

ACCESS DENIED:

A LOOK AT AMERICA'S MEDICALLY DISENFRANCHISED



Executive Summary

A startling 56 million Americans are “medically disenfranchised” because they live in areas with insufficient numbers of primary care physicians to provide important primary and preventative care. The medically disenfranchised represent nearly one in five Americans – of all income levels, racial and ethnic groups, and insurance status – who are at great risk of not having a “medical home” to address their basic health needs from the common cold to migraines or high blood sugar. Notably, the number of medically disenfranchised is likely *underestimated* given limitations in available data and methodology.

No matter where they live – in rural pockets of America’s farm land, in urban neighborhoods, or in suburban developments – the medically disenfranchised face disparities in access to primary and preventive health care. The toll of these unmet needs is steep, from higher death and disease rates to wide health disparities in communities where residents have few or no primary health care options.

Unmet health care needs are not just a consequence of being poor and uninsured. Americans at all income levels are feeling the primary health care pinch. Even those lucky enough to have good health insurance face a large and growing shortage of primary health care options. In fact, the number of communities deemed as having too few primary care physicians is growing precisely as demand is projected to grow with a rapidly growing pool of baby boomers turning 65 over the next several years.

The medically disenfranchised live in every state and in most counties. In particular, this report finds that:

- 21 states each have over one million medically disenfranchised residents.
- Over half (55.9 percent) of Alabama’s residents are medically disenfranchised.
- At least two in five residents in Alabama, Alaska, Florida, Kansas, Mississippi, Missouri, Oregon, South Carolina, and Utah are medically disenfranchised.
- Over 1,500 counties across the country do not have health centers and have medically disenfranchised individuals.

Moreover, even those with health insurance can experience poor access to a usual source of primary care. While more than half (52 percent) of the uninsured have no regular source of health care, in fact most people living in medically disenfranchised areas *have* health insurance.

The Importance of a Regular Source of Primary Care

A medical home is a patient-centered, regular, and continuous source of primary care, proven to provide better health outcomes and lower costs of care. Although health insurance often facilitates access to care, it does not guarantee access to a usual source of care or to a medical home. While the benefits of primary care and medical homes are well-documented, having *both* a medical home and health insurance will most effectively improve access to care and produce better health outcomes.

Health Centers as Important “Health Care Homes”

Community, Migrant, Homeless, and Public Housing Health Centers provide high quality, affordable primary care and preventive services to low income and traditionally underserved communities. Health centers break down the barriers to health care in America’s poorest communities. Today, health centers serve 16 million patients in every state and territory, including 1 in 8 uninsured persons, 1 in 9 Medicaid beneficiaries, and 1 in 4 low income individuals. They have demonstrated that they improve health outcomes for their at risk patients and mitigate health disparities. They also generate cost savings to patients, communities, and payers by reducing the need for expensive inpatient, emergency, and specialty care services.

Health centers expand on the concept of a medical home in several ways, including:

- Providing services that usually fall outside traditional primary care, such as dental care, behavioral health care, and pharmacy services;
- Being open to all residents regardless of ability to pay;
- Being located in areas designated by the federal government as in high need of primary care;
- Customize and tailor their services to meet the specific needs of their patients and communities;
- Being committed to community health improvement and patient involvement; and
- Offering enhanced access to care – such as transportation services, translation, and same day appointments.

Because they go above and beyond the role of a medical home, health centers may be more appropriately described as “health care homes.”

Challenges to Expanding the Health Centers Program

Clearly, growing the federal Health Centers Program would make major strides in reducing the number of medically disenfranchised Americans. **Without health centers, the number of medically disenfranchised Americans would in fact be 21% higher.** Yet several challenges must first be overcome:

- Health Center Appropriations. Federal appropriations have not kept up with cost of care or the number of communities that desire and stand ready for a federally-supported health center.
- Workforce Shortage. The demand for primary care providers will likely increase 38% from 2000 to 2020 – a problem intensified by national primary care shortages and misdistribution issues and an already large number of vacancies at health centers.
- Infrastructure. Health centers need assistance with the costs of construction, health information technology (HIT), and building modernization.
- Need for Insurance Expansions. Growth in the uninsured and underinsured populations and the weakening of public insurance commitments leave health centers stretched thin.
- Importance of Medicaid and Medicare Coverage and Revenue. As the largest insurer of health center patients, sustaining accurate Medicaid reimbursement and Medicaid enrollment are essential to a health centers’ viability. In addition, more than 75% of all health centers face a cap in their Medicare payments, which fails to keep up with the cost of health care.

