
This article simulated increased funding under the Bush Administration’s initiative to expand health centers as well as reductions in uninsurance to determine the effect on racial/ethnic disparities in access to care among the low income. Authors used survey data and health center grant revenues reported in the Uniform Data System, and adjusted data for intrinsic links between insurance coverage, health center capacity, and access to care. Authors found that people living in areas with greater health center capacity are more likely to have a usual source of care and an ambulatory care visit compared to those who living in other areas. Authors also found that both increasing insurance rates and health center capacity improve access to care and narrow access disparities. Findings were especially pronounced in the case of minorities. Moreover, health center expansion may offset much of the adverse impact rising uninsurance has on access. Expansions in both insurance and health center capacity most effectively improve access and narrow disparities.


Authors examined medical records of a nationally representative sample of health center patients with chronic illness, as well as patient and health center characteristics associated with health outcomes, between 1999 and 2000. Using nationally recognized quality of care indicators, authors found that health center quality of care was comparable to or better than care delivered elsewhere, as measured by reduced hospitalizations and emergency department visits, higher vaccination rates, and higher cancer screening rates. Moreover, racial and ethnic disparities in quality of care were eliminated after adjusting for insurance. Although health centers experience limitations in providing care to the uninsured as measured by outcomes slightly behind those of insured patients, findings are similar to national trends. However, authors note that as health centers serve more uninsured patients, these patients will likely experience improved health outcomes. Authors also find that health centers with computerized decision support tended to provide better care than those without, and health centers may require additional resources to meet the needs of their uninsured patients.

Authors reviewed health center patient records from nationally representative samples of community health centers in 1994 and 2001. Over this time, health centers provided more preventive services and treated more chronically ill, near-elderly, and uninsured patients while improving quality and continuity of care. Authors found no disparities by race/ethnicity or insurance status in delivery of preventive services. The authors conclude that these findings suggest that the Federal Health Center Growth Initiative through 2006 will greatly improve access to quality care for underserved populations, while likely reducing national disparities for racial/ethnic minorities and the uninsured. However, health center expansion should coincide with expansions in insurance coverage and the primary care workforce.


Health centers are important providers of prenatal care for low-income women, accounting for 17.2% of all low-socioeconomic status (SES, defined here as births to mothers with less than 12 years of education) births nationally, including 25.4% of all low-SES Asian births, 20.6% of all low-SES black births, and 18.9% of all low-SES Hispanic births. Low-SES women seeking care at health centers experience lower rates of LBW compared to all low-SES mothers (7.5% vs. 8.2%). This trend holds for each racial/ethnic group, which is particularly noteworthy for African American women who are especially at higher risk for adverse pregnancy outcomes. Nationally, 14.9% of all low-SES black infants are born at LBW compared to 9.1% of low-SES white infants, a disparity of 5.8%. Comparatively, this black-white disparity is narrower at health centers, where 10.7% of health center black infants are born at LBW compared to 7.4% of health center white infants, a difference of 3.3%. If the LBW black-white disparity seen at health centers could be achieved nationally, there would be 17,100 fewer LBW black infants annually.


Found that as the proportion of a state’s low income population served by health centers grows, the black/white and Hispanic/white health gap narrows (i.e., declines) in such key areas as infant mortality, prenatal care, tuberculosis case rates, and age-adjusted death rates. The study also concluded that Medicaid alone has little direct impact on health disparities, but Medicaid coverage for low income patients is key to health centers’ ability to serve more of the low income in states, and in so doing reducing disparities. As evidence of this the GW researchers found that health center penetration (defined as the proportion of state low income served by health centers) had its lowest impact in reducing disparities for heart disease and diabetes related death rates. These diseases
disproportionately affect older low income and working-age minority adults, who are the least likely to have Medicaid coverage. Hence, it is the combination of customized, supported health care with comprehensive health insurance that may most effectively reduce health disparities.


