PRIMARY CARE ACCESS:
An Essential Building Block of Health Reform

MARCH 2009

NATIONAL ASSOCIATION OF Community Health Centers
Executive Summary

The Pressure Is On

The emerging national discussion on how best to fix the U.S. health care system could not come at a more important time. America is in the midst of an economic recession that is driving up the numbers of uninsured, adding millions to public insurance programs, and leaving states with shrinking budgets and difficult choices. These factors place added pressure on the nation’s safety net providers, including the national network of Community Health Centers. Health centers have more than 40 years of experience in reaching out to underserved communities and have shown their ability to adapt to meet new needs. Nearly all health centers report rising demand for their services in light of the economic downturn – a demand that, in turn, creates new pressures in terms of capital, workforce, and operations.

Growing Needs of the Medically Disenfranchised

Even before the recession, access to affordable primary health care has posed one of the most persistent challenges to our health care system. In a previous report, Access Denied (March 2007), we found that 56 million Americans lacked adequate access to primary health care because of shortages of such physicians in their communities. Today, we find the number of medically disenfranchised has reached 60 million, despite that fact that health centers added 2 million people to their patient rolls over the same period.

Even people who have an insurance card can be medically disenfranchised, but it is low-income, uninsured, and minority populations who are disproportionately affected. These individuals, and the millions of others who confront additional barriers to care, require a source of regular, continuous primary and preventive care—a medical home. The medical home model is patient- and family-centered, coordinated, continuous, and proven to yield better health outcomes, remove barriers to needed care, minimize health disparities, and lower overall costs. Expansion of medical homes is even more effective when coupled with the expansion of insurance coverage.

Community Health Centers Addressing Primary Care Needs

Were it not for the remarkable growth rate of Community Health Centers in recent years, the number of medically disenfranchised would have been even higher. Health centers currently provide high quality, affordable preventive and primary care to more than 18 million low-income and marginalized people. The health center model has successfully narrowed health disparities and has demonstrated savings of up to $18 billion annually for the national health care system. Health centers' comprehensive array of services has expanded on the medical home concept and underscores the importance of “health care homes” in the health care infrastructure. Even with the current pressures they face, and in recognition of the
The Primary Care Imperative

Keeping pace with escalating demand is a perilous challenge for safety net providers, especially today. Rising costs, workforce shortages, capital needs, limited insurance coverage, and payment structures that fail to reflect the value of primary care have hampered providers and patients. Fortunately, the recently passed $787 billion American Recovery and Reinvestment Act (ARRA) provides an historic opportunity to change the way health care is delivered in America by expanding care to more people through a robust Community Health Center Program. The ARRA contains $2 billion in one-time funding for health centers, plus additional funds to strengthen the primary care workforce pipeline, to boost adoption of health information technology in health centers, and to provide much needed Medicaid relief to the states. However, the change should not stop there. Health reform and continued targeted investment can make significant and meaningful improvements in the accessibility and quality of primary care by:

1. Making a primary health care home for everyone in America an explicit goal of health reform.
2. Investing in the development of the primary care workforce.
3. Stemming the erosion in primary care through payment reforms that reward results and quality of care improvements.
4. Stimulating capital investment in the primary care safety net.

Clearly, the expansion of insurance coverage, while a vital step, can only take the country so far. From states and communities already experimenting with their own reform efforts, we know that federal, state, and local governments must continue investing in the health care safety net even if universal coverage is achieved. We also know that true progress in resolving this crisis entails removing all barriers to care, including provider shortages, the lack of insurance coverage, and cost, as well as geographic, linguistic, and cultural barriers. And most importantly, the increased demand for primary care that comes from expanding coverage must be met with an augmented primary care infrastructure.

Producing a high performing health care system – one that improves access to needed care, reduces health disparities, and is cost-effective – is dependent upon broader access to primary care, particularly in the form of medical or health care homes. Moreover, targeting the medically disenfranchised and underserved for such efforts will produce significant gains in national health. Building on their success as leaders in primary care, Community Health Centers stand as exemplary partners in national health reform. Their well-regarded experience in meeting the needs of underserved communities includes effective outreach and enrollment, care coordination and integration, chronic care management, and cultural competency – all essential elements in expanding access to effective care.
**Introduction**

The emerging national discussion on how best to fix the U.S. health care system could not come at a more important time. The effects of a severely stressed economy have far-reaching consequences for our nation and, indeed, our public health. Massive layoffs and job losses are swelling the ranks of the uninsured and leaving states with shrinking budgets and difficult choices. For every one percent increase in unemployment, more than one million people lose their health insurance and another million people enroll in Medicaid and SCHIP. And families on tight budgets are being forced to choose between health care and food, or health care and heat — and evidence shows these families are more likely to have children in poorer health.1 States, facing massive budget shortfalls, are struggling to sustain the health care safety net that is needed now more than ever. Many states are reacting by cutting Medicaid eligibility or benefits, as well as other needed services.2

These factors place added pressure on the nation’s safety net providers, including the national network of Community Health Centers. Yet over the course of their history, health centers have demonstrated a remarkable ability to adapt in times of crisis. Health centers’ resilience comes from being community-focused with an existing network to mobilize and target community needs. When Hurricane Katrina hit the Gulf Coast in 2005, health centers were among the few responders that addressed the complex and immediate health care needs of communities in the wake of the disaster. Now, the U.S. has been struck by a disaster of a different but no less powerful variety: an economic crisis that is causing the highest rate of unemployment in decades.3 Nearly all health centers report rising demand for their services – a demand that creates new pressures in terms of capital, workforce, and operations.

Even before the recession, a lack of access to affordable primary health care posed one of the most persistent challenges to our health care system. Our previous report, *Access Denied* (March 2007), found that 56 million people lacked adequate access to primary care because of shortages of such physicians in their communities. Even the insured can be medically disenfranchised. Yet, low-income, uninsured, and minority populations are disproportionately affected.4 These are the very populations that experience some of the most egregious health care disparities. **Today, we find the number of medically disenfranchised has risen to 60 million.**

The number of medically disenfranchised grew three times faster than population growth – a sign that access to primary care is worsening and even reaching the doorstep of middle class America. Were it not for the remarkable growth rate of health centers, the number of medically disenfranchised would have been even higher. This growing challenge makes it clear that having insurance is not enough to guarantee access to care. If every person in America woke up tomorrow with an insurance card in his or her hand, the unfortunate fact is that many would still not be able to access the primary care they need.
The greatest gains for our health care system – in terms of better health and reduced costs – are produced by breaking down access barriers and reducing health disparities that all too often affect the poor, uninsured, and racial/ethnic minorities. Community Health Centers are specifically designed to address this very problem. They provide primary care and other health and social services to over 18 million patients – primarily low-income, minority, Medicaid-enrolled, or uninsured. Health centers must be located in areas where care is needed but scarce, or where it is plentiful but only for the privately insured. Their comprehensive approach to health care is geared to mitigate the effects of poverty and remove the barriers to access that confront vulnerable populations. This is why Community Health Centers stand as ideal partners in health reform.

