INTRODUCTION

The 2008 election results led highlighted health insurance reform as a major domestic policy goal. One policy option is a national approach similar to the 2007 statewide health insurance mandate of the Massachusetts Health Care Program, which requires most residents (with few exceptions) to carry employee-based or private healthcare insurance. Massachusetts also developed a government-sponsored public health insurance option to distribute the risk across a larger pool. A recent analysis by researchers at the Northeast Mississippi Area Health Education Center’s Mississippi Center for Health Workforce projected health care needs of Mississippians based on sudden and significant changes in utilization rates that are experienced when an individual transitions from lacking health insurance coverage to being covered.

Using 2006 U.S. Census Small Area Health Insurance Estimates, adult and child utilization rates, and Mississippi State Board of Medical Licensure data, a statewide estimate for healthcare demand was calculated (4,934 visits per doctor per year). Similar estimates were calculated for each county and compared to the statewide physician demand to estimate the number of primary care physicians needed in each county. That estimate was then compared to the number of primary care physicians in the county to estimate health care shortages (see the full report for more detail).

Map 1 shows the projected number of primary care physicians each county would need if 48% of those who were uninsured became insured, based on analysis from the Massachusetts baseline year (prior to implementation of the health insurance mandate) and the year after implementation. Mississippi would need 52 primary care physicians to have adequate state-wide coverage of care based upon current physician utilization rates; however, there are systematic county-level shortfalls due to the misdistribution of primary care physicians across the state. Hinds County has an excess of 216 primary care physicians (indicated by the negative number). Other population centers such as Forrest, Harrison, Lee, and Lauderdale counties also have similar excesses in care providers. However, 38% of the 82 counties would experience a shortfall of more than five primary care physicians if a health insurance mandate is implemented, a shortfall of nearly 25,000 physician visits each year.
Map 2 shows the required percent change in primary care physicians by county, putting the findings in Map 1 into the context of how many primary care physicians already practice there. Again, population centers experience an excess of primary care physicians, as evidenced by the negative numbers shown. Meanwhile, 49 counties (60%) would need to increase their physician supply by 25% or more to provide access to enough physicians to enable the appropriate number of visits per patient. These counties include Issaquena, whose percent increase cannot be calculated due to their lack of any primary care provider. Twenty of the 82 counties, again including Issaquena, need to at least double their primary care workforce for access to be adequate.

Further analysis, including micro-region analyses, are available at http://www.nemsahec.msstate.edu, in the full report. If the goal of comprehensive healthcare reform is to increase the level of access to medical care each citizen maintains, then the demand of such care must be seriously considered in any reform effort. As physicians may be able to provide extra office visits to partially cover the added demand, the question becomes at what cost. Though this question is outside the scope of this research, further consideration of the costs and benefits of such a change must be thoughtfully considered.

REFERENCES
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