Health Centers: A National Profile

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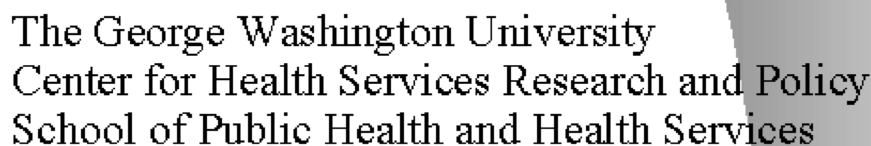
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Introduction

Begun in 1965 as an eight-site demonstration, federally funded health centers have grown into a nationwide network of approximately 700 comprehensive primary care practices located in nearly 3000 urban and rural communities and serving more than 9 million patients through a network of 6500 clinicians.[1] An integral part of the modern health care system, health centers have improved access to health care and patient health status. In his Fiscal 2002 budget, President Bush has called for a doubling of the program.

This National Profile of federally funded health centers offers an in-depth look at health centers, the patients they serve, the services they furnish, and information on revenues and expenditures. The national data presented in this profile are derived from the Uniform Data System, a special reporting system covering all federally funded health centers, which collects ongoing information on patients, revenues, expenditures, and medical and administration activities.[2]

In General

In 1999, federal funding allocated under §330 of the Public Health Service Act supported 690 health centers in all states, the District of Columbia, Puerto Rico, the Virgin Islands, and the Trust Territories. Health centers operated in over 3300 community clinical sites, 53% of which were rural and 47%, urban. Figure 1 shows the categories of health center grants in 1999 under each of the four principal grant categories (general grants, grants to serve migrant and seasonal farm workers, grants to serve homeless persons and families and public housing health care). Many health centers hold grants in more than one of these four categories and offer special services tailored to the needs of these unique sub-populations.

Patients Served by Health Centers

Health centers are structured as family practice programs. Moreover, under federal law, their practices must be located in communities that are medically underserved, as measured by poverty, a lack of health insurance, the limited availability of primary health care, and poor health status. In order to receive start-up and operational funding, health centers must make their services available to all community residents, participate in public insurance programs, and furnish care to uninsured patients in accordance with ability to pay.

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[1] "Experts With Experience" Community & Migrant Health Centers Highlighting a Decade of Service (1990-2000) U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care.

[2] The UDS data requirements apply to all health centers except new starts. Thus, the actual number of operational health centers may exceed the number whose data can be found in the UDS. In addition, there are approximately 200 "federally qualified health centers" that meet all federal health center funding requirements but do not receive a grant under §330 of the Public Health Service Act. Like federally funded health centers, these "look alike" FQHCs qualify for special federal Medicare and Medicaid payment rates and assume other important duties, such as provision of outstationed enrollment services to Medicaid eligible persons.

The data on the patients served by health centers reflect not only their mission, but also the standards under which they operate. Health center patients reflect the family practice emphasis placed on the program. In 1999 slightly more than 40% of patients seen at health centers were children, approximately half were working age adults, and 7 percent were elderly. (Figure 2.)

Health center patients are remarkably racially and ethnically diverse. Figure 3 shows that in 1999, one third of all patients were Hispanic, nearly 36% were non-Hispanic white, 26% Black or African-American, 1% Native American, and 3% Asian/Pacific Islander. In keeping with the living arrangements of different racial and ethnic groups in the U.S., health centers located in or serving urban communities were somewhat more likely to treat Black and African American patients, while those in rural areas were more likely to have White-non-Hispanic patients.

Virtually all health center patients are low income. (Figure 4) Nationally, nearly 90% of all health center patients in 1999 had family incomes below twice the federal poverty level. Health center patients in urban areas were somewhat more likely to experience deep poverty (i.e., family incomes below 100% of the federal poverty level).

Health center patients also are far less likely than persons generally to have a source of health insurance and far more likely to depend on public insurance. In 1999, more than 40% of all health center patients were completely uninsured, and one third depended on Medicaid and the State Children's Health Insurance Program (SCHIP). Only 15% of all patients had private insurance. (Figure 5) The dramatic differences between health center patients and the general population where health insurance is concerned can be seen in Figure 6. Nationally, health center patients in 1999 were only about one fifth as likely to have private insurance, nearly 3 times as likely to be completely uninsured, and more than 3 times as likely to depend on Medicaid.