The health center model has a proven record of success in narrowing health disparities and has demonstrated significant returns on taxpayer investment. People who receive a majority of their care at a health center have significantly lower medical expenses – 41 percent lower – than those who receive their care elsewhere. They also generate billions in economic benefits annually for their low-income rural and inner-city communities. Spreading these benefits to more communities is the hallmark of a major health center initiative to reach 30 million patients by the year 2015 under their ACCESS for All America plan.

This report, Primary Care Access: An Essential Building Block of Health Reform, examines why primary care can and should be the foundation of any health care reform effort, and how building on the success of Community Health Centers could anchor primary care health access in communities that have been unable to sustain sources of stable, high quality health care.

America’s Medically Disenfranchised

An insurance card can make access to care easier, but it does not by itself guarantee access to care. Not surprisingly, those who have both insurance coverage and a place to access care fare best. Yet access to primary care is limited or non-existent for millions of U.S. residents because of primary care physician shortages in their communities. This is compounded by dwindling numbers of providers willing to treat low-income people who rely on public insurance or who are uninsured.

Two years after our initial estimate of the number of U.S. residents considered medically disenfranchised, we find that this problem has only worsened. In 2005, 56 million individuals – 19.0 percent of all residents – lacked adequate access to primary health care because of shortages of such physicians in their communities. In 2007, the number of medically disenfranchised rose to 60 million, with the percentage of disenfranchised residents rising by almost 1 percent (to 19.8 percent). Refer to the Appendix for the methodology.

Continued investment in the growth of the Health Center Program has done its job. The number of medically disenfranchised could have climbed much higher without growth in the Health Center Program. While the total number of medically disenfranchised grew 6 percent over this two-year period, the number of health center patients grew by more than twice that amount (13 percent). Yet, the accelerated rate of growth among the medically disenfranchised in today’s economic climate poses an enormous challenge. Research tells us little about who the medically
disenfranchised are. However, other estimates on access barriers show that the insured are not immune, and that people who are uninsured, poor, and minority are disproportionately affected.\(^4\)

Notably, medical disenfranchisement represents only one measure of medical underservice. Beyond the number of primary care providers physically present in a community, millions of others face multiple and compounding barriers to care — be they financial, linguistic, cultural, or geographic.

**Impact of Medical Disenfranchisement.** Available providers can only appropriately treat a certain number of people within a community. Very often the medically disenfranchised are people who routinely negotiate barriers of distance, time, and cost to find physician services outside of their communities because there are few or none available where they live. Communities with greater availability of primary care physicians see earlier diagnoses and lower mortality rates for certain forms of cancer,\(^8\) fewer cases of infant mortality and low birth weight,\(^9\) and lower overall mortality rates.\(^10\) A lack of health care professionals serving minority, low-income, uninsured, and publicly insured populations means that these same populations are more likely than white, higher income, and privately insured individuals to suffer poorer health outcomes because they face inaccessible or uncoordinated care.\(^11\)

**Other Estimates of Primary Care Need.** Medical disenfranchisement is a powerful indicator of need. At 60 million, the medically disenfranchised population is significantly larger than the number of uninsured, which stood at 45.7 million in 2007.\(^12\) Other data sources reinforce the enormity of the access problem. According to the Center for Studying Health System Change (HSC), 59 million people reported not getting or delaying needed care in 2007. This is a sharp increase over the 36 million people that HSC identified in 2003. The more recent survey found that the insured actually experienced more erosion in access to care as compared to the uninsured, and that access deteriorated more for those in fair or poor health than for those in good health. One quarter of the uninsured in poor or fair health went without care. The most commonly cited barrier to care was cost, but rising rates of individuals reported difficulties in finding a physician along with other barriers to care.\(^13\) The 2006 U.S. Medical Expenditure Panel Survey uncovered 56 million – nearly 1 in 5 people – who reportedly lacked a usual source of care. The survey further revealed that minorities, low income, and uninsured individuals are less likely to have one. The uninsured are particularly affected; only about half of the uninsured report having a usual source of care.\(^14\)

Quantifying the medically disenfranchised, or the impact of physician shortages, is based on available data on primary care physicians. A better method would incorporate nurse practitioners (NPs) and physician assistants (PAs) – two important providers of primary care in underserved areas – in addition to factoring in the extent to which existing primary care physicians are providing patient services. Many do not work full time and others do not serve traditionally at-risk patients. Accordingly, the federal government must collect more accurate and thorough data on primary care providers as a first step in ascertaining the true extent to which primary care resources are available
in a given community. This may support an argument that identifying true health care need is best done at a community level. At the same time, more research is needed to determine the appropriate limits of a rational primary care service area. Such data and analysis efforts are urgently needed to inform health care reform efforts.

**Addressing Primary Care Needs**

To understand how to solve the problem of medical disenfranchisement, one must go to the communities where they live and work. Studies show they originate from communities experiencing the most acute health disparities and therefore require more interventions and health care screenings. They need regular, continuous primary and preventive care. They also need an interpersonal relationship with a primary care provider who customizes care to the patient’s or family’s particular needs, involves patients in the management of their care while coaching them on changing unhealthy behaviors, coordinates care across the health care system, and is dedicated to quality improvement and enhanced communication with patients. To accomplish all this, care is best delivered through a team of health professionals. Also called a “medical home,” this model of care has been shown to prevent sickness, manage chronic illness effectively, mitigate disparities, and reduce the need for avoidable, costlier care such as an emergency department (ED) visits or hospitalizations.

The expansion of medical homes can facilitate the effective use of health care, improve health outcomes, minimize health disparities, and lower overall costs of care. Low-income, minority, and uninsured populations would especially benefit from the expansion of medical homes because their health is more likely to be compromised, and they are more likely to use costly hospital-based care for avoidable conditions. Policymakers will want to pay close attention to where those individuals are able to turn for affordable, accessible primary health care. The national network of Community Health Centers plays a vital role in identifying and meeting the broadly defined health care needs of traditionally at-risk patients.

*The Promise of Community Health Centers.* The very populations that would most benefit from primary care are the same populations targeted by the national network of Community Health Centers. The Federal Health Center Program is designed to overcome access, quality, and cost challenges in a health care marketplace that too often leaves the most vulnerable behind. It is even designed to go beyond a typical medical home so that they are more appropriately considered to be “health care homes.” Health centers’ federal mandate requires that they:

- **locate in or serve areas designated as medically underserved** and where too few physicians locate;
- **serve all without regard to ability to pay** or insurance coverage;
- **customize their services** to meet the specific health care and cultural needs of their patients;
- **offer services that make accessing health care easier** (such as transportation, translation, and community outreach services) and that increase the effectiveness of
the health care they receive (such as case management, health and nutrition education, and home visits);

- offer comprehensive services that often include services not normally seen in primary care settings (such as dental, behavioral health, and pharmacy services);
- offer enhanced access to care through evening and weekend hours and locations convenient to residents; and
- operate through patient-majority governing boards, ensuring that the centers are responsive to the most pressing local health care needs and are fully community-oriented.

