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Free Clinics and the Uninsured: The Need for Remote Area Medical in Central Appalachia After Health Reform.

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ABSTRACT

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In 2008, the election of President Barack Obama brought health care to the forefront of national discussions and led to the passage of the Patient Protection and Affordable Care Act (ACA). The legislation changed the rules of health care delivery in the United States, but the ACA did not do one fundamental thing: It did not end the need for many of the nation's most needy patients to seek free medical care from groups such as Remote Area Medical (RAM).

A mobile clinic, RAM brings together volunteer dentists, physicians, nurses, and other professionals as well as support staff for multi-day clinic events to provide free, on-site care to anyone presenting for treatment without qualification questions. This thesis looks at the ongoing need for RAM in central Appalachia after the passage of the ACA due to a continued lack of comprehensive health care coverage for all Americans.

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CHAPTER 1

INTRODUCTION

The lines of RAM patients in Wise, Virginia, often start on a Wednesday, two days before the annual clinic opens. By Thursday evening, hundreds of people have been standing for hours in the July heat by the livestock gate at a rural county fairground to be seen on Friday morning. Some are in wheelchairs. Many carry children. Most come from within a short drive, though some have come from hundreds of miles away. They are a quiet, surprisingly jovial group, all looking for the same thing: free health care. It was 2008 when I first saw this scene. I had signed up with RAM as a media and public relations volunteer due to my years of experience working in that capacity for a large, regional health care system that had just purchased the hospital in Wise County. I would continue to volunteer at this Wise County clinic over the next three years as well as work with a group to found the first RAM clinic in Bristol, Tennessee. Serving as a volunteer with RAM in a public relations capacity gave me the opportunity to talk with those coming to these clinics, understand their situations, and see the reality of their health care needs.

Volunteers working at RAM clinics are on medical missions, yet these "expeditions" – as RAM calls them – do not always take place in poor, third-world nations. A majority of them take place in the United States, a country that by far outspends every other nation in the world in medical care, yet leaves approximately 16 percent of its population without medical coverage.[1] While disparities in Appalachia bring the need for health care reform into sharp relief, this example of medical need is a highlighted reflection

[1]Laxmaiah Manchikanti, "Health Care Reform in the United States: Radical Surgery Needed Now More Than Ever," *Pain Physician* 11, no. 1 (March 2008): 17-20.

of a national issue. Free clinics are spread across the United States, from those holding regular hours in medical buildings to more unusual clinics such as RAM that have the look of military operations set up for a limited time to see patients.. Proponents of national health reform have held up these clinics – often highlighting those run by RAM – as an example of the need for changing the system.[2]

Based in Knoxville, Tennessee, and originally created in 1985 to bring free health care to third-world counties, RAM changed the focus of its work to Appalachia in 1992 with its first clinic in Sneedville, Tennessee. Since that time, RAM has continued to bring a volunteer corps of dentists, physicians, nurses, and hundreds of other health care professionals, as well as support volunteers, to locations in the central Appalachian mountains such as Wise, Virginia, which is home to RAM's largest clinic.[3] From the eighty-four patients treated at that initial clinic in Sneedville, RAM has continued to see demands for its services increase to thousands of patients per clinic, with a total of 22,983 patients treated in 2010 alone.[4] Since the change in demographic focus twenty-five years ago, more than 65 percent of RAM clinics are now held in the United States – mostly in the central Appalachian region – bringing health and dental care to tens of thousands who have few other options.

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[2] An example can be found at www.singlepayeraction.org, which has numerous references to RAM.

[3] For the purpose of this paper, central Appalachia is defined as the 83 counties in the mountainous regions of West Virginia, eastern Kentucky, southwest Virginia and east Tennessee labeled by the Appalachian Regional Commission as central Appalachia. "Subregions In Appalachia," Appalachian Regional Coalition website, http://www.arc.gov/research/MapsofAppalachia.asp?MAP_ID=31 (accessed June 10, 2011).

[4] Remote Area Medical, "Accomplishments," RAM website, http://www.ramusa.org/learn/accomplishments.htm (accessed February 20, 2011).

As is shown in this thesis from records provided by RAM, the people coming to these clinics have varying backgrounds and economic situations. Some are unemployed. Others are homeless. Many are the working poor. In the clinic lines are children and the elderly. So why do the poor, the homeless, and even the employed in the United States need to wait outside in the July heat to receive free care at a county fairground? And why will this not change with the passage of the ACA? This thesis looks at three primary reasons: The ACA does not adequately address how to enroll all people into the system, it does not advance the need of providing dental coverage, and the ACA is vulnerable to political change that could further reduce its ability to bring coverage to the uninsured.

Before addressing the ACA, Chapter 2 of this thesis reviews the history of health care issues in central Appalachia from the post-Civil War period when modern medicine first began moving into this region at the beginning of the twentieth century to the current efforts to address continuing issues such as health care networks, medical provider shortages, and cultural barriers. It evaluates why many in central Appalachia are still seen as a people apart from the rest of America and the special challenges residents in this region face. By reviewing national rankings that place much of central Appalachia near or at the bottom of national lists for education, health status, and income and examining efforts by public and private groups to deal with these issues, this chapter discusses some of the theories of why this mountainous area of America continues to struggle.

Chapter 3 then gives a detailed look at the history of RAM from the early experiences of clinic founder Stan Brock in South America to a breakdown of those coming to recent clinics and why Brock feels his work will continue in the age of health reform. This chapter also surveys the place free clinics have in today's health care system,

who are some of the people using these clinics, and how many of those involved in the day-to-day operations of these clinics feel the need for their work will remain and perhaps even grow.

A detailed look at the ACA in relation to how it will impact the population using free clinics is given in Chapter 4, including a brief review of efforts over the past 100 years to bring nationalized health care to the United States. From early reform efforts of the Progressives to the creation of the 906-page Affordable Care Act passed in 2010, the path to nationalized health care has taken nearly 100 years and is still unfinished. The ACA creates new regulations for many areas of the healthcare system – including requirements for technological changes, pay-for-performance reimbursements, and the creation of Accountable Care Organizations – yet this chapter focuses on the areas directly impacting the topic of this thesis regarding the uninsured and underinsured utilizing RAM and similar free clinics.

Chapter 5 contains a review of the three major reasons the ACA will not adequately address the needs of those coming to RAM clinics by breaking it down into three parts: enrollment issues, a lack of dental coverage, and political vulnerability. While some proponents for the health reform feel much of their work is done – as can be seen by the Robert Wood Johnson Foundation's recent announcement to end its Cover the Uninsured Week Campaign – due to the passage of the ACA[5] – this chapter reveals why populations

[5] Robert Wood Johnson Foundation, "Looking Back on Cover the Uninsured Week," Robert Wood Foundation website, http://www.rwjf.org/coverage/product.jsp?id=72459&cid=xdr_ccs_001 (accessed July 12, 2011).

such as those in central Appalachia will continue to line up for hours hoping to receive free care from volunteers.

CHAPTER 2

HEALTH CARE AND DISPARITY IN CENTRAL APPALACHIA

Perceptions of Appalachia have their origins dating back to just after the American Civil War when "local color" writers began exploring the area for articles about unusual places and found aspects of the people living in the region that were different. "The inventory invariably began with speech patterns and personal comportment and included both expressive culture … and social behavior," writes John Alexander Williams in his book, *Appalachia: A History*.[1] Historian Henry D. Shapiro said as late as the end of the nineteenth century, the American intelligentsia was still referring to this eastern mountain region as an undiscovered place. "In December 1895, at the annual banquet of the Cincinnati Teachers' Club, [William Goodell] Frost announced the discovery of a new world," Shapiro writes, adding that Frost – who eventually was to become president of Berea College in Kentucky and considered an advocate for Appalachia – referred to the region as a place where "a hardy race descended from our pioneer ancestors continued to live in the virtual conditions of pioneer days. Lacking adequate transportation facilities, Appalachian America had been isolated from the rest of the nation for so long that it appeared as a world fundamentally different from the world with which the rest of us were familiar."[2] Frost's perception of Appalachia, as well as the sort presented by Horace Kephart in his book *Our Southern Highlanders,* have been criticized by modern scholars. One such critic is researcher John Puckett, who argued that these men presented a "jaundiced view of the region" that ignored the reality of the middle class of mountaineers

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[1] ,John Alexander Williams, *Appalachia: A History* (Chapel Hill: The University of North Carolina Press, 2002), 198.
[2] Henry D. Shapiro, *Appalachia On Our Mind* (Chapel Hill: The University of North Carolina Press, 1978),119-120.

who had very different lives than the "half-wild creatures" presented by Kephart.[3] These two separate views of Appalachia are reflected in Sandra Lee Barney's analysis of the early history of modern medicine in *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930*. Barney discusses the transformation of health care in Appalachia from the use of traditional healers – many of whom were women – to modern physicians and how the two interacted together going into the early twentieth century. "The scarcity of professional medical care before industrialization was a direct result of the low population of central Appalachia at that time," Barney writes. "Not surprisingly, small communities could not attract the gradually improving medical care available in cities and prosperous commercial farming centers."[4] Without professional medical care, many in rural central Appalachia were dependent on traditional healers for their care. "Even in recent decades, mountaineers have expressed strong beliefs in magical cures and the healing power of prayer," writes Barney, adding that that attitude has continued to cause many in the region to fail to seek medical care and accept most illnesses as something to be endured.[5] Yet, not all residents of the region "irrationally" rejected medical care. Barney cites rising poverty and landlessness as a burden that kept residents from easy access to treatment, but many still traveled long distances for modern care if it

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[3] John Puckett, *Foxfire Reconsidered* (Urbana, Ill.: University of Illinois Press, 1989), 319-320.
[4] Sandra Lee Barney, *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930* (Chapel Hill: The University of North Carolina Press, 2000), 17.
[5] Ibid., 26. This reference to enduring illness comes from Emma Bell Miles as quoted by Emnion G. Williams, "Dr. Williams Discusses Attitude of State Department of Health to Curative Clinics," *VMN* 56, no. 3 (June 1029): 199.

were available. "Mountain poverty and isolation, not tradition, prevented Appalachian residents from obtaining medical care," she writes.[6]

While the ideas regarding whether the people in the central Appalachia are "different" from the rest of the nation can be debated, there remains a history of disparity in the region that is very much a reality. Even at the time of the Civil War, Appalachia was one of the poorest regions of the United States.[7] During part of the nineteenth century, residents of this area held only half the wealth of the average American. "Appalachian residents occupied a precarious position that provided little disposable currency for the purchase of professional goods and services," writes Barney, adding that the situation kept professional medical providers out of the region because they were unable to make a living practicing medicine.[8]

This disparity between central Appalachia and the rest of the nation has continued, and, with the creation of the Appalachian Regional Commission (ARC) in 1965 the national government has been able to study many of the factors contributing to these problems over four decades and into the twenty-first century. [9] The ARC's website lists numerous reports that have been presented over the last decade, and the cumulative picture they present is that central Appalachia consistently ranks near the bottom in income, education, and access to health care facilities.

A 2004 ARC report entitled *An Analysis of Disparities in Health Status and Access to Health Care in the Appalachian Region* states that while the overall health of the U.S.

