M. and Passel, J., “The Scope and Impact of Welfare Reform's Immigrant Provisions”, Urban Institute, Washington, D.C. 2002, Available at: [http://www.urban.org/UploadedPDF/410412\\_discussion02-03.pdf](http://www.urban.org/UploadedPDF/410412_discussion02-03.pdf)

<sup>54</sup> Mohanty, S. A. et al., "Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis.", *American Journal of Public Health* (August 2005), Volume 95, Issue 8, 1431-1438, Available at: <http://ajph.aphapublications.org/cgi/content/full/95/8/1431>

<sup>55</sup> Ibid. p. 1436, citing Massachusetts Immigrant and Refugee Advocacy Coalition. "Unequal access: a report on barriers children in low-income immigrant families face in accessing food stamps and health insurance. 2000, Available at: <http://www.miracoalition.org>

<sup>56</sup> Hospital Inpatient Data File, calendar year 2008, Florida Center for Health Information and Policy Analysis, Florida Agency for Health Care Administration.

<sup>57</sup> The Urban Institute, "Low-Wage Workers with Children Face Difficulties Gaining Ground", Report Summary, September 11, 2007, Available at: <http://www.urban.org/publications/901114.html>

<sup>58</sup> Rustgi, S. D., Doty, M. M. and Collins, S. R., "Women at Risk: Why Many Women Are Forgoing Needed Health Care", *The Commonwealth Fund*, May, 2009, Available at: [http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF\\_1262\\_Rustgi\\_women\\_at\\_risk\\_issue\\_brief\\_Final.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf)

<sup>59</sup> Ibid.

<sup>60</sup> Ibid. p. 4

<sup>61</sup> Ibid.; see also, Department of Health and Human Services, The Office of Women's Health: State Profiles, Available at: [http://www.healthstatus2010.com/owh/chartbook/ChartBookData\\_list.asp](http://www.healthstatus2010.com/owh/chartbook/ChartBookData_list.asp) ; National Women's Law Center, "Why Women Should Vote - Basic Facts", Available at: <http://www.nwlc.org/health.cfm?section=health>

<sup>62</sup> U.S. Department of Health and Human Services, The Office of Women's Health: State Profiles, Available at: [http://www.healthstatus2010.com/owh/chartbook/ChartBookData\\_list.asp](http://www.healthstatus2010.com/owh/chartbook/ChartBookData_list.asp)

<sup>63</sup> Florida Department of Health, Bureau of Epidemiology, cited in Florida Department of Health, "Women's Health: Data Report 2006" (November 7), Available at: <http://www.doh.state.fl.us/Family/wh/2006data.pdf>

<sup>64</sup> National Center for Health Statistics, Office of Communication, Press Release, Available at: [http://www.cdc.gov/media/pressrel/2008/r081015.htm?s\\_cid=mediarel\\_r081015](http://www.cdc.gov/media/pressrel/2008/r081015.htm?s_cid=mediarel_r081015).

<sup>65</sup> The Health Council of South Florida, Inc. "Racial and Ethnic Health Disparities in Miami-Dade County.", Report prepared for The Miami-Dade County Health Department (February 29, 2008)

<sup>66</sup> Ibid.

<sup>67</sup> Ibid. p. 19

<sup>68</sup> Klarreich, K., Women's Fund of Miami-Dade, Women's Advocacy Project and Research Institute on Social and Economic Policy, Florida International University, sponsors, Emily Eisenhauer, research Director, "Portrait of Women's Economic Security in Greater Miami", Women's Fund of Miami-Dade: Miami-Dade County, FL, 2009, Available at: [http://www.womensfundmiami.org/Advocacy/Portrait\\_WES.pdf](http://www.womensfundmiami.org/Advocacy/Portrait_WES.pdf)

<sup>69</sup> Ibid. p.1

<sup>70</sup> Ibid.

<sup>71</sup> Ibid.

<sup>72</sup> Ibid.

<sup>73</sup> Nilda Soto M.D., Director of Open Door Health Center.

<sup>74</sup> Marcela Duckett, "Prescription for Health Care Reform: Indigent Voices Are Muted Amid National Debate.", The Charlotte Post, August 20, 2009, Available at: <http://www.thecharlottepost.com/index.php?src=news&srctype=detail&category=News&refno=1925>

<sup>75</sup> Cited in Duckett, 2009

<sup>76</sup> Interview with José Greer, M.D., Medical Director of St. John Bosco Clinic

<sup>77</sup> Miami-Dade County Planning and Zoning Department, Research Division, "Miami-Dade County at Glance: Housing Affordability." (February 2008, Issue 5)

<sup>78</sup> Social and Economic Development Council and Miami-Dade County Department of Planning and Zoning (Planning Research Section), "An Overview of the Socio-Economic Conditions of Miami-Dade County." Miami-Dade County: Department of Planning and Zoning 2007, Available at: <http://www.miamidade.gov/planzone/pdf/Overview%20of%20the%20Socio-Economic.pdf>

<sup>79</sup> Felland et al, 2009

<sup>80</sup> Ibid. p.1

<sup>81</sup> Ibid.

<sup>82</sup> Lamoureux, 2009

<sup>83</sup> New York Times editorial, "The Baucus Bill", October 10, 2009, Available at: <http://www.nytimes.com/2009/10/11/opinion/11sun1.html>

<sup>84</sup> Herszenhorn, D. M., "Baucus Bill Would Bar Illegal Immigrants from Insurance Exchanges." New York Times, September 14, 2009, Available at: <http://prescriptions.blogs.nytimes.com/2009/09/14/baucus-bill-would-bar-illegal-immigrants-from-insurance-exchanges>

<sup>85</sup> Data provided by Rev. Michael Daily, Director of Good News Care Center based on the Quarterly Reports (2008) for the Volunteer Health Care Provider Program.

<sup>86</sup> Information provided by Mr. Cesar Scheker, Administrator at The League Against Cancer via email.

<sup>87</sup> Rev. Michael Daily, Director of Good News Care Center in Miami-Dade originated the concept of "charter clinic".

<sup>88</sup> Ibid.

<sup>89</sup> Ibid.

<sup>90</sup> Summary from email exchanges with Rev. Michael Daily.

<sup>91</sup> Original Bill, Florida House of Representatives, Charter Clinic Proposal 01-26-07, draft, Rep. Juan Carlos Zapata.

<sup>92</sup> Ibid.

<sup>93</sup> Although in some cases, in specific junctures, they could represent the main source of funding.

<sup>94</sup> This program endows health care professionals with sovereign immunity protection for uncompensated services provided to eligible patients. Just in Miami-Dade County 10,410 licensed healthcare professionals and 6,066 staff volunteers provided services for approximately 300,400 patient visits in fiscal year 2007-2008. Florida, Volunteer Health Service Program 2007-2008 Annual Report.