Health centers serve over 18 million patients, most of whom are low-income, minority, and uninsured or publicly insured. The vast majority (71 percent) of health center patients have family incomes at or below poverty, while nearly all are low-income (Figure 1). At the same time, 39 percent of health center patients are uninsured and another 35 percent are covered by Medicaid. Thus, health center patients represent a substantial share of the nation’s underserved people, including 1 in 5 low-income, uninsured individuals, 1 in 4 minority individuals under 100 percent of poverty, and 1 in 7 rural residents. The numbers of uninsured, low-income, and Medicaid patients seen at health centers are growing faster than these groups nationally. Moreover, rates of chronic illness are rapidly rising at health centers, as shown in Figure 2. Services for these conditions are necessary but costly to provide.

![Health Center Patients are Predominately Low-Income, Uninsured, or Publicly Insured, 2007](image1)

![The Numbers of Patients with Diabetes and Hypertension Rose Faster than the Total Number of Patients, 2000-2007](image2)

Health centers also reduce the risk of new health problems. By providing comprehensive health care and enabling services under one roof, engaging in quality improvement initiatives, conducting regular community-wide needs assessments, delivering patient- and community-centered care, and embracing a “team approach” to care, health centers have led to improved screening rates and outcomes for their patients as well as reduced health care disparities. In fact, uninsured health center patients are more likely to receive the care they need than the uninsured nationally. Moreover, numerous independent experts have found that health centers’ quality of care is equal or superior to the quality of care provided by other primary care providers.
Health centers also generate substantial savings to the health care system while bringing needed economic resources to the poor communities they serve. Our previous research, produced in collaboration with the Robert Graham Center and Capital Link, found that people who use health centers as their usual source of care have 41 percent lower total health care expenditures than people who get most of their care elsewhere. As a result, health centers save the health care system up to $18 billion annually. At the same time, health centers produce more than $12.6 billion in annual economic benefits and help to sustain more than 140,000 jobs, in turn helping to attract or retain other local businesses (including other health care providers), sustaining a sense of “community,” giving residents a feeling of pride, and fostering neighborhood revitalization. These savings extend to federal and state Medicaid spending. Health center Medicaid patients are significantly less likely to use the ED or be hospitalized for preventable conditions and are therefore less costly than Medicaid patients treated elsewhere.

In recognition of health care needs among the medically disenfranchised and others, health centers have committed to reach 30 million patients by 2015 and ultimately all medically disenfranchised. The strategy for reaching this aggressive goal is guided by the ACCESS for All America plan, which charts a course for increasing federal support for the Health Center Program and the accompanying policy priorities necessary for continued expansion. Once health centers reach 30 million patients by 2015, their cost savings are predicted to grow to as much as $40 billion annually, while bringing an additional $40.7 billion in annual economic benefits and supporting 460,000 jobs in their local communities. By serving as effective health care homes, health centers have the ability to create a much more efficient health care system that improves access to care and further reduces health disparities.

**Challenges to Meeting the Needs of the Medically Disenfranchised**

The promise of health center expansion relies on a strong base of financing that supports growth and quality innovations, workforce development, capital and construction projects, and even the expansion of insurance coverage. These challenges must be tackled in order to prevent a collapse of the nation’s primary care system and provide broader access to care for all, yet are exacerbated by the current economic crisis. Congress began to address a number of these issues in the American Recovery and Reinvestment Act of 2009 (ARRA), signed into law by President Obama on February 17. The $787 billion stimulus package contains $2 billion in one-time funding for health centers, plus additional funds to strengthen the pipeline of primary care workforce and to boost the adoption of health information technology (HIT) in health centers. These provisions will go a long way toward meeting the challenges limiting health centers’ expansion efforts and ability to provide broader access to primary care.

“We’re having a hard time. What makes our situation unique is when our demand goes up, our revenue doesn’t necessarily go up as well.”

Utah health center staffer
Salt Lake Tribune, December 11, 2008
**Financing.** Health centers are not immune to rising costs seen across the health care spectrum, yet their at-risk patients tend to be sicker than the general population and have special needs that require more time and resources to address.\(^{25}\) The continued growth of federal appropriations for health centers remains the principal factor behind expansion of the program. Despite this, federal funding has not kept up with the escalating costs of care. Federal grant funding as a proportion of uninsured costs has slowly declined over the years (Figure 3 below). Moreover, the demand and readiness for health centers among communities is greater than current and previous appropriations can support. During the first expansion initiative, which began in fiscal year 2002, for every one application that received funding, there were at least two more applications scored “fully acceptable” or higher that were not funded. In FY2008, 260 New Access Point applications were received, but funding was only available for 42.\(^{26}\)

![Figure 3](image)

**Federal Health Center Grants Have Not Kept Up with the Cost of Care**

Financing

Source: Bureau of Primary Health Care, HRSA, DHHS, 2000-2007 Uniform Data System

Fortunately, the ARRA includes $500 million for health center services in recognition of the rising demand for their care in light of the economic downturn. This funding will cover new sites and added services, as well as the costs related to treating rising numbers of uninsured patients. This money has already been dispersed to provide start up funding for 126 of those unfunded applications and to address the "increased demand for services" at every health center nationwide. Although this one-time support goes a long way to cover health centers’ quickly escalating costs, additional and *permanent* funding is necessary to reach more unmet need and ensure that these additional services and sites are sustainable.

Nearly as important as federal financing are state and local support. State and local funding allows centers to expand care to more uninsured, launch needed capital improvement projects and HIT, and provide other needed services, including behavioral health and dental care. The vast majority of states provide direct funding to health centers beyond public insurance payments. At least 38 states and the District of Columbia appropriated $518 million in funding to health centers during State Fiscal Year (SFY) 2009, displayed below in Figure 4.\(^{27}\) Although 19 states increased direct funding for health centers, 13 actually decreased their financial backing of health centers.\(^ {28}\) Such decreases and looming shortfalls in state budgets may be a harbinger of further cuts.
Workforce Shortages. The success of any health reform effort will depend on a strong and evenly distributed primary care workforce. Trends show that the U.S. is falling short of meeting primary care workforce needs in terms of supply, placement, and practice decisions. According to a recent national survey of physicians, 78 percent say there is a current shortage of primary care doctors and 49 percent report plans to reduce the number of patients they see or stop practicing entirely in the next three years. The vast majority of these surveyed physicians were primary care professionals. Even as practicing primary care physicians pull back on patient care, fewer medical students are entering primary care, and instead are selecting more lucrative specialty care fields. Most notable is the 51 percent decline in students entering family practice residencies. Training capacity through primary care residency programs has also slipped. Not only are primary care physicians in short supply, nurse practitioners (NPs) and physician assistants (PAs) are as well. As of 2004, an estimated 80 percent of NPs and 44 percent of PAs worked in a primary care discipline, and the numbers of new NP and PA graduates are falling.

