



## Spreading the Safety Net — Obstacles to the Expansion of Community Health Centers

John K. Iglehart

During the presidency of George W. Bush, his administration's agenda of "compassionate conservatism" — with its emphasis on market-based, rather than government-sponsored, approaches to

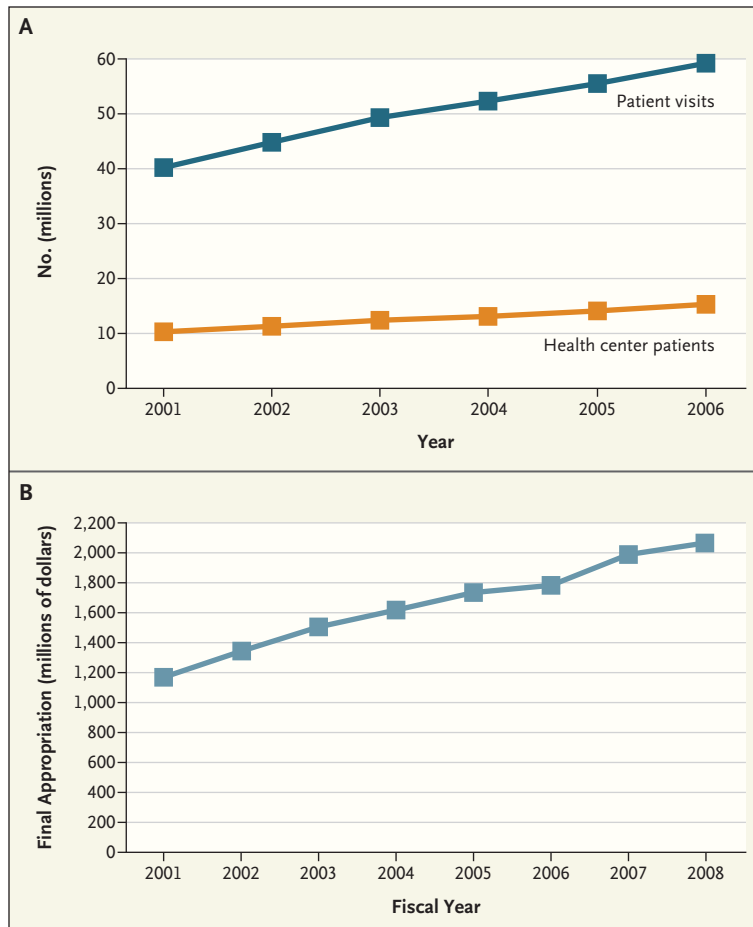
health care services and income support — has been rejected by Democrats innumerable times. This philosophical conflict has resulted in stalemates on many health care issues, and the administration's proposed 2009 budget, which calls for reductions of \$200.9 billion in Medicare and Medicaid spending over the next 5 years, only deepens the political divide between the parties. Amidst this partisan standoff, however, Bush has remained resolute in fulfilling one early campaign pledge that most Democrats enthusiastically embrace: doubling the number of community health centers (CHCs) over a 5-year period, so

that millions more people who lack insurance or have limited access to private medical care can be treated at publicly funded facilities. Bush's commitment persuaded more Republicans to support CHCs, and the result has been a politically effective bipartisanship on this front, since most Democratic legislators have long considered such centers a vital component of any expansion of health care coverage.

The CHC initiative, launched in 1965 as part of the Lyndon B. Johnson administration's War on Poverty, was largely the brainchild of Dr. Jack Geiger, who drew inspiration from a South

African movement that had fostered the creation of facilities where poor workers could receive both public health services and medical care.<sup>1</sup> Geiger's primary policy goals were combining these disparate models and removing financial barriers to access. These goals, along with an emphasis on empowering the community to participate in decision making for CHCs by requiring that the majority of their board members be patients, were built into the centers' operating principles.

Reflecting this "power to the people" philosophy, the funding mechanism for CHCs consists of federal grants that bypass state governments and flow directly to these nonprofit, community-based organizations. The commitment of Bush, a former governor, to expanding CHCs therefore seems out of political character and contrasts



**Numbers of Patients and Visits (Panel A) and Annual Federal Appropriations (Panel B) for Community Health Centers.**

Data are from the National Association of Community Health Centers.

with his preference for promoting private insurance by issuing tax credits. Nevertheless, the commitment is an implicit acknowledgment that expanding insurance coverage and increasing the number of CHCs are complementary strategies and that both are required in order to improve access to care.

Bush made his pledge to double the number of CHCs during his first presidential campaign in 2000. He followed through in the first annual budget that his administration formulated (for 2002,

see graphs), launching the President's Health Center Initiative. During a visit last December to a CHC in Omaha, Nebraska, Bush reiterated, "I happen to think [CHCs] are an integral part of a health care system because they provide care for the low-income, for the newly arrived, and they take the pressure off of our hospital emergency rooms."