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[6] Ibid., 27.
[7] Ibid., 18.
[8] Ibid.
[9] Bruce Behringer and Gilbert H. Friedell, "Appalachia: Where Place Matters in Health," *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 3, no. 4 (October 2006):1.

population has increased over the last forty years along with improvements in standards of living, advancements in medical treatment, and improved access to health care, that is not the situation for all:

> The data and analysis presented in this report identify significant disparities in health status between the Appalachian region and non-Appalachian U.S., with the Appalachian region generally experiencing more adverse health outcomes. …Improvements in health outcomes have not been realized by all segments of the population and have resulted in significant disparities along a number of dimensions including gender, ethnicity, socioeconomic status, and geographic location.[10]

Relative to the rest of the United States, the report states that Appalachia appears to experience considerable excess of heart disease deaths (651 deaths per 100,000 compared to 585 deaths per 100,000) and experiences excess mortality from all cancers (422 to 416).[11]

In 2008, Joel Halverson updated the 2004 *Disparities* report with a new study entitled *Underlying Socioeconomic Factors Influencing Health Disparities in the Appalachian Region.* According to this report, although Appalachia is a diverse region when looked at as a whole, the area suffers excessive mortality compared to the U.S. average. Yet, when reviewed on a regional level, the study shows some "well-defined clusters with [even] higher rates of mortality for heart disease and all-site cancer are found in part of central and southwestern Appalachia than other parts of the region that are comparably disadvantaged on several socioeconomic measures."[12]

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[10] Joel Halverson, *An Analysis of Disparities in Health Status and Access to Health Care in the Appalachian Region* (Appalachian Regional Commission, 2004): 2, http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=82 (accessed January 6, 2011).
[11] Ibid., 5.
[12] Joel Halverson, *Underlying Socioeconomic Factors Influencing Health Disparities in the Appalachia Region,* Mary Babb Randolph Cancer Center/Office of Social

A review of recent ARC data shows that while the gap between U.S. national and Appalachian averages in areas such as income and poverty levels is notable, a closer look shows that in central Appalachia the differences are more serious. According to its website, the ARC compares each county in the Appalachia region with national averages on three economic indicators: three-year average unemployment rates, per capita market income, and poverty rates. Based on that comparison, each Appalachian county is classified within one of five economic status designations: distressed, at-risk, transitional, competitive, or attainment. Distressed counties are those that rank in the worst 10 percent of the nation's counties.[13] Of the 420 counties in the 13 states defined by the ARC as Appalachia, 82 are listed as being "distressed" counties, and a majority of those are located in central and southwest Appalachia.[14]

In its *County Economic Status* report for 2011, the ARC states that the entire Appalachian region suffers from higher poverty rates when compared to the rest of the nation.[15] According to the report, prior to the 2007 economic downturn, the U.S. poverty rate was 12.4 percent, compared to 13.6 percent for the Appalachian region as a whole. Inside the region, the number of residents living below the poverty line for Appalachian counties in Kentucky was 24.4 percent; for Appalachian counties in Virginia, the rate was

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Environment and Health Research Department of Community Medicine, Robert C. Byrd Health Sciences Center, West Virginia University. Appalachian Regional Commission (2008): 69, http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=9 (accessed January 6, 2011).

[13] Appalachian Regional Commission, "Distressed Counties Program," ARC website, http://www.arc.gov/distressedcounties (accessed January 6, 2011).

[14] : Appalachian Regional Commission, "County Economic Status Report, Fiscal Year 2012", http://www.arc.gov/research/MapsofAppalachia.asp?MAP_ID=55 (accessed January 6, 2011).

[15] Appalachian Regional Commission, "County Economic Status Report, Fiscal Year 2011," http://www.arc.gov/reports/custom_report.asp?REPORT_ID=36 (accessed January 6, 2011).

15.4 percent; for Appalachian counties in Tennessee, the rate was 14.2 percent; and for Appalachian counties in West Virginia (which encompass the entire state), the rate was 17.9 percent.[16]

In 2007, per capita income for the United States was $32,930. For Appalachian Kentucky counties, that number was $15,690. For Appalachian Tennessee counties, the number was $23,227; for Appalachian Virginia counties, the number was $20,042; and for Appalachian West Virginia counties, the number was $21,879.

A 2011 report released by the Robert Wood Johnson Foundation in cooperation with the University of Wisconsin Population Health Institute listed central Appalachian Virginia counties near the bottom of state in a county health ranking. In Wise County, Virginia – ranked 126 out of the 132 counties in Virginia – morbidity, health behaviors, clinical care, social and economic factors, and health outcomes all ranked below state and national benchmarks.[17] Nearby Buchanan County, Virginia, presented even worse results. Table 1 below highlights some of the findings.

Health Outcomes	Buchanan County, Va.	Wise County, Va.	National Benchmark
Poor or Fair health	31%	28%	10%
Adult Smoking	37%	34%	15%
Teen Birth Rate	44 per 1,000 females	53 per 1,000 females	22 per 1,000 females
Primary Care Providers	2,022:1	1,227:1	631:1
Children in Poverty	29%	29%	11%

Table 1. Health Outcome Comparisons of Sample Central Appalachian Counties[18]

[16] Ibid.
[17] "County Health Rankings," *County Health Rankings* website, http://www.countyhealthrankings.org/virginia/wise (accessed May 25, 2011).
[18] Ibid.

In 2003, an article in the *Annals of the American Academy of Political and Social Science* reviewed why so many residents in this core section of Appalachia remained poor while much of the rest of the nation had continued to progress:

> In 1960, one the eve of his presidential campaign, Senator John Kennedy journeyed into the inner reaches of Appalachia. He found families living in shacks with no running water or indoor toilets, minimal dirt roads, and a landscape left wasted, filthy, and poisoned by years of opportunistic coal mining and timber cutting. Jobs were scarce, and the powerful meted out jobs in return for obedience. One hundred years of exploitation and external control created an economically dependent and democratically stunted society.[19]

The point of the research in the *American Academy of Political and Social Science* journal was to examine why this section of America had fallen so far behind the norms of the rest of the nation and what efforts had been undertaken to change it. What it discovered was a population of people existing in the region who were mistrusting of outside powers and who have been as neglected as their lands had been ravaged. Government regulation of industry – especially around coal and timber – had been minimal, natural resources had been stripped from the land by outside owners, and government intervention had been inconsistent. Even with the creation of the ARC, congressional guidance had changed the organization's direction time and time again, with focuses often looking more at infrastructure issues rather than how to resolve the bigger problems of the distressed areas. Part of the reasoning behind the ARC's actions was a prevailing theory at the time that the

[19] Amy K. Glasmeier and Tracey L. Farrigan, "Poverty, Sustainability, and the Culture of Despair: Can Sustainable Development Strategies Support Poverty Alleviation in American's Most Environmentally Challenged Communities?" *Annals of the American Academy of Political and Social Science* 590 (November 2003): 142.

region suffered from a "culture of poverty"[20] that came from the isolation of the region and that an injection of funds would help resolve.[21] According to an article by Amy K. Glasmeier and Tracey L. Farrigan, who published the article in *Annals of the American Academy of Political and Social Science*, the ARC felt the region was suffering in a large part from simply being economically isolated, without taking into account the history of why Appalachia came to be the way it is.[22] While the ARC had its exact definitions of "distressed areas," Glasmeier and Farrigan consider these counties from a different perspective – that of the overall life fulfillment. "We carried the analysis [by the ARC] a step further by suggesting that the socioeconomic condition of an individual in a distressed county carries with it special burdens that encumber his or her ability to secure a satisfying, fulfilling, and self-determined life experience," the pair writes[23]

The resulting research by Glasmeier and Farrigan found a "legacy of resource extraction in the region." A vast majority of these resources were being extracted by outside ownership groups with little interest in the residents of the area. The economies of these regions were thus overly dependent on a few industrial sectors – largely coal mining – with few other options for employment. The residents were left under the control of

[20] For the purpose of this thesis, the definition of "culture of poverty" is that of American Michael Harrington from his work *The Other Poverty: Poverty in the United States*, (New York: Macmillian, 1962), 15-16. Harrington states that a culture of poverty is a situation in a population that creates an immunity to progress and where failure is not individual but is a social product, i.e., to exist in poverty is in the character of the people making up the population.
[21] Dwight B. Billings and Kathleen Blee, *The Road to Poverty: The Making of Wealth and Hardship in Appalachia* (New York: Cambridge University Press, 1999), 11.
[22] Glasmeier and Farrigan, "Poverty, Sustainability, and the Culture of Despair," 144..
[23] Ibid.

these outside owners, creating "a citizenry deeply suspicious of outside interest and fearful of the local power structure."[24]

This observation is a reflection of the internal colony idea of Appalachia developed in the mid-twentieth century by Helen Lewis and Edward Knipe in their essay "The Colonialism Model: The Appalachian Case," which theorizes that the region has been stripped of its natural resources by outside interests, and thus created a deep-seated mistrust of outside forces.[25] "It cannot be disputed that the coal interests came into the region 'uninvited,' that the cultural patterns changed as a results of this intrusion, and that the area is controlled by representatives of the [coal] industry," Lewis and Knipe write.[26] These two researchers focus on the impact the coal industry has had on the people of central Appalachia in both limiting progress while also actually pushing local residents further into poverty and despair. "One important consequence of coal mining was that it did not open up the mountains. It isolation of the area went beyond just physician isolation; it now included social isolation," they write.[27] Not all exploiters were external; the pair state that even those who are local to an area and take part in extracting – such as local mine owners – take on the attributes of outsiders while becoming even more disparaging of their neighbors.[28]

Why it was acceptable for external forces – as well as some internal forces – to take advantage of people in this region is explained with Ronald Eller's research in *Miners,*

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[24] Ibid., 139.
[25] Helen Lewis and Edward Knipe, "The Colonialism Model: The Appalachian Case," in *The Colonialism Model: The Appalachian Case* (Boone, N.C.: Appalachian Consortium Press, 1978), 15.
[26] Lewis and Knipe, "The Colonialism Model: The Appalachian Case," 24.
[27] Ibid., 17.
[28] Ibid., 22-23.

Millhands, and Mountaineers. Eller states that outside perceptions of the region during the nineteenth century led some of the abuse imparted upon central Appalachia. "During the twentieth century, 'hillbilly' culture would become the standard means of rationalizing the poverty of an exploited region. In the late nineteenth century, it became a major justification for the swift acquisition of mountain land and resources by outsiders," Eller writes.[29]

As the federal government began bringing health programs to the region in the mid-twentieth century, that mistrust of outsiders translated into difficulties in implementation that continue to this day. This situation helps to explain why so many who could be eligible for assistance in this region fail to enroll. A 2006 article appearing in the journal *Preventing Chronic Disease* argued that the "mountains shape people's lives" and that the history of this region has created a situation where the delivery of programs hits a wall of "skepticism, some distrust of health professionals, and fear of being taken advantage of by the system."[30] Political boundaries for health care services – programs differ from county to county and state to state – and data exchanges between these different governmental groups are disorganized with varying and unstable levels of funding controlled in large part through political channels. This creates a situation where attempts to organize health status reports for the region as a whole become "a logistical and statistical nightmare."[31] Without an environment of trust and a better understanding of the population by those on the outside

[29] Ronald Eller, *Miners, Millhands, and Mountaineers*, (Knoxville, Tenn.: University of Tennessee Press, 1982): 43.
[30] Bruce Behringer and Gilbert H. Friedell, "Appalachia: Where Place Matters in Health," *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 3, no. 4 (October 2006): 3.
[31] Ibid.

working to bring in health care programs, successful implementation of a larger health care coverage system – such as is being presented by the ACA – will be a difficult challenge.

