



## Community Health Centers in Low-Income Areas

*Tom Manning*

Community Health Centers—specifically, Federally Qualified Health Centers—are providing low-income communities with high-quality preventive care while reducing avoidable hospital stays.

Like the old-time family doctor, Community Health Centers (CHCs) provide primary care to millions, including one in three Americans in poverty, while accounting for only about one-half of one percent of U.S. health-care spending (\$15.6 billion for 22.7

million patients in 2013).

With total U.S. health-care spending approaching \$3 trillion annually, among the most significant health trends as the population ages and as obesity rates rise is the growth of chronic illnesses. In low-income communities, the prevalence of disabling chronic illnesses is above national averages. One study found that diabetics in low-income neighborhoods are 10 times more likely to have an amputation than those who live in more affluent areas.<sup>1</sup>

Fortunately, advances in medicine enable CHCs and other primary-care providers to care for more conditions. And with appropriate intervention and management at the primary-care level, fewer conditions require costly hospitalization or nursing-home care. More cases of asthma and diabetes, for instance, are being managed by patients working with family doctors and avoiding life-threatening acute episodes or early disability.

### The Role of Health-Care Reform

The shift to preventive care and chronic-care management in a low-cost, primary-care setting such as a CHC is the essence of health-care reform. Low-cost community-based care, enabled by medical and scientific advances, is driven by necessity. After all, the United States competes in a global economy with other advanced countries that spend less on health care and show better results.

The U.S. health-care system is an inverted pyramid, with heavy investment in after-the-fact intervention and little investment in a foundation of primary and preventive care. Consider the hallmarks of our inverted system:

- Atop of the upside-down pyramid is specialty care and hospital-based treatment. Only one in eight U.S. doctors is a general practitioner, whereas the Organization for Economic Co-operation and Development (OECD) says its member nations average one in four.<sup>2</sup>
- Primary-care doctors earn the least; specialists earn far more.
- Preventable hospitalizations are high. With a system that rewards cure rather than prevention, the nation has twice the average OECD rate of asthma-related hospitalizations and nearly eight times Canada's rate.
- Compared with our industrialized peers, we have vastly higher health-care spending—more than 17 percent of GDP, compared with roughly 8 percent to 11 percent.
- U.S. health-care quality is low relative to expenditures. Public-health measures such as life expectancy tend to be below OECD averages.

Changes are under way. We're beginning to see more emphasis on primary and preventive care, a shift toward payment for outcomes rather than procedures, care management and coordination among providers, and care networks able to take full responsibility for the patient.

At the state level, Massachusetts had the most direct model for the Affordable Care Act (ACA), and another New England state had a noteworthy pre-ACA reform initiative. Rhode Island required that private insurers nearly double their spending on primary care, from an average of 5.9 percent (considered typical nationally) to 10.9

percent over five years, ending in 2014. Known as the "Affordability Standards," the spending requirements included improved management of chronic conditions, widespread adoption of electronic health records, and a move toward comprehensive payment reform. In early 2014, the state reported that the approach was on track.

The ACA benefits low-income people by expanding insurance coverage through private insurance exchanges, expanding Medicaid eligibility, and driving health-system change via payment reform (incentives rewarding prevention and penalizing unnecessary procedures).

Such strategies drive the provision of health care toward primary care. Whereas uninsured people typically do not have a doctor and might turn to emergency rooms, most newly insured seek out a family doctor and get a check-up. Health-care networks, which can share in savings if they meet quality standards, place a new emphasis on keeping patients healthy while providing care in the lowest-cost appropriate setting, often the primary-care level.

In addition to those drivers, the ACA includes measures that directly support CHCs and primary care:

- \$11 billion to support the expansion of Federally Qualified Health Centers through a combination of capital and operating grants (to be expended by the end of federal fiscal year 2015),
- scholarships and loan-repayment support for primary-care physicians and support staff, and
- new programs funded through the Center for Medicare and Medicaid Services Innovation Center.

### The Bigger Picture

How does ACA support of CHCs and primary-care expansion square with many states' strategies to limit the growth of Medicaid spending? In fact, the strategies can and should be complementary.<sup>3</sup>

#### Medicaid and Health Centers

Expanded primary care, with its emphasis on prevention and early disease detection, is the fundamental strategy many states adopt to reduce the high costs and personal tragedies stemming from unmanaged chronic conditions and avoidable hospitalizations.