Overall, federal grants to CHCs will have increased from \$1.1 billion when Bush took office to \$2.2 billion in fiscal 2009, if Congress accepts his proposed bud-

get for this program. Under this proposal, a substantial portion of the new resources would be targeted at expanding CHCs that operate in impoverished areas. This emphasis recalls the administration's insistence with regard to the State Children's Health Insurance Program (SCHIP) that states enroll virtually all children with family incomes below 200% of the federal poverty level before accepting children with greater means.

CHCs, which now number 1200 nationally, operate in some 6000 urban and rural sites in every state and territory (many have facilities in multiple locations) and will serve an estimated 16.3 million people this year. About 40% of these patients are uninsured, 35% are covered through Medicaid, and the remainder are Medicare beneficiaries or have private insurance. Patients who are uninsured pay according to a sliding scale based on ability to pay (with some paying nothing).

Two thirds of CHC patients are members of racial or ethnic minority groups, and many lack proficiency in English. More than two thirds live on incomes at or below the federal poverty level (\$20,650 for a family of four in 2007), and more than 92% have incomes below 200% of this threshold. Because their population is relatively young overall and is disproportionately made up of young women and children, there is a high demand for primary care services, but many centers also offer assistance in applying for Medicaid and SCHIP coverage, health education, and translation and transportation services.

Although CHCs have expanded over the past 7 years, the chaotic

mix of private and public activities that make up the health care system has evolved in ways that present the centers with major challenges. As more people have lost their employer-sponsored or Medicaid coverage and become uninsured, greater demands have been placed on CHCs, and those pressures may well increase as the economy softens. Other challenges include recruiting and retaining physicians, nurses, and allied professionals who can provide primary care; securing specialty referrals for uninsured and Medicaid patients; and functioning in the face of budget cutbacks in Medicaid and SCHIP.

Although CHCs and public hospitals are the most visible safety-net providers, physicians in private practice, given their sheer number, are the main source of care for the uninsured and Medicaid enrollees. But the number of doctors providing charity care has dropped significantly over the past decade, increasing the burden on CHCs and emergency rooms.<sup>2</sup> Meanwhile, it is difficult to attract physicians to staff positions at CHCs, because hospitals and medical groups can offer them higher salaries. The shortage of primary care physicians, particularly in rural areas, led to 809 vacancies overall at CHCs (12% of the 6500 full-time-equivalent physician positions in 2004).<sup>3</sup>

The provision of specialty services also remains problematic for most CHCs, which cannot find many specialists willing to treat

uninsured patients who have no source of payment. According to a survey, CHC medical directors report that their inability to secure specialty referrals, particularly for uninsured patients, poses problems that are “pervasive and affect sizable numbers of patients.”<sup>4</sup> The survey found that CHCs affiliated with a medical school or hospital had more success than others in securing access to specialty services, but very few (fewer than one in five) have such affiliations.

CHCs, which participate in policy activities largely through the National Association of Community Health Centers (NACHC), are striving to attract more physicians through myriad channels at the national, state, and local levels. These efforts include a call for expanding the National Health Service Corps, which places primary care clinicians in communities with the greatest need; the offering of internships to medical students and residents; and contacts with medical schools and teaching hospitals that may be interested in collaborating with community-based organizations. Dan Hawkins, senior vice president for policy at the NACHC, notes that his organization has “an aggressive growth strategy for CHCs, the goal of which is to serve 30 million people by 2015 and 51 million by 2022.”<sup>5</sup> NACHC has formed a partnership with A.T. Still University, says Hawkins, “to create a dental school in Arizona that has diversity and ser-

vice in community-based settings as its core mission; its inaugural class of 54 students graduated last June. Most recently, we again teamed with A.T. Still to develop a college of medicine in Mesa, Arizona, with the same focus.”

Hawkins points out that “CHCs meet the definition of a ‘medical home’ as developed by primary care medical organizations, but we will not be able to reach our expansion goals if we cannot attract a greater number of clinicians to these centers and more federal support from Washington.” Despite good intentions on both sides of the aisle, it remains uncertain whether Congress or the new administration will see the continued expansion of CHCs as a vital step toward reforming the health care system.

Mr. Iglehart is a national correspondent for the *Journal*.

1. Moments in leadership: case studies in public health policy and practice. New York: Pfizer, 2007.

2. Isaacs SL, Jellinek P. Is there a (volunteer) doctor in the house? Free clinics and volunteer physician referral networks in the United States. *Health Aff (Millwood)* 2007;26:871-6.

3. Rosenblatt RA, Andrilla CHA, Curtin T, Hart LG. Shortages of medical personnel at community health centers: implications for planned expansion. *JAMA* 2006;295:1042-9.

4. Cook NL, Hicks LS, O'Malley AJ, Keegan T, Guadagnoli E, Landon BE. Access to specialty care and medical services in community health centers. *Health Aff (Millwood)* 2007;26:1459-68.

5. Robert Graham Center, American Academy of Family Physicians. Access denied: a look at America's medically disenfranchised. Washington, DC: National Association of Community Health Centers, 2007.

Copyright © 2008 Massachusetts Medical Society.