



**Geiger Gibson/RCHN Community Health Foundation  
Research Collaborative  
The George Washington University  
School of Public Health and Health Services, Department of Health Policy  
Research Brief #1**

**How Does Investment in Community Health Centers Affect the Economy?**

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## **Executive Summary**

The economic slowdown has prompted policymakers to focus on investments that can produce rapid economic gains in communities. Building on a previous analysis, this Research Brief estimates that a \$250 million appropriations increase in the community health centers program would yield health care for an **additional 1.8 million patients** and a **nationwide four-to-one return on investment**:

- nearly \$1 billion in direct community economic benefits, and
- over \$1.1 billion in indirect benefits in jobs and other community investments.

On a state-by-state basis, each \$1 million in federal appropriations would assure care for an additional 8,400 patients and a **six-to-one rate of return with more than \$6 million in direct and indirect economic benefits**.

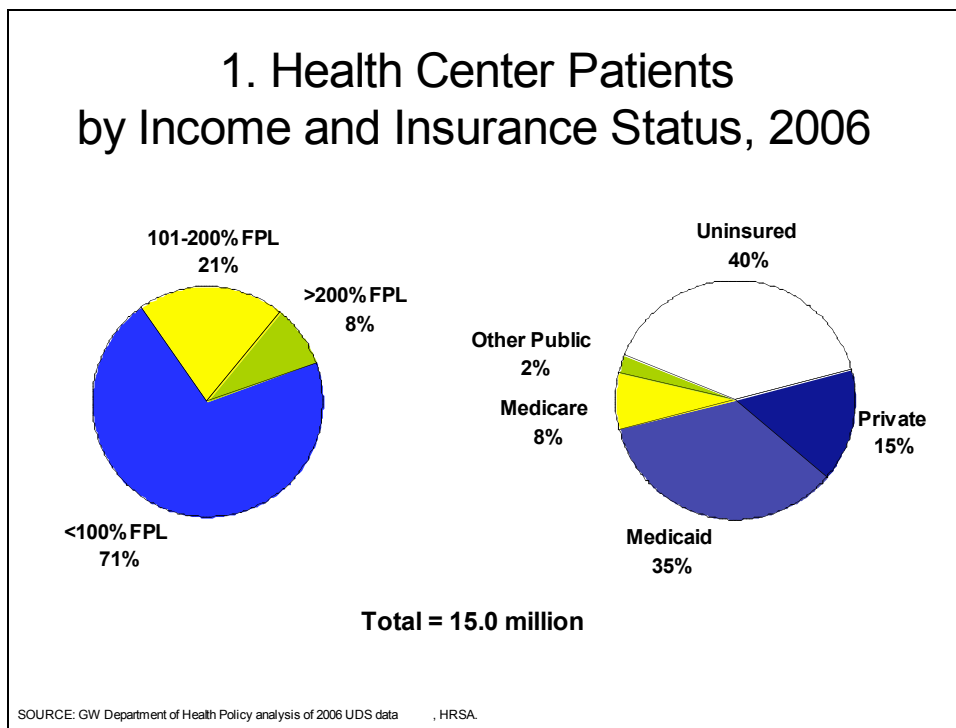
## **Overview**

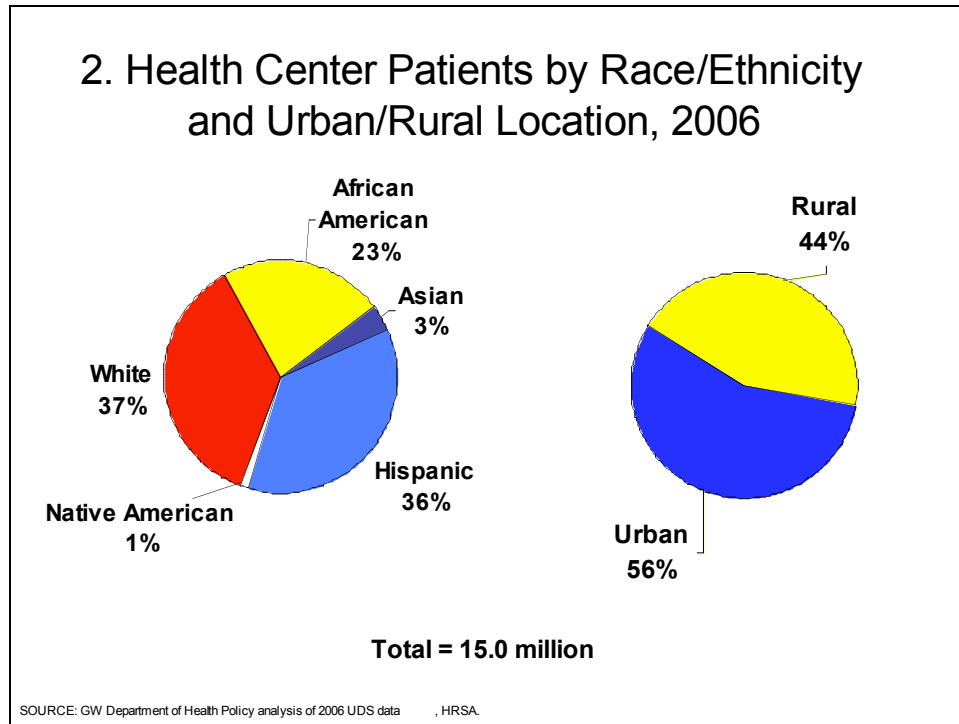
The current economic slowdown has prompted policymakers to focus on investments that can help produce rapid economic gains in communities. The stimulus package signed by President Bush on February 13, 2008, is intended to provide a short term infusion of funds into the economy. However, experts predict that the economic downturn could be lengthy and serious; as a result, lawmakers are expected to continue to search for additional investment strategies. Of particular importance are investments that not only offer urgently needed services but that also are able to rapidly transform themselves into productive employment and services in hard-hit communities.