CHAPTER 3

FREE CLINICS AND REMOTE AREA MEDICAL

In 1953, a 17-year-old Stan Brock ran away from home. His escape from a life in Britian world took him to Guyana, South America – then called British Guiana – where he found work on the remote Dadanawa Ranch. For fifteen years, Brock worked on the ranch alongside the Wapishana and other native tribes. It was an experience that would impact his entire life and eventually lead to the creation of Remote Area Medical.[1]

> The concept of a Remote Area Medical Volunteer Corps had its roots in the headwaters of The Rupununi. My dreams of airborne doctors flying into remote regions developed during life there with the Wapishana. Yet it was not until January 1994 that I got permission from the Guyana government to bring in what would soon become known as the RAM Team. I'd founded the organization in 1985, but that promise I'd made to myself in 1966 had to wait for the right political climate to be fulfilled.[2]

In 1968, Brock received an offer from the producers of wildlife television show *Mutual of Omaha's Wild Kingdom*. The opportunity took him out of South America and put him on a world stage with the show and subsequent movies.[3] Deciding to put his entertainment profession behind him, in 1985 Brock moved to an abandoned school building in Knoxville, Tennessee, and returned to his focus on taking care of others.[4] The 37,000-square-foot school building is rented from the city of Knoxville for $1 a year and

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[1] Stan Brock, *All the Cowboys Were Indians*. (Lenior City, Tenn.: Synergy South, 1999), 260.
[2] Ibid., 293.
[3] Ibid., 287.
[4] Remote Area Medical, "History," RAM website, http://www.ramusa.org/about/history.htm (accessed February 20, 2011).

still serves as the headquarters of RAM and as Brock's home.[5] Though originally created with a focus on returning to South America to provide medical care, more than 60 percent of RAM's work now takes place in the United States.[6]

Brock had been organizing small groups of physicians to take trips back to the Amazon for nearly six years from his small home in Knoxville when officials from nearby Hancock County approached his group for help in 1991. The last dentist had left the county a year before and local residents had no where to turn for help. Brock agreed to organize a small clinic to see if there was some help that could be provided. "We were surprised by the turnout, and it just grew from there," Brock said.[7] According to clinic records provided by RAM, Hancock County – located seventy-two miles north of Knoxville, Tennessee, and on the southern edge of central Appalachia – was suffering from "wide unemployment in the county, with a substantial number of indigent residents. Hancock numbers among the poorest counties in the United States. All treatment provided by Remote Area Medical was free." There were two volunteer dentists at the clinic, two registered dental assistants, and one registered nurse. There were two dental chairs at the clinics, only one of which was equipped with a dental cart. The second chair only had a light. Dental X-ray equipment was also available at the clinic.[8] There had not been a dentist in Hancock County since December 1990. At that time, the dentist was only in attendance twice a week. As a result,

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[5] Ariel Leve, "Saint Stan Brock: Who Are You?" *The Sunday Times,* April 5, 2009. http://women.timesonline.co.uk/tol/life_and_style/women/ariel_leve/article6015125.ece (accessed January 16, 2011).
[6] RAM "History."
[7] Huffington Post Investigative Fund. "In Rural Virginia, Relief for the Uninsured is Rare." YouTube video. http://www.youtube.com/watch?v=wlGsLfzJteI (accessed May 10, 2011).
[8] Remote Area Medical, *Clinic Report Emergency Dental Clinic: Hancock County* (May 9, 1992), 2.

the primary purpose of the May 9, 1992, Remote Area Medical Clinic was emergency dental treatment.[9]

The report states that the team arrived on the scene at 9 a.m. after driving in from Knoxville. At 9:55 a.m., the registered nurse began taking vital signs of patients and screened them for potential problems, including allergic reactions to medications, high blood pressure, and heart problems.[10]

> Patients were predominantly adult between 20 and 70 years of age. Problems were mainly long term decay requiring extractions. Several patients were juveniles between 18 months and seven years of age. These were given check-ups and fluoride treatments. The oldest patient was 85. One patient was 27 and 38 weeks pregnant. The team worked non-stop until 13:15 hours, by which time 20 patients had been attended. Lunch break was taken in relays, and the full team was back on the job by 14:00.[11]

One of the volunteer dentists who had accompanied RAM in a past expedition to Mexico in 1992 described in the clinic records that "the condition of the patients to be worse than the average cases he had seen in Santiago Ixcuintla (one [RAM] patient required six extractions)." The clinic ended at 6:60 p.m. that day with 52 patients treated.[12]

In 1993, RAM increased its efforts in the United States, holding nine clinics in Tennessee and another two in Kentucky, some with dental, vision, or medical, or a combination of the three. The first of these was held again in Hancock County, based on the same model as the 1992 clinic, but stretched over a period of two days. "There was a high incidence of premature tooth decay and loss even among patients in their early thirties," a RAM report reads. "Lack of care through cleaning and the inability to seek regular dental checkups were clearly strong contributing factors. Many of the patients were

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[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Ibid., 3.

smokers. One woman had a mouth lesion caused by chewing tobacco." A total of 84 patients was treated during this expedition.[13]

Since that time, RAM has continued to expand its clinics. They are a partnership between the mobile clinic and local organizations in each community served. The local groups help prepare the site, organize local volunteers, and raise much of the funding for the event. RAM assists with logistics, provides needed equipment, and recruits many professional clinical volunteers from around the country, especially dentists. Services offered depend on local needs and can range from one specialty – such as dental – or as in the case with the Wise, Virginia, clinic, a complete line of medical services including mammograms, chest X-rays, eyeglasses, and even minor surgery. There are never any charges for treatment and not even any form of identification required. Volunteers hand out numbers to patients who are treated on a first come, first served bases.

As RAM began offering a variety of services at its clinics, organizers began documenting patient numbers per the services they received, as some patients received more than one of the provided services of medical, dental, and vision – or sometimes all three. The early years of RAM clinics in the United States typically saw patient encounters below 500 for each expedition. But as more clinics were held, publicity increased and more patients arrived. While other non-governmental organizations hold similar clinics around the country, RAM has gained a high level of exposure due in part to the personality of Brock. Media accounts of the clinics often highlight RAM's founder and his habit of treating his expeditions as something akin to a British military excursion, including khaki

[13] Remote Area Medical, *Clinic Report: Emergency Dental Clinic to Hancock County, Tennessee,* (March 26-27, 1993), 2.

uniforms for core volunteers and staff members. A 2009 *The Sunday Times* (London) article on a Tennessee clinic held by RAM described him this way:

> A tall, lean man with thick grey hair in a weathered leather bomber jacket and khaki uniform strides over to the metal gate where a crowd has gathered. …He stands bone-straight, hands clasped behind him. A British voice, sonorous and genial, silences the crowd. He begins calling out numbers. One by one they step forward.[14]

On July 14-16, 2000, RAM held its first clinic in Wise County, Virginia, at the Lonesome Pine Airport. Wise County is in the heart of Southwest Virginia (and thus central Appalachia) and is a coal community. It was the 220th clinic held by RAM and would come to be the largest ongoing clinic organized by the group. More than 100 separate entities joined RAM to create the initial clinic, offering multiple services, including medical, dental, and vision. According to records provided by RAM, by 6 a.m. on Friday approximately 260 people were lined up for treatment. By 8 a.m. more than 500 people had lined up for treatment and organizers quickly were overcome by the number of patients arriving. "When we broke off the traffic entry, the line of cars still trying to get into the clinic site would have produced another five hundred," the RAM report of the event states. Because of the size of the crowd, volunteers had difficultly accessing the site. By the end of that first day, the clinic had seen 669 patients, with twenty-five of those being children. Despite heavy, ongoing rains, an additional 500 people presented at the clinic the next morning, and RAM closed entrance to the clinic at 9 a.m. "Work [on that second day] was very intensive with over thirty patients deferred for completion tomorrow in eye exams, and eight dental patients were deferred," the report of the clinic states. That second day saw 652 patients treated, with twenty-four of those being children. Day three

[14] Leve, "Saint Stan Brock."

of the clinic saw another 567 patients presenting for treatment, with a total patient number that weekend of 1,888, of which eighty-one were children. "One interesting note. A young woman in her twenties was getting married in two weeks. She had six teeth in the front that were broken. The dental team, using 'direct bonding' techniques were able to give her six new front teeth and a smile she could be proud of for her wedding (about $1,200 worth of free care)," the report of the event states. RAM estimates that the total value of care provided on that first Wise County clinic was $205,555.[15]

RAM has repeated the Wise County clinic annually since that first event. In 2003, the clinic moved from the Lonesome Pine Airport to the Wise County Fair Grounds. According to a report of that event provided by RAM, the first Friday morning of the clinic saw more than 1,000 in line by 9 a.m. On that first day, RAM set an organizational record of 1,803 patient encounters, with numerous patients receiving multiple services provided by a total 640 volunteers. By 8 p.m. Friday, patients already were lining up outside the gates awaiting treatments for the next day. On day two of this clinic, RAM had 1,564 patient encounters provided by 882 volunteers. On day three, 225 people were lined up outside the gates by 6 a.m. awaiting treatment. By 10 a.m., all patients wanting to be seen were admitted into the clinic. "Many very sophisticated procedures have been done during this three-day period," the clinic report states, "including full-mouth dentures, general anesthesia for dental surgery on children and adults, sygmoidoscopes, extensive lab work, mammograms, etc. Plus, large amounts of expensive brand-name drugs, such as Cipro, have been dispensed." A total of 558 prescriptions were filled at the clinic with an

[15] Remote Area Medical, *Clinic Report Expedition # 220. Wise County, Va.,* (July 13-15, 2000), 12.

estimated total value of $33,480. The total number of patient encounters for this clinic was 4,749; services provided had an estimated value of $653,309.[16]

This upward trend has continued for the Wise County clinic. The most recent clinic, held on July 23-25, 2010, had a total of 2,347 patients and 6,858 patient encounters with an estimated total value of patient care at $1,924,721. RAM also conducted a demographic study of patients during this clinic in 2010. Of the 2,347 patients treated that weekend, 82.9 percent were from Virginia; the rest came from 17 other states. Of those, most were from Tennessee and Kentucky, while others came from Ohio, Indiana, Georgia, Florida, and South Carolina. Most of the patients were Caucasian – 94.2 percent – and the male/female split was 44.1 to 55.8 percent, respectively. According to patient self reports, a little more than half were uninsured, 18.1 percent were on Medicaid, and 17 percent were on Medicare. Only 3.5 percent of patients reported that they had employer insurance, while another 3.5 percent reported that they had private insurance. Just 0.3 percent of the patients reported that they had vision or dental insurance, and 40.1 percent said they were unemployed.[17]

Since those early days in 1992 treating fewer than 100 patients, RAM clinics have grown into major operations, as seen in 2010 data provided by RAM:

Total Numbers:

Volunteers:	13,058
Patients:	22,983
Patient Encounters:	42,585
Value of Care:	$9,862,980

[16] Remote Area Medical, *Clinic Report: Expedition #369, Wise County, Va.*, (July 24-27, 2003), 12.

[17] Remote Area Medical, *Clinic Report: Expedition #369, Wise County, Va.*, (July 23-25, 2010), 3-4.

Dental Statistics:

Dental Patients:	13,240
Fillings	10,515
Cleanings:	3,162
Extractions:	21,190

Vision Statistics:

Vision Patients:	10,721
Eyeglasses Made:	7,756

Medical Statistics

Medical Patients:	17,721[18]

The patients using RAM clinics come from many walks of life. Many are employed. Some have not seen a physician in years. Others have had surgery for conditions such as heart failure or cancer but were unable to afford follow-up treatment, so they come to these outdoor clinics for additional care. What they all have in common is an inability to find treatment in the system now in place, and Brock feels that will not change with the passage of the ACA. "I seriously doubt we will be out of a job any time soon," Brock said.[19]

When discussing free clinics, it is important to understand exactly what qualifies for this title. In her 2010 article, "Free Clinics in the United States," Dr. Julie Darnell documented her study of free clinics and said they "have evolved from outlaw forces in medicine treating drug addicts and runaway youth, and shunned by the American Medical

[18] Remote Area Medical, "Accomplishments," RAM website, http://www.ramusa.org/learn/accomplishments.htm (accessed February 20, 2011).
[19] "In Rural Virginia, Relief for the Uninsured is Rare," YouTube video. http://www.youtube.com/watch?v=haIEXAb0Pqo&feature=autoplay&list=PLCFD6297A2A2AA2FE&index=4&playnext=4 (accessed May 10, 2011).

Association to an established component of the health system."[20] Darnell set out to document how many free clinics exist in the United States, what different services they offer, and how they survive in the world of increasing health costs. For her research, Darnell set the following criteria: A free clinic must be a private nonprofit or a component of a nonprofit; it must provide medical, dental, vision, mental health, or pharmaceuticals directly to patients; a majority of its patients must be uninsured; it must not charge patients or have charges over $20; it must not bill, deny service, or reschedule a patient due to an inability to pay even the minimal charge or requested donation; and it must not be solely a family planning, sexually transmitted disease testing, or pregnancy testing operation. Using these criteria, the researcher identified 1,188 free clinics in the country located in every state with the exception of Alaska.[21]

Darnell then identified what types of patients these clinics served. Her findings were not surprising. Patients were the uninsured, racial minorities, those who did not qualify for government assistance but still lacked an ability to pay for health services, and the homeless. These clinics had a mean of 747 new patients each year and a mean of 1,796 unique patients each year.[22] The clinics had a mean of 3,217 medical visits and 825 dental visits annually. In total, these clinics treat a total of about 1.8 million unique patients each year.[23]

A majority of the patients in Darnell's study lived below the Federal Poverty Limit (FPL), and 96.9 percent of the patients had incomes under 200 percent of the FPL. This

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[20] Julie S. Darnell, "Free Clinics in the United States," *Archives of Internal Medicine* 170, no. 11 (June 2010): 946.
[21] Ibid.
[22] New patients refers to the number of patients using the clinic for the first time, while unique patients is the total of individuals served by the clinic.
[23] Ibid., 948-949.

