

COMMENTARY

Community Health Centers and the
Underserved: Eliminating Disparities or
Increasing Despair

GORDON SCHIFF and CLAUDIA FEGAN

HEALTH disparities—those persistent blemishes that stubbornly resist cosmetic efforts to cover up their unsightly figures and ugly implications. Not only are they an embarrassment, but even when the pain and suffering they represent is overlooked, it is impossible to ignore the nagging questions disparities raise about the fairness of our society and health system.

Community Health centers—those primary care jewels. They serve as shining examples of primary care that is accountable, accessible, and culturally sensitive to underserved and vulnerable populations. Not only are they a source of pride to the communities of local advocates and staff who built and struggle to sustain them but, as Politzer et al. show in this issue of the *Journal*, they can actually improve outcomes on measures such as low birthweight pregnancies and vaccination rates.

Our nation has declared war against health disparities, officially adopting as one of its two highest priority health goals “eliminating racial and ethnic disparities in health by the year 2010” (1). Deploying health centers in this war against disparities makes sense given their record of nondiscriminatory service to all residents regardless of ability to pay and their proven accomplishments in delivering services

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to our most vulnerable citizens. But before marching off to any war, we need to scrutinize the goals, the weapons, the costs, and the rhetoric, not merely waving the flag of (prenatal care-enhanced) motherhood, (nutrition-improving 5-a-day) apple pie, or (covering-the-uninsured) health centers.

Even according to their own press statements (2), community health centers care for only 20% of the underserved and only 10% of the uninsured. This means that even with the “President’s strategy for greater investment in health centers,” which Politzer lauds, the vast majority of underserved will remain so. More distressing is the Bush Administration’s substitution of this modest additional funding to community health centers (an average increase of 13% annually, barely exceeding the medical inflation rate) for any serious plan to provide health coverage to the forty-three million Americans who currently lack any health insurance, and the additional tens of millions who have inadequate insurance, are transiently/intermittently uninsured, or will soon join the ranks of the uninsured—expected to swell to 52 million by 2006, the year the Bush community health center funding initiative is fully implemented.

Consider the paltry amount of money being allocated with so much fanfare to health centers this year—a *total* of \$1.5 billion. This amounts to \$36 for each uninsured person. Contrast this to the average annual per capita health care costs in the U.S., \$5600, and it is obvious that Bush’s funding (even when increased to \$2.2 billion in 2006)—will not stretch very far to provide comprehensive coverage for the uninsured. Nor is it likely to have much impact on health disparities. Overcoming disparities requires equity in distribution of resources; this is the opposite. This funding disparity becomes even more stark when we realize that the vulnerable patients served by community health centers are hardly *average* in their health needs. Can we expect these clinics to address the needs of this populations’ well-documented, higher-than-average burden of illness, which often requires extra services, such as social services, mental health care, or substance abuse assistance, with 2% of the dollars the private HMOs are paid to care for each enrollee? How can we expect community health centers to care for a sicker cohort, with less funds, and at the same time (in the words of Politzer in support of the President’s health center initiative) “produce measurable changes in health status”?

In fairness, some patients may have other funding sources to cover certain aspects of their costs (e.g., inpatient or Medicaid). But as health centers are intimately and painfully aware, cutbacks resulting from current budget crises are affecting virtually every State in the U.S. This means that increasingly these “other” sources are being cut back. For example, in our state (Illinois), Medicaid has resorted to delaying payments to providers 3 months or more because of budget shortfalls. Recently Kid Care (special children’s Medicaid plan) in Illinois enrolled 1700 kids, while the same month it dis-enrolled 1400; and in New York on a recent month, the numbers dis-enrolled exceeded those newly enrolled. So, what the Bush administration gives with one hand, it is taking away with the other. Or as Uwe Rheinhardt put it, “the hard-won incremental breakthroughs in the fight on behalf of the uninsured” are little more than “small steps up on a downward-rolling escalator” (3).