Moving Forward

As the nation and elected leaders increasingly converge on solutions for possible national health care reform, providing more Americans with access to primary health care should be a top priority. Having insurance coverage without a source of care is as worthless as having currency without a marketplace. With access to primary care one has a fighting chance at good health and can avoid costly emergency room care that is too often the last resort for the medically disenfranchised and the uninsured.

Congress has taken a bold step, investing \$750 million in new funding over the past six years in federally-supported health centers, thereby decreasing the number of medically disenfranchised by more than 5 million. This year, it has appropriated an historic \$207 million increase for health centers, potentially providing access to a health care home for 1.5 million more Americans. The new funding also helps stabilize existing health centers, which are seeing growing numbers of low income and chronically ill individuals.

More must be done to prepare for growing primary health care demand, through further investment in health centers and other sources of primary health care, and in training the primary health care providers who will care for today’s aging Americans and the millions waiting in line behind them.

Appendix A

State Population and Total Population Considered Medically Disenfranchised,* 2005

State [#]	Population, 2005	Total Medically Disenfranchised, 2005	Percent of Population Medically Disenfranchised
Alabama	4,557,808	2,548,219	55.9%
Alaska	663,661	297,730	44.9%
Arizona	5,939,292	1,265,402	21.3%
Arkansas	2,779,154	514,009	18.5%
California	36,132,147	3,997,327	11.1%
Colorado	4,664,119	905,759	19.4%
Connecticut	3,510,297	451,912	12.9%
Delaware	843,524	283,217	33.6%
District of Columbia	550,521	82,867	15.1%
Florida	17,789,864	8,150,146	45.8%
Georgia	9,072,576	1,335,787	14.7%
Hawaii	1,275,194	25,583	2.0%
Idaho	1,429,096	557,137	39.0%
Illinois	12,763,371	1,677,848	13.1%
Indiana	6,271,973	582,284	9.3%
Iowa	2,966,334	529,620	17.9%
Kansas	2,744,687	1,362,340	49.6%
Kentucky	4,173,405	662,654	15.9%
Louisiana	4,523,628	1,475,774	32.6%
Maine	1,321,505	72,315	5.5%
Maryland	5,600,388	380,441	6.8%
Massachusetts	6,398,743	1,269,791	19.8%
Michigan	10,120,860	1,656,884	16.4%
Minnesota	5,132,799	578,171	11.3%
Mississippi [†]	2,921,088	1,320,128	45.2%
Missouri	5,800,310	2,572,776	44.4%
Montana	935,670	108,035	11.5%
Nebraska	1,758,787	126,605	7.2%
Nevada	2,414,807	607,000	25.1%
New Hampshire	1,309,940	149,594	11.4%
New Jersey	8,717,925	187,300	2.1%
New Mexico	1,928,384	367,889	19.1%
New York	19,254,630	2,374,642	12.3%
North Carolina	8,683,242	1,861,481	21.4%
North Dakota	636,677	95,675	15.0%
Ohio	11,464,042	1,156,683	10.1%
Oklahoma	3,547,884	324,075	9.1%