200 percent designation is important, as many hospitals and health systems have "charity care" designations that are similar. For example, Mountain States Health Alliance – a 13-hospital not-for-profit system serving Northeast Tennessee, southwest Virginia, eastern Kentucky, and western North Carolina – offers free charity care to patients at 200 percent or below the FPL, well above the ACA's rate of 133 percent of the poverty level for Medicaid coverage.[24] So why would patients who would apparently qualify for charity care or Medicaid still need to access free clinics? Part of the answer is that for the government and health systems, these numbers do not tell the whole story. Along with meeting FPL minimums, patients must also document resources, which are also taken into the equation. According to the CMS website, simply having an income around the poverty level does not get one into the system:

> Medicaid does not provide medical assistance for all people with limited incomes and resources. Even under the broadest provisions of the Federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services for everyone. You must qualify for Medicaid. Low-income is only one test for Medicaid eligibility.[25]

For TennCare — Tennessee's Medicaid program — just finding where to start in the system can be difficult. According to the TennCare website, "There are several different groups of people that may qualify. And, each group has different income limits. Some of the groups also have limits on how much you own – your 'resources.' These are things like bank accounts, cars, and land."[26]

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[24] Kaiser, "Summary," 1.
[25] U.S. Centers for Medicare and Medicaid Services, "Overview," U.S. MS website, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, Washington, D.C. https://www.cms.gov/MedicaidEligibility/ (accessed March 1, 2011).
[26] TennCare, "Eligibility," Tennessee Bureau of TennCare website, State of Tennessee, http://www.tn.gov/tenncare/mem-eligibility.html#1 (accessed March 1, 2011).

The people who qualify for government health care coverage programs often have difficulty working their way through the complex maze of paperwork and reporting of financial minutiae,[27], and for this reason frequently go without coverage even when it is potentially available. Free clinics offer patients an option where care is provided regardless of the ability to pay and without an extensive or complicated qualification process. "Free clinics suggest an alternative model of primary care to the underserved, and the merits of the free clinics model ought to be discussed as viable options to serve the uninsured," Darnell writes in her article.[28]

While the part free clinics play in the health care system is important, getting a clear picture of their actual contribution is difficult. Darnell points to her study as perhaps the first to take such a comprehensive look at these clinics.[29] Government reports list formal existing practices staffed by full-time professionals. Clinics such as RAM are not factored into equations regarding providers, and understanding each clinic's impact must be done on a case-by-case basis, but looking at others aside from RAM reveal the number of patients being seen has continued to escalate.

In Bristol, Virginia, the Healing Hands Health Center – which operates year round offering medical and dental services – saw 1,453 patients in 2003, its first year of operations. In 2009, that number had climbed to 5,212. Healing Hands Board President Beth Rhinehart said she feels her clinic will continue to see patients even in the age of health reform. "The question we are repeatedly asked is, 'With the implementation of health care reform, will free clinics still be needed?' Free clinics are the best model for

[27] See Chapter 5 for detailed documentation of this issue.
[28] Darnell, "Free Clinics in the United States," 951.
[29] Ibid., 946.

addressing this situation because they are community based, highly efficient, and reduce the cost of health care by keeping people without insurance out of hospital emergency departments."[30] The Blue Ridge Free Dental Clinic in Cashiers, North Carolina, has been open since 2005 and has seen its patient visits rise from 394 that first year to 1,159 in 2010. "We closed the year with a waiting list of 500 individuals," said clinic Board President Ron Keller. "We don't expect that number to decline in the near term."[31]

In an article published in the June 14, 2010, issue of the *Archives of Internal Medicine*, Drs. Richard and Patricia Gibbs – the couple who founded the San Francisco Free Clinic – said the coming health care reform changes will not dramatically change the role of free clinics. "With a national plan to expand health insurance passed by Congress and signed by President Barack Obama, some may mistakenly think that free clinics will no longer be needed. However, it is clear that the health care expansion will not cover all of the uninsured and will take several years to put into practice. Free clinics will be there to catch those who fall through these gaps."[32] While some clinics will integrate into the new system, others will continue on their current path and work to fill the holes left by the system. The physician pair said with their California clinic it is simpler to work outside the system taking care of those who are not covered by the current system or the federal reform efforts. "In considering public grants, it became apparent we did not want public money at all. The applications are long and complex, and much of each dollar is spent in reporting

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[30] *Annual Report, 2009*. Healing Hands Health Center. Bristol, Va., 2009, 2.
[31] "Five Years and Counting," *Blue Ridge Free Dental Clinic Spring Newsletter*. Blue Ridge Free Dental Clinic. Cashiers, N.C. Spring 2011. http://www.blueridgefreedentalclinic.org/docs/BRFDC-Newsletter-Spring-2011.pdf, (accessed June 5, 2011), 2.
[32] Richard Gibbs and Patricia Gibbs, "Free Clinics – A Personal Journey," *Archives of Internal Medicine* 170, no. 11 (June 2010): 954.

requirements," they wrote, adding that "until we have true universal coverage, clinics will be needed where the uninsured can receive the care that all people deserve."[33]

Though research on free clinics as a whole is not comprehensive, that which has been done – and what can be discovered in discussions with those who run these clinics – shows these clinics have a strong connection to the communities they serve and treat all patients who present regardless of covered status. They resolve issues of enrollment by understanding those they serve. They resolve the issues of coverage by admitting all. It is a formula for success that has been used by RAM since 1992.

[33] Gibbs and Gibbs, "Free Clinics – A Personal Journey," 954.

CHAPTER 4

U.S. HEALTH CARE AND THE ACA

The investment in the U.S. health care system today is unrivaled in the world. No other nation spends as much per capita, has as many academic medical centers, and has such widespread availability of life-saving technology as the United States. At the same time, no developed country leaves such a high percentage of its population without health care coverage.[1] For all its technology, training, and financial cost, the United States ranks among the bottom of developed nations in overall health outcomes.

A 2007 Commonwealth Fund International Health Survey revealed that while health care costs in the United States have skyrocketed past those of other nations, the country still fails to cover a large portion of its citizens. As can be seen in Figures 1 and 2, the investment is nearly twice of comparable countries that offer more comprehensive plans to their citizens without the same levels of complexity to become enrolled. The cost per capita of providing health care in the United States is higher than 13 other countries used in a sample by the Organization for Economic Co-operation.[2] After adjusting to its higher per capita income levels, the United States spends $477 billion – which is $1,645 per capita more on health care than any other surveyed country. Of those other nations, uninsured rates ranged between 0 -2 percent of the population.[3].

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[1] Manchikanti, "Health Care Reform in the United States," 17-19.
[2] *Health at a Glance 2009.* Organization for Economic Co-Operation and Development, Dec. 8, 2009. www.oecd.org/health/healthataglance (accessed April 20, 2011).
[3] Ibid.

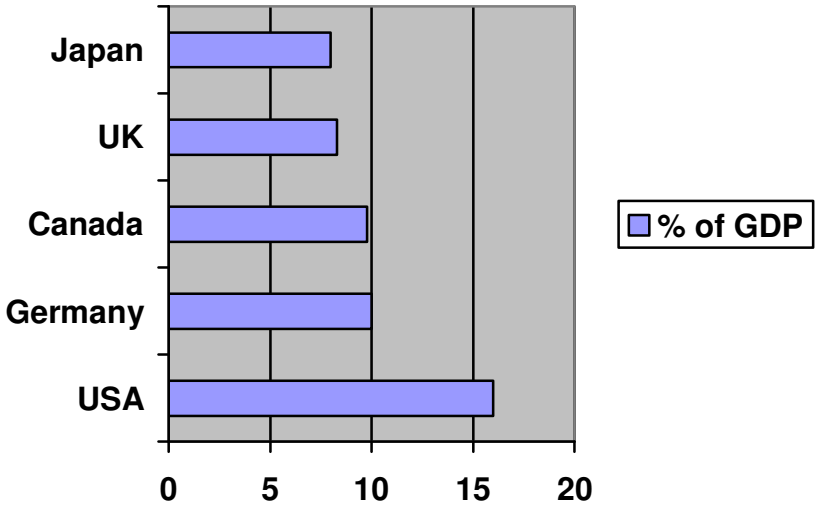

FIGURE 1. Percent of National GDP Spent on Health[4]

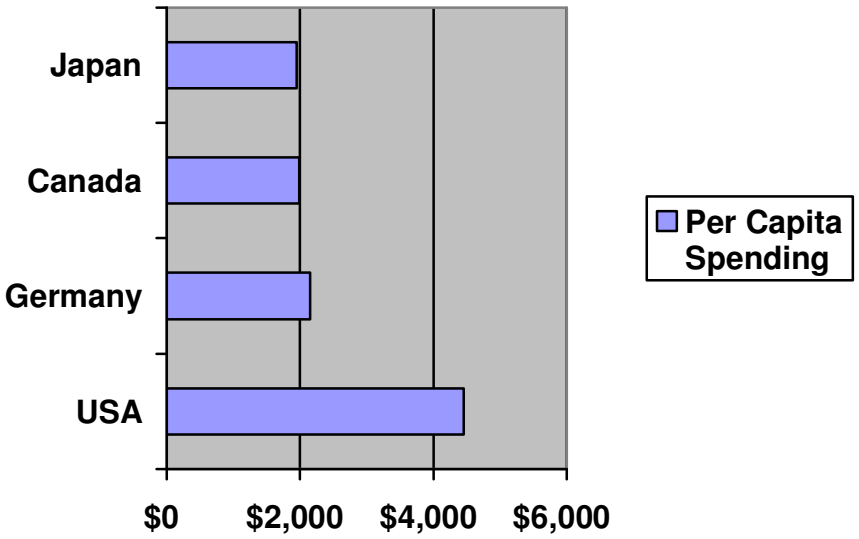

FIGURE 2. Per Capita Spending on Health Care[5]

[4] Commonwealth Fund, "2007 International Health Policy Survey in Seven Countries," Commonwealth Fund website, http://www.commonwealthfund.org/Content/Surveys/2007/2007-International-Health-Policy-Survey-in-Seven-Countries.aspx (accessed January 18, 2011).

[5] *Health at a Glance 2009.* Organization for Economic Co-Operation and Development, Dec. 8, 2009. www.oecd.org/health/healthataglance (accessed April 20, 2011).

Despite the investment by the United States, health outcomes in the country do not approach those of other nations spending far less. According to a 2010 article published in the *New England Journal of Medicine*, the United States health care system ranked 37th in the world:

> Despite the claim by many in the U.S. health policy community that international comparison is not useful because of the uniqueness of the United States, the rankings have figured prominently in many arenas. It is hard to ignore that in 2006, the United States was number 1 in terms of health care spending per capita but ranked 39th for infant mortality, 43rd for adult female mortality, 42nd for adult male mortality, and 36th for life expectancy. These facts have fueled a question now being discussed in academic circles, as well as by government and the public: Why do we spend so much to get so little?[6]

These poor results with such heavy investment can somewhat be explained by looking at where the money is being spent. By far, the largest discrepancy in spending between the United States and other countries reviewed in the OECD report was in administration. The U.S. system spends six times more per capita than peer nations – $412 versus $72 per person – in actually administering its system. The unusual blend of governmental (i.e. Medicaid and Medicare), private, and non-governmental providers along with regulations across states and the complexities of bringing all of these together creates a system loaded with paperwork and regulation.[7]

Thus, the many different payer options with different eligibility requirements available in the health care system in the United States create a complex web that is difficult to navigate, even for professionals inside the industry, and extremely expensive.

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[6] Christopher J.L. Murray and Julio Frenk, "Ranking 37th — Measuring the Performance of the U.S. Health Care System," *New England Journal of Medicine* 362, no. 2 (January 2010): 98-99.
[7] Manchikanti, "Health Care Reform in the United States," 22.

Hospital systems must depend on entire departments of administrative staff to process the paperwork generated by this plethora of different payers. The cost for keeping the system operational is dramatically higher than in peer nations while results, according to the *New England Journal of Medicine* article referenced above, are lower.