For low-income communities, CHCs are central to that strategy. The basic economic logic can be seen in a simple comparison of the cost of a CHC medical appointment that addresses an issue before it becomes serious (about \$150) to the cost of hospitalization when things get out of hand (typically, more than \$10,000). Although a true comparison is not simple (patients see their doctor three or four times per year and are seldom admitted to the hospital), hospitalizations occur too often. About one in four have been judged preventable.<sup>4</sup>

A full economic analysis, beyond the Medicaid budget, would also need to consider such factors as the increased output of a healthier workforce, the ongoing value for children of better health and fewer school absences, and the shift of economic activity from hospital and nursing-home care to the activities of a healthier population. Such an analysis is extremely complex and subject to debatable assumptions, but it's not hard to imagine that preventing health

problems and managing chronic conditions would create sustained and substantial benefits for both individuals and society.

### Other Determinants of Health

The goals of better health at lower cost have created a renewed appreciation for the power of the nonmedical determinants of health—education, good housing, steady employment, public safety, and the like. The quality of such social factors is considered a better predictor of health than the quality of medical care.<sup>5</sup> That understanding is reenergizing the original CHC paradigm, one in which a primary-care provider is connected not just with other medical professionals, but also with a full range of social supports for patients.<sup>6</sup>

CHCs are particularly well situated to contribute to such strategies:

- they are community-based, with a majority of board directors who are, by law, CHC patients;
- they are accustomed to working with a wide range of fellow community-service organizations;
- they are major employers, with 162,000 full-time-equivalent jobs at all skill levels, working at 1,300 CHC entities with approximately 9,000 service sites across 50 states; and
- they bring foot traffic to their communities, creating additional economic activity. In 2013 alone, CHCs drew 90 million patient visits by 22.7 million individuals.

Two examples of CHCs working beyond medicine to improve health in their communities are the Fair Haven CHC of New Haven, where patients at risk of contracting diabetes can volunteer at and get fresh vegetables from local community gardens, and Urban Health Plan, a CHC in the Bronx, which has legally affiliated with a local community development corporation to maximize economic opportunity.

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It's important to note that the driving logic of health-care reform—better health at lower cost—can be achieved only by continuing to move more care, when appropriate, out of hospitals and into ambulatory facilities such as CHCs. Hospitals are irreplaceable for numerous life-saving and life-improving interventions, but fewer activities need to be done within those four walls.

Within a landscape of improved health and benefits to low-income communities, it is important to acknowledge that the shift is not without consequences. With hospitals as major employers in low-income communities, the benefits of health-care reform will result in the loss of many hospital jobs and the need to retrain many workers in the arts of prevention, chronic-care management, and other wellness strategies.

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### Endnotes

- <sup>1</sup> Carl D. Stevens, et al., "Geographic Clustering of Diabetic Lower-Extremity Amputations in Low-Income Regions of California," *Health Affairs* (August 2014), <http://content.healthaffairs.org/content/33/8/1383.abstract>.
- <sup>2</sup> Though largely European, the 34 OECD countries also include Australia, New Zealand, Japan, South Korea, Israel, Canada, Chile, Mexico, Turkey, and the United States.
- <sup>3</sup> To control Medicaid spending, many states are adopting the reform agenda (increased investment in primary and preventive care). Efforts to control Medicaid spending are typically characterized as "cutting Medicaid," though it usually means "slowing the growth in spending." Medicaid eligibility expansion under the ACA is 100 percent federally funded for FY 2014–2016, and 90 percent federally funded thereafter. So it is possible for a state to cut its own share while expanding eligibility.
- <sup>4</sup> Misha Segal et al., "Medicare-Medicaid Eligible Beneficiaries and Potentially Avoidable Hospitalizations," *Medicare & Medicaid Research Review* 4, no. 1 (2014): [http://www.cms.gov/mmrr/Downloads/MMRR2014\\_004\\_01\\_b01.pdf](http://www.cms.gov/mmrr/Downloads/MMRR2014_004_01_b01.pdf).
- <sup>5</sup> Richard Wilkinson and Michael Marmot, eds., *Social Determinants of Health: The Solid Facts*, 2<sup>nd</sup> ed. (Copenhagen: World Health Organization–Europe, 2003).
- <sup>6</sup> See Barry Zuckerman, MD, "Tackling Health-Related Needs: Boston Medical Center Pediatrics," *Communities & Banking* 24, no. 3 (summer 2013), <http://www.bostonfed.org/commdev/c&b/2013/summer/tackling-health-related-needs-boston-medical-center-pediatrics.htm>; and J. Michael McGinnis, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* (March–April 2002), <http://content.healthaffairs.org/content/21/2/78.full.pdf+html>.

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