Community health centers are located in rural and urban communities that tend to be particularly affected during economic downturns because of their vulnerability to eroding financial conditions. In 2006, the nation's 1,002 federally funded community

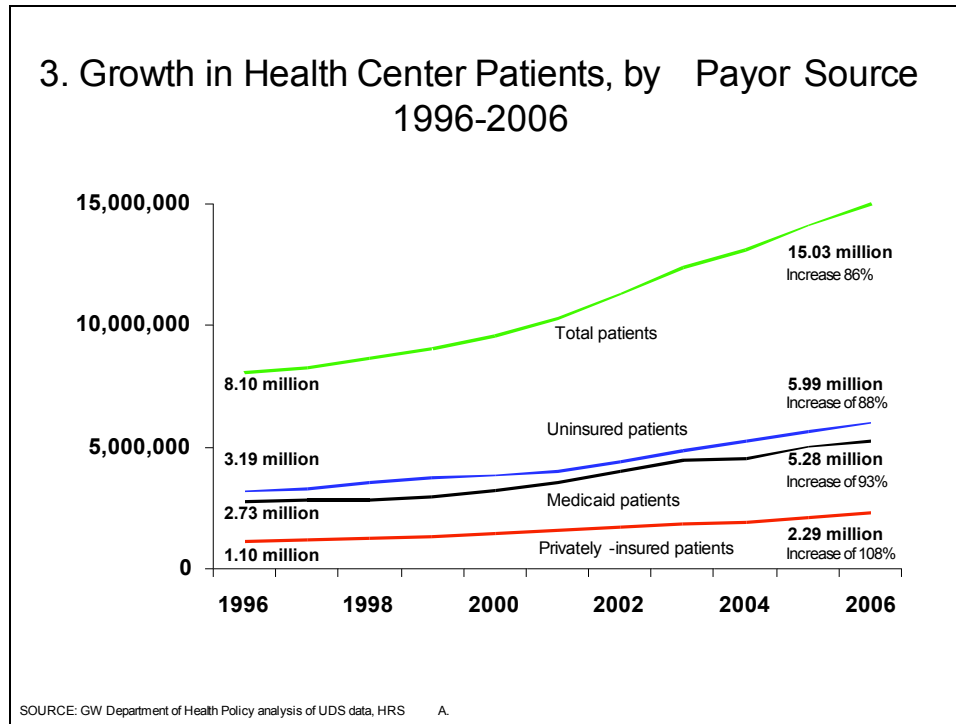
health centers operated in over 6,300 rural and urban medically underserved communities characterized by high levels of poverty, high rates of uninsured persons, and elevated health risks.

During 2006, health centers employed more than 97,000 health care professionals and administrative staff (including clerical and patient support staff) and furnished comprehensive primary medical and dental care to more than 15 million community residents, 90 percent of whom are low income, 40 percent of whom have no health insurance, and two thirds of whom are members of racial and ethnic minority groups. In 2006, 44 percent of health centers operated in rural locations, while 56 percent were located in urban areas, as shown in **Figures 1 and 2**.





Health centers have demonstrated capacity to grow rapidly to meet patient need, as shown in **Figure 3**. Indeed, rapid expenditure of funds is an express condition of federal grant awards: health centers that receive site expansion funds must be able to implement proposed service expansions within 90 days of grant receipt.