As President Obama took office in 2008, these costs – especially in the context of the nation facing a serious financial crisis – helped energize the debate on the need for reform. Public sentiment was strong that a change needed to be made that would help lower costs while improving outcomes. But the president faced a century of disagreement over what a national system should look like. Should the nation look to other Western countries for guidance or create something unique that worked in the existing system? The end result was the Affordable Care Act (ACA).

Reforming health care in the United States has been a goal of presidents since the early twentieth century. One of the first calls for change came from Theodore Roosevelt in 1912 when he campaigned on a platform calling for health insurance for industry.[8] Roosevelt , who had already served two terms as U.S. president, became a core part of the Progressive Movement as he served as the presidential candidate of the Bull Moose Party in a third run for the nation's top office.[9] Roosevelt lost that third attempt, yet his attempt was later followed in the 1920s when a group called the Committee on the Costs of Medical Care proposed group medicine and voluntary insurance, but the initiative failed

[8] Kaiser Commission on Medicaid and the Uninsured, "National Health Care – A Brief history of Reform Efforts in the U.S.", Kaiser website, Kaiser Family Foundation, Washington, D.C http://www.kff.org/healthreform/7871.cfm. (accessed May 1, 2011): 1.
[9] Heather A. Haveman, Hayagreeva Rao, and Srikanth Paruchuri, "The Winds of Change: The Progressive Movement and the Bureaucratization of Thrift," *American Sociological Review* 72, no. 1 (Feb. 2007): 124.

when the group hit opposition accusing them of promoting "socialized medicine."[10] While support for better access to health care has been popular with the American public for much of the last 100 years, that support becomes divided when discussions come to the point of how to reach that goal.

It was during World War II that industry began providing medical insurance as a benefit on a large scale.[11] With the war's end, President Harry Truman called on Congress to pass a national, single-payer health care plan as part of his "Fair Deal," and during his second term – with his party in control of both houses of Congress – he nearly accomplished his goal. But he was opposed by those dedicated to providing care: physicians. The American Medical Association (AMA) launched a national campaign to prevent the passage of Truman's plan and to promote the use of private health insurance. [12] The AMA stated it was fighting against "socialized medicine" and that the national health care plan was part of a communist plot to destroy America.[13] Truman's proposal failed and it was another decade before the nation revisited the issue. The 1960s saw the United States with a strong economy and strong employer-based insurance coverage for those in the middle and upper classes. As part of his Great Society plan, President Lyndon Johnson focused on the health care needs of the poor and the elderly, and thus Medicaid and Medicare were born in 1965.[14]

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[10] Kaiser Commission on Medicaid and the Uninsured, "National Health Care – A Brief history of Reform Efforts in the U.S.": 1.
[11] Ibid., 3.
[12] Jill Quadagno, "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945-1996," *Journal of Health and Social Behavior* 45 (2004): 30.
[13] Ibid.
[14] Kaiser Commission on Medicaid and the Uninsured, "National Health Care – A Brief history of Reform Efforts in the U.S.": 5.

Attempts continued and failed after 1965 to create a national health plan – most notably in the 1990s when President Bill Clinton placed his wife, Hillary Clinton, at the head of the Health Care Task Force, only to be defeated in this attempt by a Congress controlled by his own party.[15] Then – as was discussed in Chapter 4 – the nation began facing dramatically rising health care costs. After the election of President Obama, the country saw its first real comprehensive change to the delivery of health care since 1965.[16]

The passage of the Affordable Care Act in March 2010 with its graduated approach to implementation over four years is expected to completely revamp the health care and insurance industries in this country. The Congressional Budget Office estimates the ACA will lower the rates of the uninsured from 16 percent of the nation to somewhere around 6 percent.[17] In its current form, the ACA will expand the private insurance industry's place in the health care system from covering 65 percent of non-elderly Americans to 73 percent.[18]

At 906 pages, the legislation is complex but can be broken into four main areas: expansion of Medicaid, changes in the rules regarding private coverage, new regulations on health care quality, and emphasis on promotion of community health and well being. On top of these changes sits the overriding rule that everyone must carry some form of health insurance.[19]

Though there are formulas in deciding who qualifies, the general rate of those eligible for Medicaid will be raised from 120 percent to 133 percent of the poverty level.

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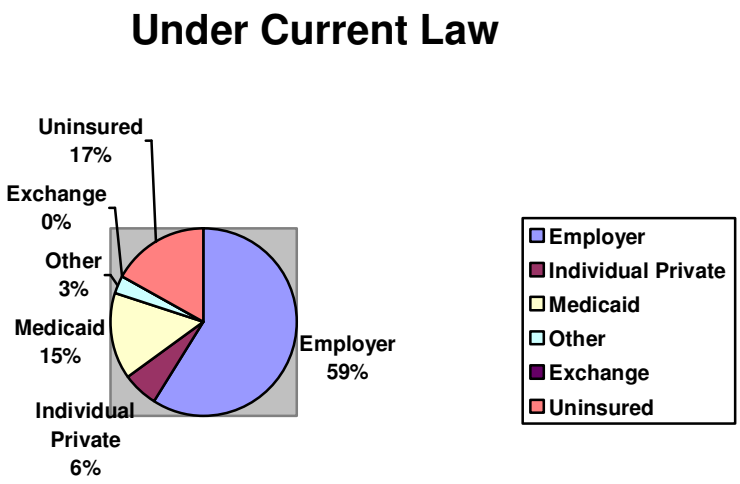
[15] Ibid., 8.
[16] Ibid., 8.
[17] Georgia Health Policy Center, "Health Reform: From Insights to Strategies, A Variety of Perspectives," 5.
[18] Ibid.
[19] *Patient Protection and Affordable Care Act*, Subtitle F, Part 1, Sec. 1501.

This is expected to increase Medicaid rolls by 16 million people. The federal government will cover the initial cost of the expansion but will begin passing on that cost to states in 2017.[20]

Changes in private coverage are comprehensive, with insurers now facing new rules regarding exclusions, caps, premium costs, and high-risk pools. One major component of this area includes the creation of exchanges. These exchanges are something of a virtual market of different private health care plans that will be offered for sale to those who do not have employer-provided insurance and do not qualify for Medicaid. The Exchanges will be regulated by the federal government in an attempt to keep costs low and coverage fair. Individuals may qualify for tax credits to go toward these purchases depending on their income.[21] With much public discourse focused on the expansion of Medicaid, it is the creation of these exchanges that the government predicts will meet the needs of the uninsured, as can be seen in Figure 3 below:

[20] Ibid., Subtitle B, Part 1, Sec. 10201.
[21] Ibid., Subtitle E, Part I, Sec. 1401.



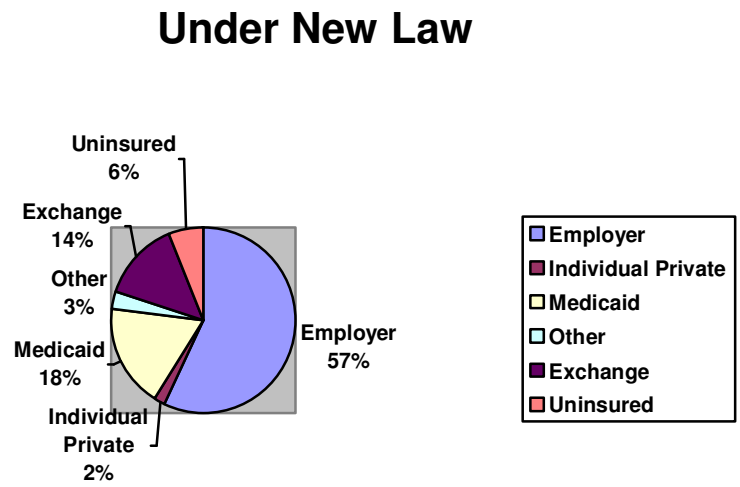


FIGURE 3. Expected Changes in Coverage under the ACA[22]

[22] Georgia Health Policy Center."Health Reform: From Insights to Strategies, A Variety of Perspectives." Georgia Health Policy Center website. Feb. 2011. http://aysps.gsu.edu/ghpc/6098.html (accessed May 10, 2011).

By adding together the employer based insurance, the private individual insurance, and the exchanges, the percentage of those covered by private health insurance is expected to rise to 73 percent. What the ACA does not have is a "public option." A public option – something those in favor of a stronger national system felt was imperative – would create a government-run health care system – similar to Medicaid – that would be offered to everyone. Though not a single-payer plan – a system that would in effect eliminate private insurances – the public option was seen by some as an alternative to relying too heavily on private insurers. Everyone would qualify and costs would, in theory, be scaled to income. That absence of a public option in the ACA and the emphasis on putting more people on private health insurance is something a one-time insurance industry spokesman turned uninsured activist feels will keep patients coming to RAM clinics.[23]

In 2008, Wendell Potter, then-chief spokesperson for CIGNA, one of the nation's largest private health insurance companies, visited the Wise RAM Clinic. What he saw had a dramatic impact on his understanding of the U.S. health care system:

> I didn't have any idea what to expect. But when I walked through the fairground gates, it was just absolutely overwhelming. What I saw were people who were lined up – it was raining that day – and they were lined up in the rain by the hundreds waiting to get care that was being donated by doctors and nurses and dentists and other caregivers, and they were being treated in animal stalls. Volunteers had come to disinfect the animal stalls. They had also set up tents. It looked like a MASH unit. It looked like something that was happening in a war-torn country, and war refugees were there to get their care. It was just unbelievable. It just drove it home to me, maybe for the first time, that we're talking about real human beings, and not just numbers.[24]

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[23] *Democracy Now,* "Uninsured Travel from Across US for Free Healthcare from Relief Group Remote Area Medical," *Democracy Now* website, online video file, 40:22, http://www.democracynow.org/2009/7/22/uninsured_travel_from_across_us_for (accessed February 1, 2011).

[24] *Democracy Now,* "Uninsured Travel from Across US for Free Healthcare from Relief Group Remote Area Medical."

Although he had been a leader in the national health care discussion taking the side of the insurance industry, what Potter saw that weekend in 2008 in Wise County convinced him that the current system in place could not work and that only a simplified, national plan would be able to address the problem. He resigned from CIGNA and became an advocate for a health care reform plan that included either a single-payer system or at least a public option open to all. In a 2009 address before the House Democratic Steering and Policy Committee, Potter said a plan that simply encourages more people to acquire private insurance does nothing but help protect the profits of the insurance industry. "If [Congress] fails to provide a public insurance option to compete with private insurers, the bill it sends to the president might as well be called The Insurance Industry Profit and Protection Act," he told lawmakers, adding, "The public option should not be an option to be bargained away at the behest of insurance companies. … a public option must be created to provide true choice to consumers, or reform will fail to truly fix the root of the severe problems that have been caused in large part by the greedy demands of Wall Street."[25] The changes Potter wanted to see did not come to fruition, and Congress passed the ACA without that that public option.

The ACA is in its first year of implementation, with the most significant changes scheduled to take place in 2014. Many of the specifics of the regulations are yet to be determined with the government laying out details as deadlines of implementation approach. What is clear, though, is that the system will require active engagement by the patient to find what part of the system best suits his or her needs, and then enroll in that

[25] "Wendell Potter – Former Communications VP for CIGNA," YouTube video. http://www.youtube.com/watch?v=GBFKkXDSKWw (accessed Feb. 13, 2011).

particular plan. It will require an understanding of the process as well as a willingness to participate and an ability to pay. These are requirements that in the current system leave many of the nation's neediest populations out of programs for which they are already eligible. These are populations of the undereducated, the isolated, and those suffering from health disparities. These are populations that can be found standing in lines for days at RAM clinics waiting for treatment.