State [#]	Population, 2005	Total Medically Disenfranchised, 2005	Percent of Population Medically Disenfranchised
Oregon	3,641,056	1,533,234	42.1%
Pennsylvania	12,429,616	797,030	6.4%
Rhode Island	1,076,189	273,181	25.4%
South Carolina	4,255,083	1,896,296	44.6%
South Dakota	775,933	108,623	14.0%
Tennessee	5,962,959	1,222,929	20.5%
Texas	22,859,968	4,637,766	20.3%
Utah	2,469,585	1,214,063	49.2%
Vermont	623,050	32,180	5.2%
Virginia	7,567,465	783,606	10.4%
Washington	6,287,759	2,204,188	35.1%
West Virginia [‡]	1,816,856	Data Not Available	Data Not Available
Wisconsin	5,536,201	772,367	14.0%
Wyoming	509,294	106,045	20.8%
US	296,409,346	56,172,709 [#]	19.0%

* The medically disenfranchised are those people with no or inadequate access to a primary care physician due to local shortage of such physicians. They are a *subset* of the medically underserved who face various and often compounding barriers to care. The medically disenfranchised live in a primary care Health Profession Shortage Area (HPSA) or Medically Underserved Area (MUA), or who are considered a Medically Underserved Population (MUP) after subtracting a standard 2000 people for every primary care physician. For national and state estimates only, the medically disenfranchised exclude the number of people cared for by health centers in that same designated area. County level and congressional district level do not account for health center patients given an inability to align health center patients by this region. This is a conservative calculation, since there are undoubtedly individuals who live in areas with more than one primary care physician per 2000 residents, and even in areas that are not designated as HPSAs or MUAs, yet who cannot find a source of primary health care that will accept their insurance (this is increasingly true for individuals who have Medicaid and now even Medicare. For more information on methodology, see Appendix F.

[#] US and state totals of medically disenfranchised take health center patients into account (i.e., patients are deducted as explained above). While state health center patients are derived from federally-funded health centers that are required to report data annually, the US total also includes 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. State totals do not include patients served by non-federally funded health centers.

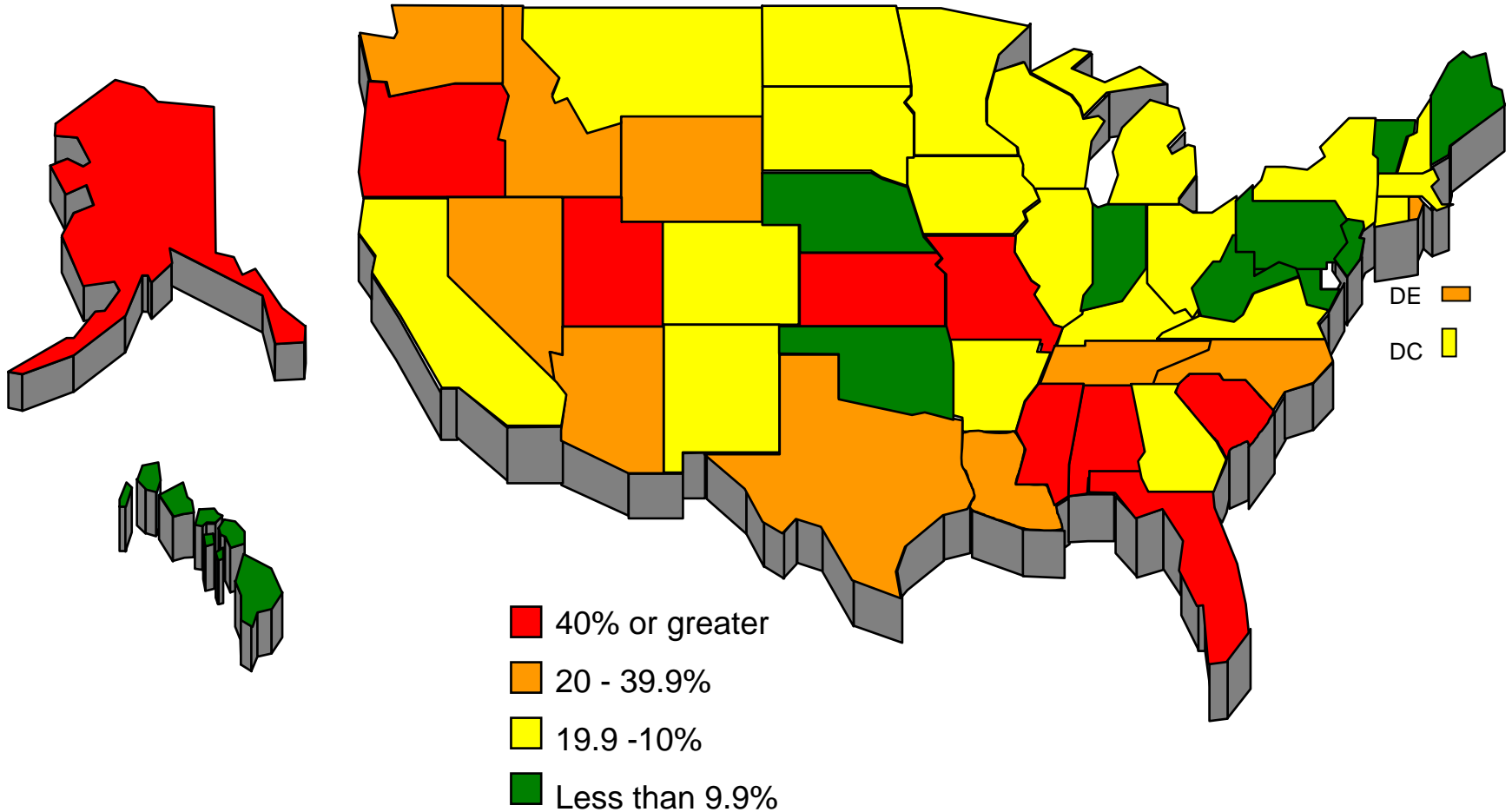
[†] Several health centers affected by Hurricane Katrina in 2005 were unable to report data or were unable to collect patient information for part of the year. This was especially the case for several Mississippi health centers.