Over the years, a steadily increasing proportion of health center patients have been without health insurance, a development that presents a particular challenge to health centers in terms of both financial resources and their ability to manage patients with serious and chronic health conditions whose needs may exceed the care and services available through a health center itself. Figure 7 shows that between 1990 and 1999, while the number of uninsured Americans generally grew by 23%, health centers experienced a 63% increase in the proportion of patients without insurance. During this time period, grants to support health center operations and development remained essentially flat, once medical care inflation was taken into account.[3]

Health center patients also include certain persons who face particularly harsh barriers to health care. Among patients served in 1999 were nearly 600,000 members of migrant and seasonal farmworker families as well as over a half million persons who were members of homeless families. (Figure 8.)

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[3] Dan Hawkins and Sara Rosenbaum, Community Health Centers: Issues and Challenges. *The Future of the Health Care Safety Net* (American Association for the Advancement of Science, Chicago, IL, 1997)

Health centers' mission, location, and operational standards can be seen in the significant, differences in insurance status between the patients served at health centers and those who receive care through office-based physician practices. These differences underscore the enormous importance of the operational grants that health centers receive. Figure 9 shows that more than 40% of all health center patients are "self pay," compared to 5% of patients treated in physician offices. Even this difference does not fully capture the significance of this distinction; since health center patients are overwhelmingly low income, it is also the case that "self pay" health center patients cannot afford to contribute even nominally to the cost of their care.

Among insured patients, there are also major differences. Figure 9 shows that more than half of all patients served in office based practices have private insurance, while only 15% of health center patients have private insurance. Similarly, while a third of all health center patients receive coverage through Medicaid, Medicaid is a source of payment for only 7% of patients seen in physician practices.

Sources of Funding and Health Center Activities

Sources of health center funding mirror the patients served. Figure 10 indicates that in 1999, private insurance, the main source of personal health care financing among the non-elderly population, represented only 6.5% of all revenues received by health centers. Federal grants accounted for 24% of health center operations, and state-administered programs (Medicaid and other state and local health programs) accounted for nearly half of all funding.

This growing dependence on state-administered program funding and away from federal grants can be seen in Figure 11. Between 1985 and 1999, federal grants as a proportion of health center operating funding fell by half, from 51% to 24%. Put another way, even as the total number of uninsured patients grew by 40%, the federal grant funds available to meet their health needs fell by half. This decline in grant funding in relation to the number of uninsured patients has meant that other sources of revenues have grown in importance, and has heightened the need to secure and sustain these revenues as a means of conserving federal grants for uninsured patients and services.

Perhaps the most remarkable shift has come in the Medicaid program. Figure 11 shows that during the 1985-99 time period, the proportion of revenues derived from Medicaid more than doubled, reflecting both growth in the number of Medicaid patients served as well as in the size of Medicaid payments received. Figure 11 reflects the fact that by 1999, these payment reforms helped ensure that state/federal Medicaid payments are in adequate proportion to the proportion of all health center patients who are Medicaid beneficiaries. In 1985, Medicaid payments were so low that proportionately, they stood at half of the ratio of Medicaid-enrolled patients to total health center patients.

Figure 12 shows that in 1999 health centers provided nearly 37 million patient encounters on a total revenue base of nearly 3.4 billion dollars. The majority of health center revenues are invested directly into the support of clinical and enabling service patient care; the remainder is invested in administration, facility development and maintenance, and other health care developmental and operational activities.

Health centers have increased their efficiency over the past several years. Figure 13 shows that in 1999, the average medical cost of a medical encounter across all health centers stood at slightly less than $54, down from nearly $60 in 1996. Most of this decline could be attributed to the declining cost in health encounters in urban health centers, where managed care enrollment is particularly common.

The range of services offered by health centers mirrors those available through physicians. However, there are notable differences as well, reflecting the differences in patients. In 1999, health center patients were over nine times more likely to make visits for reasons related to diabetes and were more than three times as likely to receive care related to the management of hypertension. (Figure 14)

Like the rest of the health care system, health centers are active participants in managed care. In 1999, one third of all health center revenues were derived from managed care operations, a figure that is far higher when managed care revenues by payer source is determined.(Figure 15) This is particularly true for revenues derived from state-administered payers; in 1999, nearly 60% of all Medicaid revenues and more than half of all other public revenues came from managed care. Figure 16 shows that managed care revenues are sensitive to the markets in which health centers participate. The proportion of revenues derived from managed care operations is greater in those states in which managed care – either for the general population or as a feature of the state's Medicaid program – is particularly prevalent.