CHAPTER 5

FAILING TO MEET THE NEED

Enrollment

Enrollment in the system is a core and unaddressed problem. The health care system in the United States is a complex web of government programs, private providers, and non-governmental nonprofit programs. The ACA will create health care exchanges – a new type of coverage that is a hybrid of private and government programs. Even in the current system, patients presenting at free clinics are often eligible for government assistance but fail to receive it. For example, according to a 2004 study published in the *Journal of Pediatric Health Care*, many children eligible for government programs do not receive available benefits because their families simply do not enroll in them. The study reviewed a pediatric clinic in Ohio where 60 percent of the children presenting for free treatment actually were eligible for insurance under the state's Healthy State program, part of the national State Children's Health Insurance Program (SCHIP). As part of the study, those 60 percent were given paperwork and referred to the government program, but only 12 percent of those referred were eventually enrolled.[1] A 2008 report by the National Institute of Health Care Management revealed that nationally, 64 percent – or 6.1 million – of uninsured children actually qualified for government health care programs but were not enrolled. This same study also revealed that while 29 percent – or 3.6 million – of eligible adults under the age of 65 were also eligible for assistance but failed to enroll.[2] Both

[1] Ann-Marie Brown and Greer Glazer, "Enrollment Success in State Children's Health Insurance Program After Free Clinic Referral," *Journal of Pediatric Health Care* 18, no. 3 (May/June 2004): 145.
[2] National Institute of Dental and Craniofacial Research, "A Look at Oral Health Disparities in Appalachia," National Institutes of Health.

studies then looked at why those now eligible failed to enroll. The *JPHC* study revealed that parents failed to enroll their children for reasons from "believing their income was too high" to "the paperwork was too hard."[3] The NIHCM report listed similar reasons, including not being aware of the different programs available and concerns over the "stigma" of receiving "welfare" type assistance.[4]

A 2007 report from the Kaiser Commission on Medicaid and the Uninsured entitled, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage*, also studied how many uninsured qualified for government coverage but failed to receive it:

> [It is] estimated that approximately 80 percent of the uninsured are eligible for public health insurance coverage or live in families with incomes below 300 percent of the federal poverty level. Of the uninsured, 25 percent are eligible for Medicaid or the State Children's Health Insurance Coverage Program (SCIP) and 56 percent are not eligible for public programs but need assistance to make coverage affordable.[5]

The report states that the complexity of the enrollment process, along with the lack of effective government outreach programs to enroll the eligible, are to blame for not reaching those who should be covered, especially those uninsured families with children. This report estimates that three-quarters of uninsured children are eligible for public coverage but not enrolled. The Kaiser report states that parents value Medicaid and

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http://www.nidcr.nih.gov/Research/ResearchResults/InterviewsOHR/COHRA.htm (accessed February 10, 2011), 3.

[3] Brown and Glazer, "Enrollment Success in State Children's Health Insurance Program After Free Clinic Referral," 147.

[4] National Institute of Dental and Craniofacial Research, "A Look at Oral Health Disparities in Appalachia," 3.

[5] Kaiser Commission on Medicaid and the Uninsured, *Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?* by John Holahan, Allison Cook, and Lisa Dubay. Issue Paper, Kaiser Family Foundation, Washington, D.C. (February 2007). http://www.kff.org/uninsured/7613.cfm (accessed January 15, 2011), 1.

SCHIP, "but lack awareness of public programs, and administrative hurdles stymie coverage."[6] The report lists as a prime need an increase in administrative assistance to this population to streamline the enrollment and renewal process, as families regularly gain and lose coverage due to "procedural barriers."[7]

While the need for outreach to these populations is great, a 2008 study by The Walsh Center for Rural Health Analysis found that the more rural the region, the less likely the population will have access to government offices for assistance. The study described public health access in rural areas as a disorganized patchwork of state and local health departments, non-governmental agencies, and private professionals where outreach efforts are handled cooperatively yet often without coordination, and results were difficult to measure.[8] Often, government health departments in less populated, more rural areas have fewer resources with higher fixed operating costs in comparison to more populated areas. The departments are typically staffed with less qualified personnel due to a smaller pool of local talent and are thereby less able to compete for grants or even federal flow-through funding, further widening the gap between them and more populated, urban areas.[9] For underserved populations, the Walsh Center report revealed that the system now in place makes it difficult for residents to gain assistance in accessing government programs. The

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[6] *Characteristics of the Uninsured*: *Who is Eligible for Public Coverage and Who Needs Help Affording Coverage, 13.*

[7] Ibid., 13.

[8] Walsh Center for Rural Health Analysis, 2008. *Financing Rural Public Health Activities in Prevention and Health Promotion*, Michael Meit, Benjamin N. Hamlin, Bhumika Piya, and Lorraine Ettaro. Final report. Prepared by Walsh Center for Rural Health Analysis/NORC at the University of Chicago and The University of Pittsburgh Center for Rural Health Practice. www.norc.uchicago.edu/.../**RuralPublicHealthFinancing**FinalReport20080613.pdf (accessed January 10, 2011). Iii.

[9] *Financing Rural Public Health Activities in Prevention and Health Promotion*, 8-9.

region also suffers from lower-than-average rates in areas such as income, education and density of health care providers; geographical isolation; and poor health habits – all of which compound the problem of health care delivery.[10]

A Lack of Dental Coverage

General medical health and oral health are directly linked; dental problems are associated with other serious medical problems including heart and lung disease, stroke, diabetes, low birth weight, and premature births. [11] According to a report by Mayo Clinic, a person's oral health serves as a window to overall health. Bacterial growth in the mouth due to poor dental health is able to breech the mouth's normal protective barriers and enter into the bloodstream. One example is how gum disease and open sores in the mouth allow bacteria directly into the blood stream causing infections such as endocardities and cardiovascular disease.[12]

Debates around health care coverage sometimes focus on access to medical clinics and primary care physicians, but a major missing link in the discussion is dental care. The vast majority of children in the United States who suffer from severe cases of dental decay are from low-income families, many of whom experience periods of homelessness.[13] A Surgeon General's report from 2000 entitled *Oral Health in America* declared tooth decay

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[10] Nina Glasgow, Nan E. Johnson, and Lois Wright Morton, *Critical Issues In Rural Health,* (Ames, Iowa: Blackwell Publishing, 2004), 185-188.
[11] Ohio Department of Health, "Oral Health and Access to Dental Care for Ohioans, 2007," www.odh.ohio.gov/.../**Oral**%20**Health**%20**Access**_2010%20exec%20sum%20update.pdf (accessed February 10, 2011).
[12] "Oral Health: A Window to Your Overall Health," Mayo Clinic website. www.mayoclinic.com/health/dental/DE00001 (assessed May 10, 2010).
[13] Marguerite A. DiMarco, Marlene Huff, Elizabeth Kinion, and Mary Agnes Kendra. "The Pediatric Nurse Practitioner's Role in Reducing Oral Health Disparities in Homeless Children," *Journal of Pediatric Health Care* 23, no. 2 (March/April, 2009): 109.

the "silent epidemic," with the worst oral health found among the nation's poor.[14] A 2007 report by the Ohio Department of Health revealed that rates of those without dental care in that state were nearly four times those without medical coverage, and that access to dental care was greater than other health needs.[15]

A 2008 report by the Kaiser Commission on Medicaid and the Uninsured revealed that a majority of low-income Americans have no access to dental care, and even those with private health insurance find themselves with limited coverage. The lack of dental health coverage in the United States is a major missing link in the overall health of the nation's population:

> Private health insurance plans often exclude dental coverage, and those that do include a dental benefit often require high levels of cost-sharing that put care out of reach for many low-income families. Similarly, dental coverage for adults in Medicaid is limited or nonexistent in most states. Those without adequate dental coverage must turn to a health care safety net that often does not focus many resources on oral health, leaving them potentially unable to access needed care.[16]

A 2008 survey on oral health by the U.S. Centers for Medicare and Medicaid Services (CMS) stated that good dental health is essential to the general health and wellbeing of all Americans, yet it also pointed out that providing this service was merely

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[14] Office of the Surgeon General, *Oral Health In America*. By David Satcher, U.S. Department of Health and Human Services, http://www.surgeongeneral.gov/library/oralhealth/ (accessed February 21, 2011).

[15] Ohio Department of Health, Oral Health and Access to Dental Care for Ohioans, 2007. www.odh.ohio.gov/.../**Oral**%20**Health**%20**Access**_2010%20exec%20sum%20update.pdf (accessed February 10, 2011).

[16] Kaiser Commission on Medicaid and the Uninsured, *Access to Affordable Dental Care: Gaps for Low-Income Adults*. By Jennifer Haley, Genevieve Kenny, and Jennifer Pelletier, Kaiser Low-Income Coverage and Access Survey, Kaiser Family Foundation, Washington, D.C. http://www.kff.org/medicaid/7798.cfm (accessed February 21, 2011): 1.

optional for states as part of participation in the CMS program. CMS does require states to provide dental coverage to children as a condition of participation in the State Children's Health Insurance Coverage Program, but the survey revealed many states taking the federal funds did not actually follow through with this requirement.[17] Only one in three children on Medicaid received an annual dental visit per recommendations, in contrast with 50 percent of children with private coverage.

The CMS survey also said some dental providers labeled the administration of dental services for Medicaid participants as "burdensome," resulting in the provider either ceasing participation in the program or limiting the number of Medicaid patients treated. The survey found that some states were actually unable to provide data on the use of dental benefits by Medicaid patients.[18] Thus, a vast majority of dental care in America is paid for privately either through out-of-pocket expenses or through employer-supplied insurance. The percentage of out-of-pocket payments for dental services (in comparison to the percentage paid by insurance) is more than three times higher than the percentage spent on care with physicians, and some studies point to as little as 4 percent of dental costs in the country being covered by public programs.[19] According to an article entitled "Dental Care: Improving Access and Quality" published in the journal *Research in Action*, the difference between the care received by those below 400 percent of the Federal Poverty Level (described as "poor") and those above this level (described as nonpoor) has continued to increase over the years. More than one-third of poor children ages 2 to 9 have one or more

[17] U.S. Centers for Medicare and Medicaid Service, *2008 National Dental Survey*, (U.S. Department of Health and Human Services Centers for Medicare and Medicaid Service Washington, D.C. 2009): 9.
[18] Ibid., 10.
[19] National Institute of Dental and Craniofacial Research, "A Plan to Eliminate," 8.

untreated decayed primary teeth, compared to 17.3 percent of nonpoor; uninsured children are twice as likely as insured children to go without dental care; a quarter of all children entering kindergarten suffer from untreated dental decay; and fewer than one out of every five children enrolled in Medicaid receives preventive dental services despite federal mandates – a finding that echoes the results of the CMS survey referenced above.[20]

While the above findings reflect national challenges, again, central Appalachia serves as a highlighted example of this problem. A 2009 article by the National Institute of Dental and Craniofacial Research states that "in many parts of Appalachia, tooth decay remains an unfortunate rite of childhood that too often leads to a lifetime of poor oral health."[21] The article pinpoints West Virginia where an estimated 40 percent of adults over 65 have none of their natural teeth.[22]

A 2002 report by the ARC on the overall health of Appalachians cited dental problems as a major issue, stating that "most Appalachian counties have not been successful at improving access to dentistry." The report says there are a very limited number of dentists in many parts of Appalachia, especially in areas on the ARC's list of distressed counties.[23]

The U.S. Health Resource and Services Administration estimates the number of dentists each county in the United States should have per its population. According to the

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[20] Mark Stanton, "Dental Care: Improving Access and Quality." *Research in Action*, no. 13. Agency for Healthcare Research and Quality (July 2003): 1-3, www.ahrq.gov/research/**dentalcare**/dentria.pdf (accessed on January 16, 2011).
[21] National Institute of Dental and Craniofacial Research, "A Look at Oral Health Disparities in Appalachia," 3.
[22] Ibid.
[23] Appalachian Regional Commission, *An Analysis of Disparities in Health Status and Access to Health Care in the Appalachia Region*, by Joel Halverson: 6-7, http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=82 (accessed January 6, 2011).