Compounding the dwindling supply of primary care professional, and their shortage in needy communities, is the fact that not enough providers are willing or able to treat Medicaid beneficiaries, the uninsured, or patients who require more specialized services. In some communities there may be adequate numbers of providers, but the doors of their practice are closed to those most in need of care. Physicians are caring for fewer Medicaid and charity care patients than in years past. Without plans to drive primary care providers to locate in and serve those areas and populations most in need of health care resources, the numbers of medically disenfranchised and underserved will continue to rise.

The primary care workforce shortage disproportionately affects the very people already facing a host of barriers to health care. As health centers work to decrease the number of people in America without a medical or health care home, the shortage of primary care physicians is a constant threat. Many health centers, especially those in rural areas, are experiencing significant clinical vacancies and challenges in recruiting clinical staff, particularly among family physicians/general practitioners, obstetricians/gynecologists, psychiatrists, and dentists. Many health centers also have trouble recruiting and retaining NPs, PAs, nurses, and other clinical positions. But even among existing health center clinicians, health center staff are overburdened.
by the complex nature of their patients’ needs, which require more time to treat than patients nationally. Comparing health center staffing to national benchmarks, health centers have 1,843 fewer physicians, NPs, PAs, and certified nurse midwives than their case load dictates they should have. By the same standards, health centers are 1,384 nurses short. **To reach 30 million patients by 2015, health centers need at least an additional 15,585 primary care providers**, just over one third of whom are non-physician primary care professionals. **Health centers will also need at least another 11,553 nurses.**

The stimulus package will generate a surge of primary care professionals in health centers across the country by providing $500 million for the National Health Service Corps (NHSC) and federal Health Professions and Nurse Training programs. The NHSC provides financial assistance to health professions students in return for post-training service in underserved communities. More than half of the 4,000 NHSC-assigned clinicians with a service obligation work at health centers today. This investment would significantly increase the NHSC field strength over the next two years, representing a huge step forward in meeting health centers’ workforce needs. An additional $89 million for existing AmeriCorps grantees and $65 million for VISTA programs could also strengthen programs like the Community HealthCorps, a vital program augmenting health center workforce and conducting outreach and health education activities at health centers. However, while these programs are effective in driving providers to underserved areas, they are not permanent placements. Therefore, creating a sustainable pipeline of providers requires an enduring and multifaceted workforce strategy involving federal and state governments.

**Capital Improvement.** Health centers are also falling severely short in meeting their financing needs for new and renovated buildings and for HIT. Many health centers are currently operating in buildings more than 40 years old, with some as old as 110 years. Because many of these buildings were not originally designed for the provision of primary health care services, delivering efficient services can often pose a challenge. As health centers work to reach 30 million patients by 2015, they will need to invest $10.5 billion in new or renovated facilities and equipment, including HIT. This is no small feat, with nearly all (94 percent) of surveyed health centers reporting that they must rebuild or renovate their facilities to continue or expand care in the next five years alone. Current capital financing programs, created over several decades when capital needs were limited and episodic, provide a patchwork of options to finance expansion; however, these programs are difficult to access, costly to implement, and extensively time consuming.

The ARRA provides an historic down payment toward the health centers’ $10.5 billion in long-term capital needs. Federally funded health centers will receive $1.5 billion in capital funding for facility construction and renovation, equipment, and HIT acquisition. The legislation also makes available, through Medicaid, more than $60,000 per eligible provider over the next six years for the adoption, maintenance, and use of electronic health records (EHRs). Health centers are specifically listed as eligible for these critical payments. This one-time capital funding will yield much needed...
economic returns and generate new jobs for low-income communities. At the same time, it provides a tremendous foundation for health center growth in the years to come.

**Insurance Expansions and Adequate Third Party Payments.** The last official count of uninsured from the U.S. Census Bureau – 45.7 million in 2007\(^2\) – clearly lags behind the worsening economic crisis. Congressional Budget Office (CBO) Director Douglas Elmendorf recently projected during a Senate Budget Committee hearing that the number of uninsured U.S. residents may jump to 54 million by 2019 unless federal policy changes.\(^3\) Other estimates predict the number of uninsured could reach 61 million by 2020.\(^4\) And a new study estimates that 86.7 million people – or 1 in 3 under the age of 65 – were uninsured at some point during 2007 and 2008.\(^5\) Also problematic is the fact that about one-fifth of insured individuals are actually *under*insured and thus face limits on coverage or substantial financial costs if faced with an illness.\(^6\) As health care costs continue to increase, it is likely that this problem will escalate in coming years.

Maintaining and expanding insurance coverage must be part of a successful health reform plan. The recent expansion of SCHIP is a vital step forward, extending coverage to an estimated 4 million additional children, which could include many of health centers’ 1.7 million uninsured children. While not the only enabler of care, insurance coverage is still a critical means for improving access to care. By increasing access to appropriate care, universal coverage would likely reduce unnecessary costs and suffering that are currently borne by the uninsured. Insurance also provides patients with better guarantees of access to needed specialty and inpatient hospital care – something that health centers commonly struggle to provide for their uninsured patients. Broader coverage will also help providers with better financial security to improve quality and access, though to do so requires that insurers pay providers accordingly. Growth in the uninsured and underinsured populations and the weakening of public insurance commitments leave health centers stretched thin. In fact, Medicaid actually leverages health centers’ ability to care for more uninsured.\(^7\)

As states grapple with budget shortfalls, they must reconcile the adverse impacts of some cost containment methods, especially if these changes affect Medicaid. In SFY09, at least 24 states and the District of Columbia are cutting or freezing provider payments, reducing benefits, or restricting eligibility.\(^8\) Missouri is among the many states that have learned the harsh budget consequences of Medicaid cutbacks. After cutting over 100,000 state residents from Medicaid, Missouri was left with a soaring uninsured health center patient population. With a 29 percent increase in uninsured patient visits between 2004 and 2006, health centers were left with higher per-patient costs of care that outpaced per-patient revenue. These centers were forced to cut back on support staff and even some of their enabling services that facilitate access to care. Meanwhile, hospitals saw their uncompensated care costs grow 38 percent over two years.\(^9\) States are considering further cuts despite the fact that Medicaid generates three dollars in business activity for every one dollar spent.\(^10\)

The ARRA provides more than $87 billion in Medicaid relief to the states, in the form of higher federal matching funds, through the end of calendar year 2010. It is hoped that this infusion of vital funding will arrest the spate of recent cut-backs and allow states to extend coverage to some of the millions who have been harmed by the economic downturn.
Shaping Health Care Reform:
Current State- and Community-Wide Initiatives

Even as they grapple with the effects of the recession, some state and local governments are nevertheless forging ahead with their own health care reform efforts. The common thread among these health care reform proposals is improving access to care, though many also include elements to drive quality improvement and control runaway health care spending. More than a dozen states are considering broad insurance expansion. The mechanisms by which they hope to do so vary. More than half the states are also working to augment access to medical or health care homes, especially for their Medicaid beneficiaries or the chronically ill. Some communities are not waiting for state or national health care reform to bring broader coverage before they build local networks of medical or health care homes. Although state and local budget shortfalls threaten to slow down or stall reform efforts already underway, other states and municipalities are closely monitoring their progress. Many of these pioneering models are transferable in whole or part to other states or even nationally.