[‡] The number of medically disenfranchised in West Virginia may be underestimated because some communities may not be designated HPSAs or MUAs despite having a qualifying physician shortage. The state has relatively fewer HPSAs compared with other similarly rural states

For more information, email research@nachc.com.

Source: Robert Graham Center. Health Services and Resource Administration (HPSA, MUA/MUP data), 2006 AMA Masterfile, Bureau of the Census 2005 population estimates, Uniform Data Set 2005 and NACHC 2006 survey of non-federally funded health centers.

Percent of Medically Disenfranchised People by State, 2005



National Average = 19.4%

Note: Does not subtract health center patients as state and U.S. medically disenfranchised figures do.
Source: The Robert Graham Center. Health Services and Resource Administration (HPSA, MUA/MUP data, 2005 Uniform Data System), 2006 AMA Masterfile, Census Bureau 2005 population estimates, NACHC 2006 survey of non-federally funded health centers.



The **National Association of Community Health Centers** (NACHC) represents the nation's health safety net: over 1,100 Community Health Centers, serving over 16 million people at 6,000 sites located throughout all 50 states and U.S. territories. Community Health Centers provide health care to low-income and medically underserved Americans, and they never turn anyone away – regardless of insurance status or ability to pay. They are local, non-profit, community-owned and federally funded.

NACHC is the leading source for information, data, research and advocacy on key issues affecting Community Health Centers. NACHC provides education, training, technical assistance and leadership development to promote excellence and cost-effectiveness in health delivery practice and community board governance. In addition, it builds partnerships that stimulate public and private-sector investment in quality health care services.

For More Information on NACHC and Community Health Centers
Please Visit: www.nachc.com



The **Robert Graham Center** is a health policy research center that is part of the American Academy for Family Physicians and operates with editorial independence.

The Graham center exists to improve individual and population health by enhancing the delivery of primary care. The center aims to achieve this mission through the generation or synthesis of evidence that brings a family medicine and primary care perspective to health policy deliberations from the local to international levels. The Graham center focuses their efforts on themes such as: the value of primary care, health access and equity, delivery and scope of the medical home, and healthcare quality and safety.

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