Challenges and Opportunities

Health center patients reflect many of the most important challenges facing the American health system today: low income and its attendant effects on health status, the special risks faced by persons who reside in poor communities with limited services, and the disparity in health status between minority and non-minority Americans. Yet at the same time, their location and mission gives health centers a unique opportunity to make a major contribution to health care improvement for all Americans. Health centers are anchored in the communities that need health care interventions the most, and their resilience over the past 35 years in the face of enormous community change is remarkable.

Theses national statistics also underscore the fact that over time, health centers have become increasingly sensitive to state health policy and practice. In 1985, the federal grant accounted for half of all health center revenue; by 1999, that figure had dipped to less than a quarter, even as the number of uninsured patients grew by more than half.

The revenues received by health centers under state administered programs reflect the growing importance of health centers to state policy. In 1996, half of all states invested in comprehensive primary health care,[4] and much of this investment focused on health centers. This figure appears to have grown over the past several years, as states have increased these investments and other states have enacted investment programs for the first time. As state and local funding has increased, and as the role of Medicaid has become more

[4] Sara Rosenbaum et. al., "State Funding of Comprehensive Primary Medical Care Service Programs for Medically Underserved Populations" 88 *AJPH* 3 (March, 1998)

pronounced, state health policy for lower income Americans has come to occupy a strong influence over the operation of health centers, and the success of health centers has become strongly intermingled with state policy choices. Simultaneously, the data contained in this profile reflect the fact that health centers have become as important to states' ability to achieve health improvements for underserved populations. Health centers are one of the central sources of primary health care for Medicaid beneficiaries and low-income adults and children. States' recognition of health centers as cost efficient health care anchors in communities that lie beyond the reach of normal market responses can be seen in their growing investment in health center services through both Medicaid and general public revenues.

Certain health center activities bear particular note because of their importance to the achievement of broad public policy goals. Forty percent of health center patients are children and adolescents, making health centers a key provider of pediatric health care. The extensive rate of diabetes and hypertension-related care furnished at health centers makes centers a logical means of investing in services and activities designed to address these terrible health problems that disproportionately affect minority Americans. The amount of dental care available through health centers makes them a major source of dental care nationally for lower income Americans, whose access to dental care appears to be disastrously low in many communities.

Finally, the fact that health centers treat not just children or adults but entire families makes health centers a particularly critical source of investment in preventive programs and services that are aimed at keeping families together and healthy. This ability to furnish a comprehensive range of treatments to entire families makes health centers a particularly important strategy for interventions aimed at promoting overall family health and wellness and reducing health and mental health risks that threaten family stability.

This national profile also underscores the challenges health centers face. Uninsured patients as a proportion of health center patients remains high, but the federal revenues available to furnish care are well below an amount that reflects the financial realities related to care for the uninsured. A changing and far more competitive health system has placed increasing financial pressures on centers to achieve greater efficiency. At the same time, as other sources of health care for the uninsured have declined in the face of growing competitive pressures, health centers have had to respond not only to the changes demanded by managed care and an increasingly competitive health system but also to growing need in their communities for services among persons without a means of paying for care.

Health problems and community health needs also have changed. The changing face of Americans as a result of the wave of immigration means that health centers, whose hallmark is the ability to adapt their services to meet community needs, have had to respond in unprecedented ways. These responses are essential not only with respect to the medical care health centers furnish but also with respect to enabling services that make health care accessible to immigrant populations. As other health problems arise in communities -- for example, the growth of HIV/AIDS in the rural South, the increasing demand for mental health care, and high prevalence of chronic physical and mental illness and disability among lower income patients – the need for additional resources also will increase.

All of these changes make health centers particularly important to the overall success of the American health system and a vital source of and link to health care in the communities they serve. This profile illustrates the shared stake in the success of health centers among their patients, the communities they serve, and state and federal policy makers.