As health centers struggle to keep up, they also find themselves scrambling to overcome a series of new challenges, consuming much of their time, energies, and resources. Rather than the shock troops in the war against disparities, many of our health clinic colleagues are beleaguered and battle weary, struggling to barely keep their heads above water. These new challenges include:

- Growing numbers of newly uninsured people, many with higher expectations for timeliness and quality of services: Given the fact that 56% of the uninsured are full-time workers, one can easily understand why lengthy waits at understaffed clinics are creating added frictions. Working patients may be frustrated when CHC’s lack the amenities of private care to which they may have become accustomed, and may complain about long wait times for appointments, rushed visits, or mid-level provider (rather than MD) care.
- Medication availability and affordability: Health centers struggle endlessly to find creative ways to provide drugs that are increasingly too expensive for their patients to purchase. Many centers are spending an enormous proportion of their energies working to jump through hoops to enroll patients in various drug company indigent care programs.
- Raised treatment bars/goals for chronic diseases such as diabetes, hypertension, elevated cholesterol, or atrial fibrillation:

Conservative treatments of the past have been displaced by more aggressive treatments and treatment goals (for example, the expectation to achieve a blood pressure of 130/80 and near normal glucose and HbA1C levels for diabetic patients).

- High administrative costs, especially for information technology systems required for billing, scheduling, insurance company and clinical documentation.
- Patient discontinuities and associated inefficiencies, as patients gain and lose various forms of public and private health insurance (in our state Medicaid must be renewed monthly).
- Competition for “paying customers” from Medicaid managed care: Healthier insured patients (who in the past provided considerable cross-subsidy to cover uninsured health center patients) are being enticed by seductive and selective recruiting, leaving behind the sicker patients and the uninsured.
- Access to specialty consultation and diagnostic services: The plain x-ray machine in the health center’s basement is no longer the definitive technology for a myriad of primary care diagnostic problems. Accessing and paying for gastrointestinal endoscopy, cardiac catheterization, CT and MRI scans, and even routine laboratory tests pose major and often insurmountable challenges.
- Challenges related to copays and sliding scales: If these are to generate sufficient revenue to offset the cost of collecting these user-fees (increasingly driven by ideological and fiscal demands to eliminate free services), how can this be operationalized without compromising the mission of these clinics to care for the poor. By serving as impediments to patients seeking timely consultations and willingness to obtain preventive services, they make it harder for health centers to do their job.
- Categorical funding constraints: Many grants support caring for one restricted type of patient (e.g., pregnant substance abusing women). Such grant funding requires complex health center reorganization and redirection of priorities, distorting the mix of services, and diminishes the incentive to reach out to other patient groups.
- Staffing problems including high turnover rates, especially for physicians (one down-side of the otherwise helpful National Health Service Corps) and new difficulties recruiting and retaining international medical graduates due to post-9/11 immigration issues.

Thus, not only are the President's "new access points" limited (only 1 of 4 health centers that applied for expansion was granted funding), but these newer challenges facing health centers further strain their ability to serve their communities. Modest funding for our nation's 3500 health center sites can not be a substitute for true universal health insurance. In fact, the survival of the centers and their ability to substantially contribute to the fight against health disparities requires reimbursement for the preventive and medically necessary services delivered. In other words, for health centers to do their jobs, every patient must be insured for the needed care they deliver.

Politzer et al. warn against counter-posing "non-medical determinants of health" to provision of "progressive primary health . . . (that is) community oriented, culturally competent, and enabling." Instead they argue for the need for both pathways for improved national health. Similarly, we caution against falsely juxtaposing funding for health centers with the imperative for national health insurance for everyone (4). The Administration's strategy may buy a few votes of support from desperate communities while it carefully avoids antagonizing private insurance companies. However, like other forms of incremental reform it will not be successful or sustainable in the long run, for the same reason that makes it politically popular now—because it fails to change the status quo in the health system (5).

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