In many cases, health centers are working in partnership with state or local governments. Regardless of the structure of health care reform, health centers can and do take leadership positions. Health centers play vital roles in serving as health care homes to new patients, often because there are no other available primary care resources in a given area. They also work to enroll uninsured patients in new programs or insurance expansions, and they provide these patients with the benefit of chronic disease management programs and integration with behavioral health, dental, and specialty care. They also partner with other providers, including hospitals, to reduce reliance on costly emergency departments (EDs) for unnecessary or avoidable care.

Lay of the Land for State Health Care Reform. As of October 2008, 14 states (California, Colorado, Connecticut, Illinois, Iowa, Kansas, Minnesota, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Washington, and Wisconsin) have proposed legislation laying the groundwork for achieving universal coverage.45 Others, such as Missouri,46 have done so more recently or may do so soon. Some of these proposals connect broad insurance expansions with efforts to guarantee access to medical homes. For example, Colorado proposed expanding scope of practice laws for nurses and dental hygienists as a means of expanding access to care in rural and underserved communities. Kansas passed legislation to improve access that also included increased funding for health centers and clinics serving low-income populations, while the governor of Washington proposed an initiative to promote health center-hospital collaborations designed to reduce avoidable visits to an ED.

Thus far, only three states (Maine, Massachusetts, and Vermont) have actually enacted comprehensive universal health insurance legislation,46 though Maine and Vermont are still refining their programs. Massachusetts’ plan was enacted in 2006, the fundamental components of which include an individual health coverage mandate, a “pay or play” mandate for large employers, a subsidized insurance program called Commonwealth Care (CommCare) for families below 300 percent of poverty, and Commonwealth Connector, which helps people find appropriate health insurance plans.47 The plan also expanded eligibility for MassHealth, the commonwealth’s Medicaid and SCHIP program. Within the first year the plan successfully reduced the commonwealth’s
uninsurance rate, from 23.8 percent among low-income adults to 12.9 percent. Moreover, the expansion of public coverage did not lead to “crowd out” of private insurance coverage.  

Researchers at The George Washington University confirm that Massachusetts’ Community Health Centers were instrumental in serving as the health care home for many of the newly insured, especially among those who could not find other providers.  

Their total patient case load grew by 50,000 between 2005 and 2007. While the number of uninsured in the commonwealth fell by half during the first year of the program, health centers began to serve even more of Massachusetts’ uninsured – from 22 percent of all uninsured in 2006 to 36 percent the next year.  

With newly insured patients, health centers’ revenues rose considerably, but were equally matched by rising costs, resulting in financial margins lingering around zero in 2006-2007. Preliminary data for 2008 suggests that these trends have continued. Moreover, the composition of revenue shifted as a higher proportion now comes from insurance payments and less from state uncompensated care grants. In fact, these insurance expansions were partially financed by reducing grants or subsidies to safety net providers.  

Health center staff helped many of their existing patients enroll for coverage, though this assistance and the shift from grants to third-party payments added new administrative costs to health centers’ already tight financial margins. In addition, reform in Massachusetts exacerbated health centers’ staffing shortages as private-practice physicians turned away many new patients who recently gained insurance. The researchers concluded that safety net providers require transitional and ongoing support to respond to the increase in demand for services and to continue caring for those who remain uninsured. The pressure on safety net providers – and even the state – will only intensify as the economy worsens, given that many newly unemployed may end up uninsured despite the commonwealth’s reform efforts.  

All state, local, and even national reform efforts should bear in mind the lessons from Massachusetts. First, broad insurance expansion may lead to a surge in demand for primary care. This was particularly the case in low-income communities across Massachusetts.  

Second, implementation of universal insurance coverage without simultaneously ensuring an adequate workforce led to a primary health care bottleneck and costly consequences. Although the rate of uninsured adults dropped, one study found that more adults reported an inability to find a primary care physician and went without care. At the same time, the rate of people seeking non-emergency care in EDs remained unchanged. Another report exposed an increase in average wait time for an appointment with an internist. A new patient went from waiting 33 to 50 days in just two years.  

Third, safety net providers need transitional and ongoing investment to cover the costs related to implementing a new health care system and meeting the needs of their at-risk patients, including those who remain uninsured.  

Many states are explicitly seeking to connect residents to medical or health care homes. These states recognize medical homes as a foundation on which to improve access and outcomes while controlling costs. As of October 2008, the National Academy for State Health Policy identified 34 initiatives in 31 states to advance medical homes for some or all of their Medicaid and SCHIP beneficiaries. All were implemented in or expanded as of 2006, and some are working in collaboration with health centers.  

Hawaii recently introduced legislation not only to define the medical home concept, but also to incorporate health centers as an accepted medical home provider. North Carolina’s 10-year old program linking Medicaid and SCHIP beneficiaries with
medical homes, Community Care of North Carolina (CCNC), draws on an extensive network of Community Health Centers and other community-based providers, hospitals, social services, and health departments. The program has achieved substantial improvement in quality of care, more appropriate utilization, and cost savings, especially for patients with chronic illness. CCNC saves the state as much as $300 million annually, with most of the savings attained through lower ED, outpatient, and pharmacy utilization.52

**Partnerships with Local Governments to Guarantee Access.** Health centers are ideal partners for aligning uninsured residents with sources of regular primary care. Two such model partnerships, one in San Francisco, California and the other in Howard County, Maryland, can be easily replicated in other communities across the county. While both recognize health insurance as essential to comprehensive care, they also illustrate how local governments can move forward in ensuring that every resident has a medical or health care home. Of particular importance is that both of these local initiatives uncovered many residents eligible for public insurance coverage, such as Medicaid, even though it was not the primary purpose of their outreach efforts. These uninsured residents will also have the added benefit of participating in health centers’ chronic care management programs. As access to coverage improves, the newly insured will be in better health and will already have a sustained relationship with a primary care provider.

