

Removing Barriers to Care: Community Health Centers in Rural Areas

Approximately 50 million people live in rural and frontier areas across the U.S.¹ Rural populations experience many of the same barriers to health care that affect underserved communities nationally, such as cost, language, and transportation. However, geographic isolation and fewer health care resources exacerbate these strains in rural and frontier areas. Rural residents are more likely to be elderly, poor, and have chronic medical conditions compared to residents of metropolitan areas.² They are also less likely to have access to transportation.³

Access to primary care in rural areas is often inadequate. In fact, 37% of rural residents do not have access to a primary care physician due to local shortages of such physicians, compared to 21% of urban residents.⁴ Compared to their non-rural counterparts, rural residents, especially rural elderly residents, are less likely to visit a primary or ambulatory care provider (50% fewer visits for rural elderly residents),² and are more likely to report being in fair or poor health (19.5% vs. 15.6%).⁵

Health Centers Remove Barriers to Care

Community, Migrant, Homeless, and Public Housing Health Centers make up one of the largest systems of care for rural America, and are frequently the only source of primary and preventive services in their communities. Also known as Federally-Qualified Health Centers (FQHCs), **about half (48%) of health centers are located in rural and frontier areas. These centers currently serve 10 million people – including 1 in 7 of all U.S. rural residents.**⁶

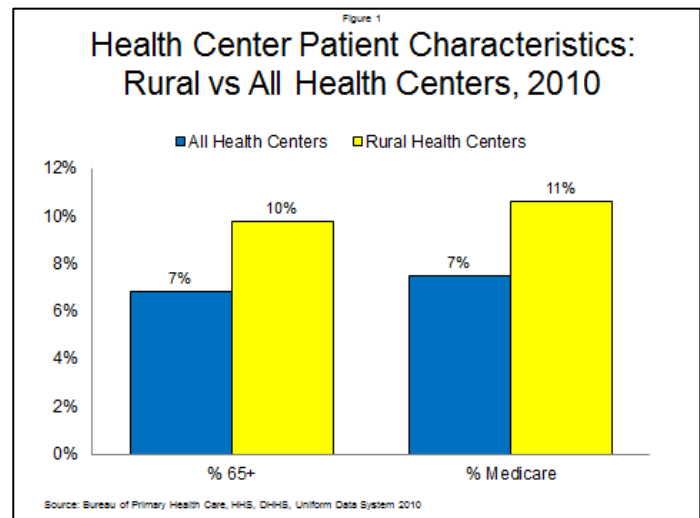
Health centers are structured to overcome complex barriers in rural communities. Unlike other primary care providers, health centers are required to care for anyone who walks in the door, regardless of insurance status or ability to pay, and are governed by a **patient-majority governing board** that gives patients a voice in the delivery of their care. These features originate from their established mission and federal program requirements. Health centers are also obligated to:

- **locate in high-need areas** identified by the federal government as having elevated poverty, higher than average infant mortality, and where few physicians practice;
- **offer services that help their patients access health care**, such as transportation, home visitation services, translation, case management, and health education; and
- **tailor their services** to fit the special needs and priorities of their communities.

Rural Health Center Patients

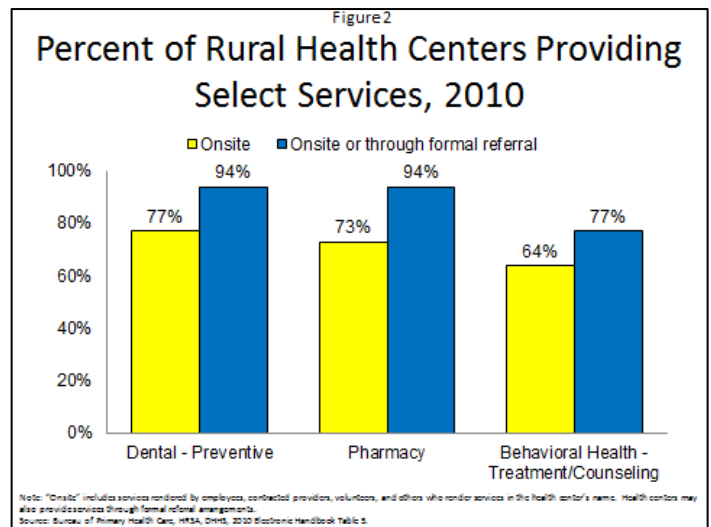
Patients of health centers reflect the underserved communities in which the centers locate. Ninety percent of rural health center patients have low incomes (less than 200% of the Federal Poverty Level) while two-thirds are uninsured or insured through Medicaid.⁷ Compared to all health center patients, patients of rural health centers are more likely to be over the age of 65 (Figure 1). It is not surprising, then, that their patients are also more likely to be Medicare beneficiaries compared with all health center patients.