HRSA website, the number of dentists needed in Wise County, Virginia, per its population is twelve, but only four serve the area, leaving a shortage of eight dentists. In neighboring Buchanan County, the residents are served by only two dentists, while the total need is set at six.[24]

Cultural issues in Appalachia discussed in Chapter 2 also play a part in dental health. Societal norms and expectations related to dental health in Appalachia are lower when compared to more urban areas.[25] According to the American Dental Association, data show regions in Appalachia have lower use of services such as orthodontics than in other areas of the country, suggesting less recognition of the importance of maintaining good dental health.[26]

According to a 2010 Kaiser Commission on Medicaid and the Uninsured Overview on the Affordable Care Act, the newly passed legislation has two areas that negatively impact improving access to dental and vision coverage. Under the law's section regarding tax-related changes, excise taxes will be imposed upon insurers who exceed the threshold of the law regarding maximum charges to employers, *except for charges regarding dental and vision coverage*. Also, under the rules regarding private insurance, "including those offered through the Exchanges and those offered outside of the Exchanges," all such plans must abide by the new standards, *with the exception of dental and vision*[27] options that are

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[24] *Find Shortage Areas: HPSA By States and County.* U.S. Health Resources and Human Services Department website. http://hpsafind.hrsa.gov/HPSASearch.aspx (accessed May 20, 2011).
[25] Christ Martin and Daniela McNeil, Richard Crout, Peter Ngan, Robert Weyant, Hilda Heady, and Marcy Marazita. "Oral Health Disparities in Appalachia," *Journal of the American Dental Association* 139 (May 2008): 598.
[26] Ibid., 599.
[27] *Patient Protection and Affordable Care Act*, Subtitle D, Part 1, Sec. 1302.

classified as "stand-alone plans."[28] In effect, when it comes to dental care, the same rules do not apply.

The poor state of dental health and dental insurance coverage among low-income U.S. populations – especially in central Appalachia – is evident, and the link between dental health and general wellbeing is well established by the above data. Despite these factors, the topic of dental health seems to have disappeared from the debate over national health care reform. While the reason for its disappearance likely rests somewhere between resources and politics, the reality of the problem can be seen by looking again at the fairground in Wise County, Virginia, and the thousands who turn to RAM for help.

Political Vulnerability

Since the passage of the Affordable Care Act in 2010, the legislation has faced strong calls for repeal.[29] Support for health reform has continued to be weak among the American public since it was passed in 2010. Public opinion polls show as recently as May 2011 a majority of likely voters favored repealing the law.[30] Since the passage of the ACA, Medicaid has also become a prime target of the Republican Party, with conservative lawmakers proposing legislation in 2011 to scale back the program and begin removing those already enrolled.[31] As both federal and state governments continue to struggle

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[28] Kaiser Commission on Medicaid and the Uninsured and Health Care Marketplace Project, "Summary of New Health Reform Law," Kaiser Family Foundation, Washington, D.C. (April 2011), http://www.kff.org/healthreform/8061.cfm (accessed January 15, 2011).
[29] Theda Skocpol, "The Political Challenges That May Undermine Health Reform," *Health Affairs* 29, no. 7 (July 2010): 1288.
[30] Rasmussen Reports, *Health Care Law: 54% Favor Repeal (August 8, 2011),* http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law (accessed Aug. 8, 2011).
[31] Mary Agnes Carey and Phil Galewitz, "GOP Pushes to Let States Reduce Medicaid Rolls," *Kaiser Health News*, May 23, 2011,

fiscally, Medicaid will remain a prime target for cuts that could actually see Medicaid rolls shrink, not expand. National elections in the fall of 2010 saw the Republican Party regain control of the House and the Democratic Party lose its filibuster-proof majority in the Senate. Then-new Republican House Speaker John Boehner labeled the ACA a "monstrosity" and called for its overturn as a political priority.[32] In January 2011, a Republican proposal to repeal the plan passed the House, but was not voted on in the Senate, so the measure died. As long as Obama is president and Congress divided, serious attempts to completely repeal the ACA will have little chance, but the law does face a vulnerability to piecemeal dismantlement.[33] Many opponents to the law have changed their focus from "repeal" to "fix."[34] Since that time, Republicans have outlined sections of the law they want to see changed, including:

- Eliminating the provision requiring employers to contribute to the cost of insurance coverage
- Allowing states more control over exchanges, which could allow lower levels of required coverage
- Eliminating the requirement of all people to have coverage[35]

Of all of the goals listed by opponents to the ACA, the most public has been the change to the requirement of each American having some form of health insurance by

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http://www.kaiserhealthnews.org/Stories/2011/May/24/medicaid-maintenance-of-effort-republicans.aspx

[32] Johnathan Oberlander, "Beyond Repeal – The Future of Health Care Reform," *The New England Journal of Medicine* 363, no. 24 (Dec. 9, 2010): 2277.

[33] Skocpol, "The Political Challenges That May Undermine Health Reform," 1288.

[34] Ibid., 1289.

[35] "Health Reform Repeal: Republican Priorities on Obamacare," *The Economist*, (May 4, 2010), www.economist.com/blogs/democracyinamerica/2010/11/health-reform_repeal (accessed May 10, 2011).

2014. Attorneys General from twenty-six states have filed lawsuits against the federal government to have this section of the ACA declared unconstitutional and removed from the legislation.[36] If successful, this change would dramatically change both the equations for financing the law and its implementation.

Keeping costs – as well as projected savings – of the ACA on target will help defend the legislation against major change, but there are already signs that cost containment could be hard to accomplish. According to the Congressional Budget Office (CBO), the ACA is projected to cut the cost of health care in the United States as more people pay into the health care system and more people are covered by private insurers. The CBO said in a report on the ACA that the estimated savings would cut the federal deficit by $124 billion over a ten-year period starting in 2011.[37] As part of that equation, the CBO estimated that just 7 percent of companies in the nation that currently offer health insurance as a benefit would choose to eliminate that benefit in favor of the $2,000 per-employee fine they would incur for not offering coverage.[38] But a recent survey of 1,300 U.S. employers reported in June 2011 that nearly 50 percent of employers said they are planning on eliminating health care benefits and accepting those fines.[39] These employees would then be eligible for additional government subsidies for purchasing private insurance in the exchanges or would be eligible for Medicaid under the new law. Either way, the federal government would be paying more to keep large numbers of Americans covered by

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[36] Skocpol, "The Political Challenges That May Undermine Health Reform," 1289.
[37] "Health Care," U.S. Congressional Budget Office website, http://www.cbo.gov/publications/collections/health.cfm (accessed May 15, 2011).
[38] "How US Health Care Reform will Affect Employee Benefits," *McKinsey Quarterly* (June 2011): 2, http://www.mckinseyquarterly.com/Health_Care/Strategy_Analysis/How_US_health_care_reform_will_affect_employee_benefits_2813 (accessed June 8, 2011).
[39] Ibid.

health insurance. Along with increased costs, employees without employers provided insurance could take the government fine – $95 annually or 1 percent of income, whichever is greater – and join the ranks of the uninsured. Such a situation could force the government then to either increase overall taxes to pay for the program or increase the fine paid by employers to well above the $2,000 mark.[40]

The responsibility placed on states in the ACA adds another level of vulnerability. States will be required to implement many of the law's key provisions, including the creation of the exchanges (under federal guidance), expanding and helping pay for Medicaid, and regulating private insurers.[41] Legislators in conservative-leaning states have already threatened to boycott the law or are arguing for looser federal regulations in the creation of exchanges – something ACA supporters say could create a race to the bottom in plan coverage.[42]

Though possible, a complete repeal of the ACA seems unlikely. But the poor public support of the measure and the expected difficulties meeting promised fiscal targets make it vulnerable to change. Weak enforcement measures – such as low fines for not carrying coverage as an individual or for not offering it as an employer – could add additional strain to meeting expectations of the ACA. The working poor could continue to find themselves without employer-offered coverage. Mandates for coverage could disappear. Regulations on exchanges could weaken the plans substantially. Any of these changes could contribute to patients finding themselves without needed health care coverage and with their best options still being free clinics.

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[40] Ibid., 7.
[41] Oberkander, "Beyond Repeal – The Future of Health Care Reform," 2278.
[42] Ibid.

CHAPTER 6

CONCLUSION

The passage of the Affordable Care Act in 2010 heralded a new era of health care in the United States. For the first time in more than five decades, a major expansion of medical coverage is being brought to the American people. But expectations that the law will end the need for free clinics in this country will go unrealized. Quantifying the part free clinics play in the current U.S. health care system is difficult, but gaining an understanding of those who come to them for care is not. They are the working poor, the homeless, the undereducated, and others who fall between the cracks of the system. Many of these are eligible to be part of the system already in place but fail to become enrolled for the variety of reasons covered in this thesis. While this is a national issue, the problem is magnified in central Appalachia, where factors such as poverty, low education levels, and a history of cultural separation create a looking glass of what is going wrong with the system. For the members of this population who use free clinics such as Remote Area Medical, the ACA will not resolve the problem. Without a focus on understanding the cultural issues and expanding outreach efforts in areas such as central Appalachia, many in this region will continue to go without health care coverage. Even for those who do enroll in the system and find themselves with medical coverage, they will continue to have difficulty accessing dental services, and this critical gap in their overall care will continue to exacerbate other health threats such as cardiovascular disease. Adequate dental coverage is not supported by the ACA, nor is an increase in the total number of dental providers for distressed regions such as central Appalachia. Furthermore, the law is sufficiently unpopular with the American public that it is more likely to be weakened than strengthened, and key portions

that would ensure the availability of care for the most vulnerable populations are subject to elimination. Thus, in the current political climate surrounding the ACA, the issues outlined in this thesis are unlikely to be addressed, and the lines of thousands seeking help at RAM clinics are likely to continue.

WORKS CITED

Appalachian Regional Commission. *An Analysis of the Financial Conditions of Health Care Institutions in the Appalachia Region and their Economic Impacts*, by Jeffrey Stensland, Curt Mueller, and Janet Sutton, 2002. www.arc.gov/assets/research_reports/AnalysisoftheFinancialConditionsofHealthCareInstitutionsinAppalachianRegion.pdf (accessed January 6, 2011).

——. "County Economic Status Report, Fiscal Year 2011." http://www.arc.gov/reports/custom_report.asp?REPORT_ID=36 (accessed January 6, 2011).

——. "Distressed Counties Program." ARC website, http://www.arc.gov/distressedcounties (accessed January 6, 2011).

Barney, Sandra Lee, *Authorized to Heal: Gender, Class, and the Transformation of Medicine in Appalachia, 1880-1930.* Chapel Hill: The University of North Carolina Press, 2000.

Behringer, Bruce and Gilbert H. Friedell. "Appalachia: Where Place Matters in Health." *Preventing Chronic Disease: Public Health Research, Practice, and Policy* 3, no. 4 (October 2006):1-4.

Billings, Dwight B. and Kathleen Blee. *The Road to Poverty: The Making of Wealth and Hardship in Appalachia.* New York: Cambridge University Press, 1999.

Brock, Stan. *All the Cowboys Were Indians*. Lenior City, Tenn.: Synergy South, 1999.

Brown, Ann-Marie, and Greer Glazer. "Enrollment Success in State Children's Health Insurance Program After Free Clinic Referral." *Journal of Pediatric Health Care* 18, no. 3 (May/June 2004): 145-148.

Commonwealth Fund, "2007 International Health Policy Survey in Seven Countries", Commonwealth Fund website, http://www.commonwealthfund.org/Content/Surveys/2007/2007-International-Health-Policy-Survey-in-Seven-Countries.aspx (accessed January 18, 2011).

"County Health Rankings." *County Health Rankings* website. http://www.countyhealthrankings.org/virginia/wise (accessed May 25, 2011).

Darnell, Julie S. "Free Clinics in the United States." *Archives of Internal Medicine* 170, no. 11 (June 2010): 946-953.

Democracy Now. "Uninsured Travel from Across US for Free Healthcare from Relief Group Remote Area Medical." *Democracy Now* website, online video file, 40:22, http://www.democracynow.org/2009/7/22/uninsured_travel_from_across_us_for (accessed February 1, 2011).

DiMarco, Marguerite A., Marlene Huff, Elizabeth Kinion, and Mary Agnes Kendra. "The Pediatric Nurse Practioner's Role in Reducing Oral Health Disparities in Homeless Children." *Journal of Pediatric Health Care* 23, no. 2 (March/April 2009): 109-116.

Eller, Ronald. *Miners, Millhands, and Mountaineers*. Knoxville, Tenn.: University of Tennessee Press, 1982.

"Find Shortage Areas: HPSA By States and County." U.S. Health Resources and Human Services Department website. http://hpsafind.hrsa.gov/HPSASearch.aspx (accessed May 20, 2011).

"Five Years and Counting." *Blue Ridge Free Dental Clinic Spring Newsletter*. Blue Ridge Free Dental Clinic. Cashiers, N.C. Spring 2011. http://www.blueridgefreedentalclinic.org/docs/BRFDC-Newsletter-Spring-2011.pdf (accessed June 5, 2011).