In 2007, the city and county of San Francisco adopted a novel, two-part approach to expanding access to health services, particularly primary and preventive care. The first component, **Healthy San Francisco (HSF)**, directly connects uninsured residents to medical homes and provides them access to specialty care, inpatient care, prescriptions, behavioral health, and other services. The second, the Employer Spending Requirement (ESR), was implemented in January 2008 and requires employers with more than 20 employees to make nominal contributions to either employer-sponsored health insurance or to the “City Option,” which gives employees access to HSF or employer-sponsored health care reimbursement accounts. HSF is financed by a mix of revenue sources, including redirecting city funds covering services for the uninsured as well as federal funding. Individual and employer contributions make up little of the overall HSF revenue.53

Not even two years old, the city has already enrolled nearly half its adult uninsured population, reaching nearly 37,000 people by the end of February 2009.54 The city set a target of enrolling 60,000 people by the end of 2009. As of December 2008, more than 850 employers were participating in the City Option. To be eligible for HSF, residents must be uninsured for at least 90 days, be ineligible for public insurance programs, and, as of February 2009, be under 500 percent of the federal poverty level. The income level was recently expanded from 300 percent of poverty. Participants pay nominal enrollment fees based on their income. This sliding fee system ranges from less than 4.5 percent of income to zero for those at or below poverty.53 Not surprisingly, outreach for the HSF program has identified many uninsured individuals who are eligible for public insurance programs.55

HSF participants select a medical home from one of 29 participating sites.53 Through the San Francisco Community Clinics Consortium (SFCCC), health centers are active partners in the HSF
program. SFCCC member centers are the health care homes for 43 percent of HSF program participants. SFCCC member centers were able to easily screen and enroll their existing, eligible patients for HSF. Beyond enrollment, SFCCC plays a key, ongoing role in creating and refining HSF through regular meetings with the San Francisco Department of Public Health. SFCCC has also expanded the health care home network for their HSF patients by coordinating their outpatient, specialty, and pharmacy care received at three local hospitals, as well as providing services not covered by HSF, such as dental and vision care. Underpinning these care coordination efforts are a shared electronic health information system linking network providers and the utilization of common quality standards.

On the other side of the nation is another municipal pioneer in securing access to health care homes – Howard County, Maryland. Despite being the third wealthiest county in the U.S., Howard County is home to 20,000 people who lack health insurance. Over 80% of these individuals are in working families. Launched in October 2008, Healthy Howard Access Plan unites eligible uninsured Howard County residents with affordable health care services. While the Healthy Howard Access Plan is not actually insurance, it provides a comprehensive array of services at a reduced cost and is built on a chronic care model. Beyond guaranteed access to primary care, participants have access to prescriptions, behavioral health, urgent or emergency, inpatient, and specialty care through other participating providers, often at deeply discounted rates. Central and unique to Healthy Howard is the pairing up of Health Coaches with every participant. Health Coaches assist participants in creating a personalized Health Action Plan and regularly monitor individuals’ progress. They manage enrolled patients’ care, refer them to specialty and other health care services when needed, guide them toward healthy lifestyles, and advocate on behalf of the patient. The program is funded through the county government, the Horizon Foundation, Aetna Foundation, and enrollee contributions.

The Healthy Howard Access Plan has since enrolled 109 participants as of February 2009, with about 140 more in the process of enrolling and approximately 1,200 additional applicants deemed eligible for public insurance programs. The county hopes to reach 2,000 participants at the end of the first year. To be eligible, adults must be county residents with incomes below 300 percent of poverty, uninsured for at least six months, and ineligible for other public insurance or care programs. Monthly fees range from $50-85 for individuals and $65-115 for couples.

Health services under Healthy Howard began on January 1, 2009. Currently, one health center – Chase Brexton Health Services, Inc.’s Howard County location – is the only actively participating primary care provider. This means that all Healthy Howard Access Plan participants are seen by the health center, which provides behavioral health, dental, and other services on top of primary medical care. Chase Brexton houses a Healthy Howard Health Coach and several of their staff members are trained to facilitate enrollment onsite. This allows the Health Coach to document a patient’s progress in his or her Health Action Plan in the center’s electronic health record, ensuring that the management of their care is shared with providers. The Health Coach is an important facilitator to specialty care needed outside the health center. This care coordination and guidance is particularly important for patients with chronic illnesses.

The Healthy Howard Access Plan was born in part from Chase Brexton’s commitment to serving the county’s uninsured. Half of their patients at the Howard County site are uninsured. Prior to Healthy Howard, the site was losing roughly $500,000 annually due to the high volume of uncompensated care. Chase Brexton worked closely with the county to create a sustainable,
supported model of care. From this collaboration with the county health commission grew others, including a partnership to provide school-based dental screenings and other dental services for county residents. Chase Brexton is now aiming to enroll one-third of their eligible uninsured patients into the Healthy Howard Access Plan over the next few months.\textsuperscript{63}

Healthy Howard is an ambitious program that will require an expansion of partner providers, especially primary care providers, in order to reach all eligible uninsured county residents. Although initial enrollment has not been large, an imminent challenge for Howard County is the lack of available primary care providers, not only for Healthy Howard participants, but for all county residents. The county is witnessing a drop in available primary care providers amid a rapid expansion of "boutique" primary care practices, which are closed to many residents regardless of their insurance status.\textsuperscript{64}

**The Primary Care Imperative: Building a Foundation for National Health Reform**

The substantial investments made by the recently enacted stimulus package, the American Recovery and Reinvestment Act (ARRA), will improve access to both coverage and health care, as will the more successful efforts of visionary state and local governments identified above. And although broader health reform will undoubtedly build on these efforts, the lesson from the experience of those state and local government initiatives makes clear that an explicit goal of improving access to primary care will remain critical. A major investment in primary care – particularly medical or health care homes – is essential not only for removing barriers to needed care, but also for improving health outcomes, minimizing health disparities, preventing illnesses, and achieving cost savings. If everyone made appropriate use of primary care, the U.S. health care system would realize $67 billion in savings annually.\textsuperscript{65} To get there, primary care must be the foundation of our health care system nationally. While the large number of individuals without any or adequate health insurance coverage creates challenges for achieving the type of fundamental health system change that is needed, targeted investments can make significant and meaningful improvements in the accessibility and quality of primary care. State and federal policymakers can take the following steps to make primary care the central part of health reform. These steps not only help achieve health centers’ goal of expanding access to millions more in need of health care homes, but will also produce a higher-performing national health care system.

1. **Make a primary health care home for everyone in America an explicit goal of reform.**

Crafting a high performing primary care system involves retooling the entire health care system. Fortunately, primary care is cost-effective, as documented above. Yet despite spending more on health care, when compared to Australia, Canada, Germany, New Zealand, and United Kingdom, the U.S. ranks last in infant mortality and health life expectancy, and second to last on mortality amendable to health care.\textsuperscript{66} Those countries, as well as Finland, Japan, Spain, Sweden, and Switzerland, perform better not only because of their universal coverage, but also because the foundation of their health care system is primary care and their clinical workforce is structured
accordingly. With the exception of Germany, these same countries still rely on community-based health centers to provide needed care to populations that remain at risk, despite having universal insurance. All of these nations have traditionally hard-to-reach communities that require customized care to meet their unique health care needs related to deep poverty or marginalization, such as enabling and social services.\textsuperscript{67}

Reform efforts should therefore make assuring a primary health care home for everyone a stated priority. The review of the international literature suggests that health reform in the U.S. will only solidify the need for health centers and other safety net providers. Health centers serve as the model and innovation leader for what primary care practice could become. Their ACCESS for All America plan envisions expanding care to reach all medically disenfranchised individuals. The federal, state, and local funds that flow to health centers today help to anchor them in communities that otherwise could not afford to maintain a health care infrastructure – and yet they constitute less than 1 percent of health care spending today,\textsuperscript{58} and would remain below 1 percent even if funding were increased to reach the 60 million more who remain medically disenfranchised.