## Study Methods

Using available data sources, it is possible to calculate the direct and indirect economic effects of an investment in health centers. The Uniform Data System, which is administered and maintained by the Health Resources and Services Administration, includes tabulated financial, service, staffing, and patient data on all federally funded health centers. The data in the UDS provide information on federal and third party revenues as well as total cost information that allow estimation of the direct economic effects of health centers.

The UDS does not include data on indirect community impact. However, by using health center expenditure data and developing economic models that factor in production as well as costs associated with economic activity generated from health center operations, previous research has shown that health centers have both a direct and indirect economic impact within their communities.<sup>1</sup>

Cross-multiplication was used to estimate the amount of new revenue and economic impact. For example, the ratio of grant dollars to economic impact was used to estimate the economic impact from a \$250 million investment. Estimates were derived using both health center data from UDS and economic impact data from *Access Granted*, and were checked as much as possible against the source data to ensure mathematical and

<sup>1</sup> National Association of Community Health Centers, 2007. *Access Granted*, available at [http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access\\_Granted\\_FULL\\_REPORT.pdf](http://www.nachc.com/client/documents/issues-advocacy/policy-library/research-data/research-reports/Access_Granted_FULL_REPORT.pdf) (Accessed February 11, 2007)

logical consistency (e.g., does the number of new uninsured still account for 40 percent of all new patients). In calculating new patients, the average cost per patient was used. Because of the lack of actual economic data, and in order to avoid overstating the precision of each calculation, estimates are provided as a rounded number.

## Findings

We derived national and state-by-state estimates of the stimulus effects of a \$250 million federal health center spending increase to help existing health centers expand existing service sites, add service locations, add necessary services, and increase their hours of operation.

### National Benefits

*Health care for more patients:* In 2006, health centers reported earning approximately \$3 in third party revenue for every \$1 in health center grant funding.<sup>2</sup> Thus, a \$250 million investment would translate into nearly \$750 million in additional third party revenues, bringing the total revenue for health centers to approximately \$1 billion. Assuming that the per capita cost of serving a health center patient remains constant at \$538, health centers would be able to serve an additional 740,000 uninsured patients and 1.1 million publicly or privately insured patients.<sup>3</sup> In sum, a \$250 million investment in health centers would allow health centers to serve an additional 1.8 million patients. More than 92 percent of these new patients would be low-income, 63 percent would be members of racial and ethnic minority groups, and 40 percent would be uninsured.<sup>4</sup>

*Direct and indirect economic benefits.* As **Table 1** shows, a \$250 million investment would result in approximately \$1 billion in new health center revenues from private and public sources.<sup>5</sup> For communities, the health center investment would translate into approximately \$2.1 billion in economic benefits, including 24,000 new community jobs and significant investment in community services and supplies.

### Urban-Rural Estimates

UDS data permit estimates tied to the urban/rural status of individual grantees. We estimate that, of the total economic activity produced by an additional \$250 million health center investment, 23 percent (\$480 million) would be generated in rural service areas, while 77 percent (\$1.6 billion) would be generated in urban communities.

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<sup>2</sup> Third party payments only include self-pay, private, Medicaid, Medicare, and other public coverage. The rate of return is estimated to be 4-to-1 if other federal, state, and local grants and contracts are included in the calculation.

<sup>3</sup> Approximately 40 percent of health center patients are uninsured.

<sup>4</sup> Based on 2006 UDS data, HRSA.

<sup>5</sup> Direct benefits estimates include all health center revenues, including other forms of federal, state, and local grants and contracts, and mirrors health center expenditures.

**Table 1. National Economic Impact of a \$250 Million Investment in Community Health Centers<sup>6</sup>**

<b>Impact measure</b>	<b>National</b>	<b>Rural</b>	<b>Urban</b>
New revenues into communities (grants and third party payments)	\$1.0 billion	\$420 million	\$600 million
Total economic activity	\$2.1 billion	\$480 million	\$1.6 billion
Additional patients served	1.8 million	830 thousand	1.0 million
Jobs created	24,000	6,000	18,000

State-by-State Impact Estimates

It is also possible to estimate the effects of health centers on state economies, since the UDS data captures state and federal revenues, to determine the rate of return derived from funds invested in each state. We estimate that for every \$1 million in additional health center grant funding that flows to health centers, each state would realize, on average, an additional 8,400 patients served, 40 percent of whom would be uninsured, and would generate on average \$6.6 million in economic benefits. State-by-state results are shown in **Table 2**.

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<sup>6</sup> Urban and rural economic and job estimates based on D.C. (urban) and Idaho (rural) health center impacts are located in Appendix C of *Access Granted*. Data from the UDS were used to estimate the distribution of impacts between urban and rural locations; hence, urban health centers accounted for an estimated 77% of new revenues, 55% of new patients, and 75% of new jobs in the community.