Georgia Health Policy Center. "Health Reform: From Insights to Strategies, A Variety of Perspectives." Georgia Health Policy Center website. http://aysps.gsu.edu/ghpc/6098.html (accessed May 10, 2011).

Glasmeier, Amy K., and Tracey L. Farrigan. "Poverty, Sustainability, and the Culture of Despair: Can Sustainable Development Strategies Support Poverty Alleviation in American's Most Environmentally Challenged Communities?" *Annals of the American Academy of Political and Social Science* 590 (November 2003): 131-149.

Glasgow, Nina, Nan E. Johnson, and Lois Wright Morton. *Critical Issues In Rural Health.* Ames, Iowa: Blackwell Publishing, 2004.

Gibbs, Richard, and Patricia Gibbs. "Free Clinics – A Personal Journey." *Archives of Internal Medicine*170, no. 11 (June 2010): 954-954.

Halverson, Joel. *An Analysis of Disparities in Health Status and Access to Health Care in the Appalachia Region*, Appalachian Regional Commission. 2004. http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=82 (accessed January 6, 2011).

——. *Underlying Socioeconomic Factors Influencing Health Disparities in the Appalachia Region,*. Final report, Mary Babb Randolph Cancer Center/Office of Social Environment and Health Research Department of Community Medicine, Robert C. Byrd Health Sciences Center, West Virginia University. Appalachian Regional

Commission. 2008. http://www.arc.gov/research/researchreportdetails.asp?REPORT_ID=9 (accessed January 6, 2011).

Haveman, Heather A., Hayagreeva Rao, and Srikanth Paruchuri. "The Winds of Change: The Progressive Movement and the Bureaucratization of Thrift." *American Sociological Review* 72, no. 1 (Feb. 2007): 117-142.

Healing Hands Health Center. *Annual Report, 2009*. Bristol, Tennessee, 2009.

"Health at a Glance 2009." Organization for Economic Co-Operation and Development. Dec. 8, 2009. www.oecd.org/health/healthataglance (accessed April 20, 2011).

Congressional Budget Office. *Health Care*. U.S. Congressional Budget Office website. http://www.cbo.gov/publications/collections/health.cfm (accessed May 15, 2011).

"Health Care Law: 51% Favor Repeal." Rasmussen website. http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/health_care_law (accessed June 1, 2011).

"Health Reform Repeal: Republican Priorities on Obamacare." *The Economist*. May 4, 2010. www.economist.com/blogs/democracyinamerica/2010/11/health-reform_repeal (accessed May 10, 2011).

"How US Health Care Reform will Affect Employee Benefits." *McKinsey Quarterly* (June 2011), http://www.mckinseyquarterly.com/How_US_health_care_reform_will_affect_employee_benefits_2813 (accessed June 8, 2011).

Hurley, Robert E. "TennCare – A Failure of Politics, Not Policy: A Conversation With Gordon Bonnyman." *Health Affairs* 25, no. 3 (May 2006): 217-225.

Huffington Post Investigative Fund. "In Rural Virginia, Relief for the Uninsured is Rare." YouTube video. http://www.youtube.com/watch?v=wlGsLfzJteI (accessed May 10, 2011).

Kaiser Commission on Medicaid and the Uninsured. "Characteristics of the Uninsured: Who is Eligible for Public Coverage and Who Needs Help Affording Coverage?" by John Holahan, Allison Cook, and Lisa Dubay. 2007. http://www.kff.org/uninsured/7613.cfm (accessed January 15, 2011).

——. "*Access to Affordable Dental Care: Gaps for Low-Income Adults*." By Jennifer Haley, Genevieve Kenny, and Jennifer Pelletier. 2008. http://www.kff.org/medicaid/7798.cfm (accessed February 21, 2011).

——. "Summary of New Health Reform Law." Kaiser website, Kaiser Family Foundation, Washington, D.C. http://www.kff.org/healthreform/8061.cfm (accessed January 15, 2011).

Lewis, Helen and Edward Knipe. "The Colonialism Model: The Appalachian Case." in *The Colonialism Model: The Appalachian Case.* Boone, N.C.: Appalachian Consortium Press, 1978.

Leve, Ariel. "Saint Stan Brock: Who Are You?" *The Sunday Times,*. April 5, 2009. http://women.timesonline.co.uk/tol/life_and_style/women/ariel_leve/article6015125.ece (accessed January 16, 2011).

Litaker, David, Siran M. Koroukian, and Thomas E. Love. "Context and Healthcare Access." *Medical Care* 43, no. 6 (June 2005): 531-540.

Manchikanti, Laxmaiah. "Health Care Reform in the United States: Radical Surgery Needed Now More Than Ever." *Pain Physician* 11, no. 1 (March 2008): 13-42.

Martin, Christ, and Daniela McNeil, Richard Crout, Peter Ngan, Robert Weyant, Hilda Heady, and Marcy Marazita. "Oral Health Disparities in Appalachia." *Journal of the American Dental Association*139 (May 2008): 598-604.

Meckel, Richard. "Delivering Oral health Services to Children in the Past: the Rise and Fall of Children's Dental Clinics." *Ambulatory Pediatrics* 2, no. 4 (July/August 2002): 255-260.

Murray, Christopher J.L., and Julio Frenk. "Ranking 37th — Measuring the Performance of the U.S. Health Care System." *New England Journal of Medicine* 362, no. 2 (January 2010): 98-99.

National Institute of Dental and Craniofacial Research, "A Look at Oral Health Disparities in Appalachia." National Institutes of Health. http://www.nidcr.nih.gov/Research/ResearchResults/InterviewsOHR/COHRA.htm (accessed February 10, 2011).

——. "A Plan to Eliminate Craniofacial, Oral, and Dental Health Disparities." National Institutes of Health. http://www.nidcr.nih.gov/NR/rdonlyres/932B8B7D-E114-4491-BE85-ABA6F29663AE/0/hdplan.pdf (accessed May 10, 2011).

Naylor, Lorenda A. "Reauthorization of the State Children's Health Insurance Program: Divergent Ideologies or Fiscal Realities?" *Clinical Therapeutics* 30, no. 3. (November 2008): 556-559.

Oberlander, Jonathan. "Beyond Repeal – The Future of Health Care Reform." *The New England Journal of Medicine* 363, no. 24. (December 2010): 2277.

Office of the Surgeon General. *Oral Health In America*. By David Satcher. U.S. Department of Health and Human Services. (2000). http://www.surgeongeneral.gov/library/oralhealth/ (accessed February 21, 2011).

Ohio Department of Health, *Oral Health and Access to Dental Care for Ohioans, 2007*. http://www.groundworkohio.org/resources/otherresources_pdf/2007%20Access%20Brief%20Exec%20Summ%20FINAL.pdf (accessed February 10, 2011).

"Oral Health: A Window to Your Overall Health." Mayo Clinic website. www.mayoclinic.com/health/dental/DE00001 (assessed May 10, 2010).

Quadagno, Jill. "Why the United States Has No National Health Insurance: Stakeholder Mobilization against the Welfare State, 1945-1996." *Journal of Health and Social Behavior* 45 (2004): 25-44.

Remote Area Medical, *Clinic Report: Emergency Dental Clinic: Hancock County*, May 9 1992.

——. *Clinic report: Emergency Dental Clinic to Hancock County, Tennessee*, March 26-27, 1992.

——. *Clinic Report: Optometry Expedition to Mud Creek, Kentucky*, June 26-27, 1993.

——. *Clinic Report: Expedition to Union County, Tennessee*, June 10-12, 1993.

——. *Clinic Report: Expedition to Briceville (Anderson County) Tennessee*, June 18-19, 1993.

——. *Clinic Report: The Remote Area Medical Expedition to Washburn, Grainger County, Tennessee*, August 7, 1993.

——. *Clinic Report: Emergency Dental Expedition to Hawkins County, Tennessee,* July 30-31, 1993.

——. *Clinic Report: Expedition Optometry Expedition to Mud Creek, Kentucky,* August 21-22, 1993.

——. *Dental and Optometry Expedition to Union County, Tennessee,* August 28-29,1993.

——. *Clinic Report: Stony Fork, Campbell County, Tennessee, Special Optometry Expedition,* August 31, 1993.

——. *Clinic Report: Dental and Optometry Expedition to Indian Mountain Clinic, Jellico, Campbell County, Tennessee*, September 18-19, 1993.

——. *Clinic Report: General Medicine, Optometry and Dentistry Expedition to Deer Lodge, Morgan County, Tennessee,* October 16-18, 1993.

——. *Clinic Report: Dental Expedition to Briceville, Anderson County, Tennessee,* November 4, 1993.

——. *Clinic Report: Medical Expedition to Pike County, Kentucky,* November 5-7, 1993.

——. *Clinic Report: Expedition to Clairfield, Tennessee, Claiborne, County,* December 4-5, 1993.

——. *Clinic Report: Expedition # 220. Wise County, Va.*, July 13-15, 2000.

——. *Clinic Report: Expedition #369. Wise County, Va.*, July 24-27, 2003.

——. *Clinic Report: Expedition #610. Wise County, Va.*, , July 23-25, 2010.

——. "Accomplishments," RAM website, http://www.ramusa.org/learn/accomplishments.htm (accessed February 20, 2011).

——. "History," RAM website, http://www.ramusa.org/about/history.htm (accessed February 20, 2011).

Reynolds, Herbert Y. "Free Medical Clinics: Helping Indigent Patients and Dealing With Emerging Health Care Needs." *Academic Medicine* 84, no 10 (October 2009): 1434-1439.

Robert Wood Johnson Foundation, "Looking Back on Cover the Uninsured Week," Robert Wood Foundation website, http://www.rwjf.org/coverage/product.jsp?id=72459&cid=xdr_ccs_001 (accessed July 12, 2011).

Shapiro, Henry, *Appalachia On Our Mind.* Chapel Hill: The University of North Carolina Press, 1978.

Skocpol, Theda, "The Political Challenges That May Undermine Health Reform," *Health Affairs* 29, no. 7 (July 2010): 1288-1291.

Stanton, Mark, "Dental Care: Improving Access and Quality," *Research in Action*, no. 13. Agency for Healthcare Research and Quality (July 2003):1-12. www.ahrq.gov/research/dentalcare/dentria.pdf (accessed on January 16, 2011).

TennCare, "Eligibility", Tennessee Bureau of TennCare website, State of Tennessee, http://www.tn.gov/tenncare/mem-eligibility.html#1 (accessed March 1, 2011).

U.S. Bureau of the Census, *Income, Poverty, and Health Insurance Coverage in the United State: 2009*. By Carmen DeNavas-Walt, Bernadette D. Proctor, and Jessica C. Smith. Prepared by the U.S. Department of Commerce, Economics and Statistics Administration and the U.S. Census Bureau, Washington, D.C., 2010.

U.S. Centers for Medicare and Medicaid Service, *2008 National Dental Survey*, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Service, Washington, D.C., 2009.

U.S. Centers for Medicare and Medicaid Services, "Overview," U.C. CMS website, U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services, Washington, D.C. https://www.cms.gov/MedicaidEligibility/ (accessed March 1, 2011).

Walsh Center for Rural Health Analysis, *Financing Rural Public Health Activities in Prevention and Health Promotion*. By Michael Meit, Benjamin N. Hamlin, Bhumika Piya, and Lorraine Ettaro. Final report. Prepared by Walsh Center for Rural Health Analysis/NORC at the University of Chicago and The University of Pittsburgh Center for Rural Health Practice, (2008). www.norc.uchicago.edu/.../RuralPublicHealthFinancingFinalReport20080613.pdf (accessed January 10, 2011).

"Wendell Potter – Former Communications VP for CIGNA," YouTube video. http://www.youtube.com/watch?v=GBFKkXDSKWw (accessed Feb. 13, 2011).

Weinstein, Milton C., and Jonathan A. Skinner, "Comparative Effectiveness and Health Care Spending – Implications of Reform," *New England Journal of Medicine* 362, no. 5 (February 2010): 460-465.

Williams, John Alexander. *Appalachia: A History*. Chapel Hill: The University of North Carolina Press, 2002.

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