2. \textit{Invest in the development of a primary care workforce.}

Policymakers should heed the challenges to expanding access to primary care as alarms over the collapse of primary care, which would cause serious problems for everyone but especially for people in underserved communities. Precisely because health centers are located in communities that have severe shortages of health care providers, they face formidable obstacles to recruiting and keeping needed clinicians.\textsuperscript{34} A multifaceted approach will be essential to produce the numbers of primary care health professionals that will be needed to reach health centers’ expansion goals, as well as to serve the needs of our overall health care system.

First, workforce development programs must be strengthened, stabilized, and expanded, fortifying the pipeline to primary care careers, and fostering opportunities for students to participate in primary care educational and training experiences, while also increasing exposure to primary care for health professional students. The federal Health Professions Training programs support training and educational infrastructure at medical, dental, and nursing schools, as well as primary care residency programs that place residents in underserved areas. Physicians and residents of Title VII funded medical schools are more likely to work in a health center than those from non-Title VII funded schools.\textsuperscript{69} Second, opportunities and incentives for health professionals entering primary care careers must be enhanced, to include placement and training opportunities in underserved areas, and training as members of interdisciplinary teams. A strong association was also found between attending Title VII funded programs and participation in the National Health Service Corps.\textsuperscript{69} Third, policy makers must carefully review state scope of practice laws to improve collaborative practice opportunities and location options for all primary care professionals.

3. \textit{Stem the erosion in primary care through payment reforms that reward results and quality of care improvements.}

The accessibility and quality of primary health care is sensitive to payment incentives. Evidence strongly suggests that in general Medicare and Medicaid payment policies significantly limit primary care investment in both safety net and private practice settings.\textsuperscript{70} The provider
payment system must be revised to reflect the essential role and value of primary care in the health care delivery system, reverse the erosion in primary care career choice among health professionals, improve access to primary care, and encourage coordinated, team-based care. It must also support quality improvement and the use of health information technology.

In a health care safety net context, Medicaid and Medicare are the principal sources of revenue to examine. While federal law mandates a specific Medicaid and Medicare payment to health centers, it is not the same for other providers. Additionally, payments from private insurers are often far less than costs, especially for health centers. As part of any health reform, significantly greater focus should be placed on the extent to which private insurers and plans emphasize payments for quality care delivered in the most cost-effective settings.

4. **Stimulate capital investment in primary care facilities, equipment, health information technology, and performance improvement.**

Augmented payment levels alone cannot ensure transition to a higher performing primary health care system. Carefully planned capital investments are required in the development of new facilities where needed, the acquisition of equipment to help modernize primary care, and of course, health information technology adoption. Technology adoption in primary care settings is crucial given it is where the bulk of health care is delivered. A deliberate investment strategy — one that includes capital investment and technical assistance — is particularly essential for health centers and other safety net providers. Such investment yields improved access to care and higher performance.

**Conclusion: Lessons for Health Reform**

The consequences for a nation with 60 million medically disenfranchised people, and the millions of others shut out of preventive medicine due to a host of factors, are far-reaching in scope. Everyone in the U.S. is ultimately affected in terms of higher costs and diminished public health. The expansion of insurance coverage, while a vital step, can only take the country so far. Producing a high performing system — one that improves access to needed primary care, reduces health disparities and medical errors, and is high in quality and cost-effective — is also dependent upon access to a usual source of care. More specifically, it is dependent on broader access to medical or health care homes. Improving access to primary care may make health insurance more affordable to those who are insured by lowering the overall costs of care. Targeting such efforts on the medically disenfranchised and underserved will produce significant gains in national health outcomes.

Primary care must therefore be the foundation on which national health reform takes shape. More specifically, an explicit goal of reform should be guaranteeing everyone in America a medical or health care home. To make this happen, policymakers must invest in the development of a primary care workforce and primary care facilities, equipment, and health information technology. They must also bring about payment reforms that reward results and quality improvements, as well as support care coordination.
Policymakers should take a hard look at the growing numbers of uninsured and underinsured and where they go for affordable, accessible primary health care. Health centers are already serving on the front lines of public health by serving the most traditionally overlooked and at-risk populations. Their success with improving health outcomes – particularly among those with chronic illness and those who experience the most egregious disparities – and their readiness to expand make health centers ideal partners in any health reform plan. Lessons from state and local health reform experiences, as well as lessons from abroad, validate this. Health centers bring to the table well-regarded experience in meeting the needs of underserved communities. This includes experience with outreach and enrollment, care coordination and integration, chronic care management, and cultural competency. In short, **health centers are model health care homes.** Local government-health center partnerships are often the lynchpin for success. Outreach for new programs will uncover many individuals eligible for existing public insurance programs, and demonstration projects may lead to larger, successful, and transferable models.

From states and communities already experimenting with their own reform efforts, we know that federal, state, and local governments must continue investing in the safety net even if universal coverage is achieved. We also know that true progress in resolving this crisis entails removing all barriers to care, including provider shortages, the lack of insurance coverage, and cost, as well as geographic, linguistic, and cultural barriers. And most importantly, the increased demand for primary care that comes from expanding coverage must be met with an augmented primary care infrastructure.

“All of the sudden they’re without jobs or an employer stopped offering health benefits. Some are the working poor and can’t afford to purchase the health plan through their employer. More people are asking and calling in regards to what special programs they might qualify for.”

Arizona health center manager
AZCentral.com, January 2, 2009


26 Based on communications with the Health Resources and Services Administration. 5 March 2009.

27 In total the amount identified is 10% ($48 million) less than the previous fiscal year, the first decline since 2006. This overall loss was due to one-time funding provided to Missouri health centers. Excluding Missouri, total state direct health center funding increased.

Primary Care Access: An Essential Building Block of Health Care Reform


Lu K, Jones E, Finnegan B. et al. Strengthening the primary care safety net for the uninsured. Health Aff. Forthcoming.


Federal Demonstration Project; Waianae Coast Comprehensive Health Center; Waimanalo Health Center; Medical Home Health Care Program; Appropriation. SB1810 SD2. 2009.


Schneider G. (2008 October 16). Healthy Howard access plan: your connection to better health. PowerPoint lecture presented in Howard County, Maryland.