Rural health center patients are also sicker than the general rural population. They are more than twice as likely to report being in fair or poor health and almost twice as likely to report limitations related to activity.⁸



Rural Health Center Services

Like all health centers receiving funding under section 330 of the Public Health Service Act, rural health centers provide comprehensive primary and preventive health care services. They also offer services that extend beyond those typically offered in primary care settings. Almost all rural health centers provide dental, behavioral health, and pharmacy services onsite or through relationships with other local providers (Figure 2). Since barriers to health care are a common problem in rural areas, health centers also provide an important array of “enabling services” that facilitate access by either bringing patients to care or care to patients. Rural health centers provide many of these services at about the same rate as health centers overall, but were more likely to provide two specific enabling services as of 2007: nursing home placement and home visiting.⁹ These services speak to the large number of elderly people living in these areas, as well as the high volume of patients experiencing geographic and transportation barriers.



Record of Success for Rural Health Centers

Research shows that health centers' efforts have led to visible results in terms of **enhanced access to needed care, improved health outcomes, reduced health disparities, and generated health care savings and significant economic benefits.**¹⁰ These impacts extend to rural communities as well.

- Rural health center female patients are significantly more likely to receive Pap smears compared to rural women nationally.⁸
- Rural health center patients experience lower rates of low birth weight than patients of other providers.⁸
- Even after adjusting for population density, rural counties with health centers exhibited 25% fewer uninsured Emergency Department visits than non-health center rural counties.¹¹
- Rural health centers yield around \$5 billion annually in economic returns through the purchase of goods and services and by generating needed jobs.¹²

These positive impacts will grow as the Health Center Program expands. While considering new grantees for the Health Center Program, the federal Bureau of Primary Health Care gives priority to sparsely populated rural areas to assist in ensuring that the Health Center Program is balanced in its funding of urban and rural areas. Thus, by strengthening and expanding the Health Center Program as a whole, rural areas will continue to benefit from expanded access to care.

¹KFF State Facts. Population Distribution by Metropolitan Status, states (2008-2009), U.S. (2009), www.statehealthfacts.org. ²Agency for Healthcare Research and Quality. "Health Care in Urban and Rural Areas, Combined Years 2004-2006." *MEPS Chartbook No. 13*. 2009. <http://www.ahrq.gov/data/meeps/chbook13up.htm>. ³The National Advisory Committee on Rural Health and Human Services. *The 2005 Report to the Secretary: Rural Health and Human Services Issues*. April 2005. ⁴The Robert Graham Center's analysis of "medically disenfranchised" populations. For more information, see NACHC and the RGC. *Access Denied*. March 2007. <http://www.nachc.com/access-reports.cfm>. ⁵Bennett K, et al. "Health Disparities: A Rural-Urban Chartbook." Rural Health Research and Policy Centers 2008. ⁶NACHC, 2011. Includes all patients of federally-funded health centers, non-federally funded health centers, and expected patient growth for 2011. Data on federally-funded health centers from Bureau of Primary Health Care, HRSA, DHHS, 2010 Uniform Data System (UDS). Proportion of all US residents does not account for health centers located in U.S. territories. ⁷NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2010 Uniform Data System (UDS). ⁸Regan J, et al. "The Role of Federally Funded Health Centers in Serving the Rural Population." *J Rural Health*. 2003 19(2): 117-124. ⁹2007 is the latest year available for this data. NACHC analysis of Bureau of Primary Health Care, HRSA, DHHS, 2007 Uniform Data System (UDS). ¹⁰Proser M. "Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care." *J Ambul Care Manage* 2005 28(4): 321-330. ¹¹Rust G, et al. "Presence of a Community Health Center and Uninsured Emergency Department Visit Rates in Rural Counties." *J Rural Health* 2009 25(1): 8 – 16. ¹²Based on 2007 revenue and applies an average economic multiplier for rural health centers of 1.3. Developed with input from Capital Link.