Authors examined 1998 South Carolina hospital inpatient data in order to determine personal and community factors that influence ambulatory care-sensitive (ACS) hospitalizations among children under the age of 18. Those most likely to have a ACS hospitalization included children that were younger, male, non-white, Medicaid insured, and those living in counties that were rural, poor, and had a health professional shortage area designation. Counties with a health center had 55% fewer pediatric ACS hospitalizations, demonstrating the importance of health centers. In noting that poverty and the lack of a provider increases rates of ACS conditions, the authors support the President’s call to increase the number of health centers to prevent ACS hospitalizations and related costs.


Recognized the Health Disparities Collaboratives as a promising federal program targeting health disparities that should be expanded.


Specifically recognized the importance of community health centers, stating that “the community health center model has proven effective not only in increasing access to care, but also in improving health outcomes for the often higher-risk populations they serve.”


Concluded that having a good primary care experience, as characterized by enhanced accessibility and continuity, is associated with improved self-reported health status as well as income disparities in ratings of overall health status.

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Authors examine the socioeconomic status of adult community health center users and their use of screening services for secondary prevention. Findings reveal that users of minority or lower socioeconomic status were not less likely to receive preventive screenings than other adult users, and the screenings conducted were most often at a CHC. The study concludes that health centers are indeed providing preventive services to vulnerable populations that would otherwise not have access to certain services. Health centers improve access to timely screening and preventive services for low income and minority patients who would not otherwise have access to certain services, eliminating disparities among patients for these services.


Carlson et al., compares uninsured Community Health Centers (CHCs) users with the uninsured nationwide. Even though health center uninsured patients are more likely to live in poverty-stricken areas, be poorly educated, and be members of a minority group than the uninsured nationally, they are much more likely to have a usual source of care than the uninsured nationally (98% vs. 75%). In addition, they are significantly more likely to receive health promotion counseling on smoking, drugs, alcohol, and sexually transmitted diseases than the uninsured nationally.


Reviews literature showing that health centers improve access to preventive services, health outcomes, and have been successful in reducing or eliminating health disparities. Health center prenatal patients are less likely to give birth to low birth weight babies compared to their counterparts nationally. When compared to uninsured patients who do not receive care at health centers, health center uninsured patients are much less likely to delay seeking care because of costs, go without needed care, or fail to fill prescriptions for needed medicine. Health center Hispanic and African-American women, as well as women patients who are low income, uninsured, and have Medicaid, are more likely to receive mammograms, clinical breast exams, and pap smears than comparable women not using health centers.


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Examines the disparity in health status among health center patients of different racial and ethnic groups and compares those findings to non-health center patients. The study compares self-reported healthy life indicators from the 1994 Health Center User Survey and the 1994 National Health Interview Survey, including in the later survey set only those identifying a usual source of care other than a health center. The study finds that while there are significant racial and ethnic health disparities in healthy life among the general population even after controlling for socio-demographic factors, these disparities do not exist among health center users. Non-white Hispanic health center users experience healthier life than both African American and white users, and no significant differences were found between white and African American users. Conversely, among non-health center users, whites experience significantly healthier life than both African Americans and Hispanics. The study concludes that the absence of disparities at health centers may be related to their culturally competent practices and community involvement, features that are often lacking at other primary care settings.


Researchers looked at trends in primary care use by Americans in 1994 and 1998. In 1994, about 44% of the overall outpatient visits in the US were for primary care, averaging about 1.3 visits per person. Community health centers (CHCs) made up 4% of total primary care visits and 20% of all visits by Medicaid and uninsured minorities. Patients living in rural areas made up almost 50% of CHC primary care visits. Established CHC patients were twice as likely to present new health problems than established patients of hospital outpatient departments, and were also significantly more likely to do so than established patients of physicians offices – indicating that continuity of care is better at CHCs. The study also showed large disparities in the number of primary care visits by race/ethnicity. Hispanics made 20% fewer visits and Blacks made 33% fewer visits per person compared to whites. The authors noted that doubling the health center program from its size in the mid-1990’s while maintaining the overall patient composition would decrease the Hispanic/white disparity by 50% and the Black disparity by 24%.

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