Conversation with David Shippee, CEO of Chase Brexton Health Services, Inc. February 12,2009.


Appendix

Methodology and Limitations

We calculated the medically disenfranchised population by identifying and summing the populations living within federally-designated primary care Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps) across the U.S. by county.\(^1\) Specifically, we used census block group to get a more accurate population estimate of the designated areas. We then used the number of full-time equivalent (FTE) primary medical care providers from the Health Resources and Services Administration (HRSA) to account for access to the primary care providers in the HPSA areas, whereas within MUA/P areas we relied on the American Medical Association (AMA) Master file to determine locations of practicing, non-federal primary care physicians.\(^2\) After aggregating the residents living in these designated areas by counties, we subtracted 2000 people for every one primary care physician, including general/family practice, practice pediatrics, and obstetrics/gynecology.\(^3\) We used the ratio of 1:2000 physicians to population as an average panel size for most primary care physicians and as reasonable estimate of the number of patients a physician can treat annually. Moreover, research has shown that this is an important threshold within counties for reducing hospitalizations for ambulatory care sensitive conditions.\(^4\) From this total, the number of patients served by Community Health Centers was subtracted for national estimates. The U.S. total also accounts for patients served by a category of health centers that do not receive federal health center funding (known as “FQHC Look alikes”) and are therefore not required to report data annually to the federal government. There are currently over 100 of these health centers around the country. In 2007, these centers served 1.3 million patients.\(^5\) In total, health centers served over 17 million patients that year.

Our estimate of 60 million medically disenfranchised Americans may be conservative for several reasons. First, it represents only those living in areas with federal physician shortage or medical underservice designations. A substantial proportion of these people may come from outside the designation area. Some states have been more successful than others in securing federal shortage area designations, and many communities may not be designated as physician shortage or medical underservice areas despite having a qualifying physician shortage. Second, migrants and the homeless are two important and traditionally at-risk and underserved populations that may not be accounted for in this study. Third, our calculation risks removing those patients served by health centers twice, once by accounting for the physician to population ratio even if those physician may be serving in health centers, and second by removing the patients served by health centers. A fourth cause of possible underestimation is that we used census block group level representation of HPSA and MUA designations for quantifying the people at risk for poor access to care; however, if a health center was present in a partial designation county, the full patient load of the health center was subtracted from the population of this geographic area. Since health center patients come from a much wider geography, this likely overestimates the impact of the health center on the at-risk population and underestimates the remaining population at-risk. This particular underestimation risk was much lower for counties in which all areas carried a shortage or underservice designation.

---

1 For more information on HPSAs and MUs/MUPs, see http://bhpr.hrsa.gov/shortage/.
2 For more information on the AMA masterfile, see http://www.ama-assn.org/ama/pub/category/2673.html.
3 For more information on these primary care specialties, see http://bhpr.hrsa.gov/shortage/hpsaguidepc.htm.
5 Based on NACHC, 2008 Survey of Non-Federally Funded Health Centers.
Additionally, we recognize that many undesignated areas have substantial numbers of people who also lack sufficient access to primary health care. It is important to keep in mind that the medically disenfranchised represent only one access barrier to primary care – local physician shortage. Other barriers, such as insurance and cost, language and culture, transportation, and special needs also hamper access to primary care. Communities not listed in this study as having medically disenfranchised will often still have populations at risk of poor access to care. Or, populations in need of primary care may be lost when they reside in counties that are too big for one new provider to serve everyone. Special considerations must be given to all access barriers.

Estimates of medical disenfranchisement may vary from year to year, especially on a local or even state level. This may be due to changes in federal designations (Table 1 below), population shifts, and because of continued poor physician distribution relative to the growth of the population.

Table 1. Growth in HPSA and MUA by Counties, 1998 to 2008

<table>
<thead>
<tr>
<th>County HPSA Status</th>
<th>1998*</th>
<th>2008*</th>
<th>HPSA FTE08*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>907</td>
<td>1720</td>
<td>6708.3</td>
</tr>
<tr>
<td>Partial</td>
<td>1150</td>
<td>632</td>
<td>5699.4</td>
</tr>
<tr>
<td>None</td>
<td>1084</td>
<td>789</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3141</td>
<td>3141</td>
<td>12407.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County MUA/P Status</th>
<th>1998*</th>
<th>2008*</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>1412</td>
<td>1702</td>
<td>21%</td>
</tr>
<tr>
<td>Partial</td>
<td>997</td>
<td>980</td>
<td>-2%</td>
</tr>
<tr>
<td>None</td>
<td>732</td>
<td>459</td>
<td>-37%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3141</td>
<td>3141</td>
<td></td>
</tr>
</tbody>
</table>


Likewise, this method also has risk for over estimating medically disenfranchised people. Since it relies heavily on shortage designations, it may overestimate in areas that have retained their designations beyond actual shortage. Another possible source of overestimation is the federal FTE physician count in shortage areas. This count is based on the physicians caring for underserved or publicly insured people and does not fully account for the total number of physicians present in these areas.

Quantifying the medically disenfranchised, or the impact of physician shortages, is based on available data on primary care physicians. A better method would incorporate nurse practitioners (NPs) and physician assistants (PAs) – two important providers of primary care in underserved areas – as well as factor in the extent to which existing primary care physicians are providing patient services. Many do not work full time and others do not serve traditionally at-risk patients. Accordingly, the federal government must collect more accurate data on primary care providers as a first step in ascertaining the true extent to which primary care resources are available in a given community. This may support an argument that identifying true health care need is best done at a community level. At the same time, more research is needed to determine the appropriate limits of a rational primary care service area. Such data and analysis efforts are urgently needed to inform health care planning efforts.
ACCESS DENIED: A Look at America’s Medically Disenfranchised. The report found that 56 million people living in America lack access to basic medical care because of a shortage of primary health physicians, making the case for greater investment in health centers. (NACHC and the Robert Graham Center, March, 2007)

ACCESS GRANTED: The Primary Care Payoff. The report shows why health centers are the best health care investment America can make because they keep health care costs down and pump money and jobs into the national economy. (NACHC, Capital Link, and the Robert Graham Center, August, 2007)

ACCESS CAPITAL: New Opportunities for Meeting America’s Primary Care Infrastructure Needs. The report examines why significant investments in health center infrastructure are critical to meeting rising numbers of medically underserved and uninsured people. (NACHC, Capital Link, and Community Health Ventures, March 2008)


These NACHC reports and others are available online at www.nachc.com/research-reports.cfm
National Association of Community Health Centers

OUR MISSION

To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

OUR VISION

The ACCESS for ALL America Plan

To reduce the ranks of America’s medically disenfranchised by preserving, strengthening and expanding health centers to reach a total of 30 million patients by the year 2015.

NATIONAL ASSOCIATION OF
Community Health Centers

7200 Wisconsin Avenue, Suite 210
Bethesda, MD 20814
(301) 347-0400
www.nachc.com