**Table 2. State Estimates of the Impact of a \$1 Million Investment<sup>7</sup>**

State	New Revenues	Total Economic Activity Generated	New Patients Served	Jobs (FTE)
AK	\$2,500,000	\$5,100,000	2,800	54
AL	\$1,900,000	\$3,600,000	8,400	41
AR	\$1,300,000	\$3,600,000	5,600	48
AZ	\$4,900,000	\$9,200,000	9,500	105
CA	\$6,400,000	\$12,900,000	12,500	141
CO	\$4,400,000	\$7,700,000	8,200	84
CT	\$6,000,000	\$12,000,000	11,900	130
DC	\$6,300,000	\$9,600,000	10,100	111
DE	\$1,600,000	\$3,500,000	5,000	44
FL	\$3,200,000	\$7,000,000	8,400	83
GA	\$1,900,000	\$5,100,000	7,400	58
HI	\$5,800,000	\$12,000,000	8,700	144
IA	\$2,900,000	\$5,900,000	7,200	74
ID	\$1,700,000	\$4,500,000	6,200	59
IL	\$4,500,000	\$9,900,000	11,700	106
IN	\$3,900,000	\$8,000,000	10,000	102
KS	\$2,500,000	\$5,100,000	8,100	74
KY	\$3,800,000	\$7,200,000	10,000	91
LA	\$1,700,000	\$4,400,000	7,000	57
MA	\$8,500,000	\$15,100,000	10,600	162
MD	\$4,900,000	\$10,800,000	9,300	113
ME	\$5,300,000	\$8,800,000	11,600	111
MI	\$4,200,000	\$8,300,000	10,700	95
MN	\$4,400,000	\$8,400,000	8,200	92
MO	\$3,600,000	\$7,700,000	8,100	88
MS	\$2,100,000	\$5,200,000	9,800	67
MT	\$1,500,000	\$3,600,000	6,200	47
NC	\$2,200,000	\$5,200,000	8,000	64
ND	\$2,300,000	\$4,700,000	7,000	64
NE	\$3,700,000	\$6,400,000	6,600	85
NH	\$4,800,000	\$10,500,000	10,000	132
NJ	\$3,700,000	\$8,200,000	9,700	85
NM	\$3,000,000	\$5,900,000	6,800	75
NV	\$2,400,000	\$4,600,000	9,300	60
NY	\$6,500,000	\$12,300,000	11,800	126
OH	\$2,500,000	\$5,800,000	7,600	67
OK	\$2,300,000	\$5,500,000	7,600	69

<sup>7</sup> Economic activity based on cross-multiplication of ratios using data from the UDS and economic impacts from *Access Granted*. New patients may be higher in some states for the similar economic or new revenue estimates due to varying average cost rate. New revenues were generated using the ratio of health center grant funding and other revenues from the UDS data.

State	New Revenues	Total Economic Activity Generated	New Patients Served	Jobs (FTE)
OR	\$4,200,000	\$9,400,000	6,400	110
PA	\$3,100,000	\$7,300,000	10,100	86
RI	\$4,300,000	\$6,600,000	9,100	86
SC	\$2,300,000	\$5,500,000	8,100	69
SD	\$2,200,000	\$4,700,000	7,100	59
TN	\$2,700,000	\$6,400,000	9,400	76
TX	\$2,800,000	\$6,300,000	7,200	78
UT	\$3,300,000	\$5,700,000	8,000	65
VA	\$2,300,000	\$5,000,000	6,800	62
VT	\$5,100,000	\$8,600,000	8,900	103
WA	\$8,400,000	\$13,800,000	13,200	155
WI	\$7,500,000	\$14,600,000	9,800	147
WV	\$4,800,000	\$12,400,000	12,300	107
WY	\$2,700,000	\$6,400,000	6,700	71

## Conclusion

Because of their location and their ability to rapidly translate additional funding into health care, community services, and employment, health centers represent an important means of stimulating hard hit communities while promoting access to health care for individuals and families experience the health care access impact of an economic downturn. Indeed, considerable evidence underscores that where health care is concerned, the adverse access effects of an economic downturn go on well beyond the time of recovery.<sup>8</sup> As a result, expanded investment in health centers can be justified even during a recovery phase.

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<sup>8</sup> Carmen DeNavas-Walt, Bernadette D .Proctor, and Cheryl Lee, United States Census Bureau: Income, Poverty and Health Insurance Coverage in the United States: 2004 *Current Population Reports* P60-229 (GPO 2005) (Table 8); John Holahan and Mary Beth Pohl, Changes in Insurance Coverage: 1994-2000 and Beyond *Health Affairs Web Exclusive* (3 April 2002, W 162-172)