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Expansion of Clinics Shapes Bush Legacy

By KEVIN SACK

NASHVILLE — Although the number of uninsured and the cost of coverage have ballooned under his watch, President Bush leaves office with a health care legacy in bricks and mortar: he has doubled federal financing for community health centers, enabling the creation or expansion of 1,297 clinics in medically underserved areas.

For those in poor urban neighborhoods and isolated rural areas, including Indian reservations, the clinics are often the only dependable providers of basic services like prenatal care, childhood immunizations, asthma treatments, cancer screenings and tests for sexually transmitted diseases.

As a crucial component of the health safety net, they are lauded as a cost-effective alternative to hospital emergency rooms, where the uninsured and underinsured often seek care.

Despite the clinics' unprecedented growth, wide swaths of the country remain without access to affordable primary care. The recession has only magnified the need as hundreds of thousands of Americans have lost their employer-sponsored health insurance along with their jobs.

In response, Democrats on Capitol Hill are proposing even more significant increases, making the centers a likely feature of any health care deal struck by Congress and the Obama administration.

In Nashville, United Neighborhood Health Services, a 32-year-old community health center, has seen its federal financing rise to $4.2 million, from $1.8 million in 2001. That has allowed the organization to add eight clinics to its base of six, and to increase its pool of patients to nearly 25,000 from 10,000.

Still, says Mary Bufwack, the center's chief executive, the clinics satisfy only a third of the demand in Nashville's pockets of urban poverty and immigrant need.

One of the group's recent grants helped open the Southside Family Clinic, which moved last year from a pair of public housing apartments to a gleaming new building on a once derelict corner.

As she completed a breathing treatment one recent afternoon, Willie Mai Ridley, a 68-year-old beautician, said she would have sought care for her bronchitis in a hospital emergency room were it not for the new clinic. Instead, she took a short drive, waited 15 minutes without an appointment and left without paying a dime; the clinic would bill her later for her Medicare co-payment of $18.88.

Ms. Ridley said she appreciated both the dignity and the affordability of her care. "This place is really very, very important to me," she said, "because you can go and feel like you're being treated like a person and get the same medical care you would get somewhere else and have to pay $200 to $300."

As governor of Texas, Mr. Bush came to admire the missionary zeal and cost-efficiency of the not-for-profit community health centers, which qualify for federal operating grants by being located in designated underserved areas and treating patients regardless of their ability to pay. He pledged support for the program while campaigning for president in 2000 on a platform of "compassionate conservatism."

In Mr. Bush's first year in office, he proposed to open or expand 1,200 clinics over five years (mission accomplished) and to double the number of patients served (the increase has ended up closer to 60 percent). With the health centers now serving more than 16 million patients at 7,354 sites, the expansion has been the largest since the program's origins in President Lyndon B. Johnson's war on poverty, federal officials said.

"They're 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," Mr. Bush said last year while touring a clinic in Omaha.

With federal encouragement, the centers have made a major push this decade to expand dental and mental health services, open on-site pharmacies, extend hours to nights and weekends and accommodate recent immigrants — legal and otherwise — by employing bilingual staff. More than a third of patients are now Hispanic, according to the National Association of Community Health Centers.

The centers now serve one of every three people who live in poverty and one of every eight without insurance. But a study released in August by the Government Accountability Office found that 43 percent of the country's medically underserved areas lack a health center site. The National Association of Community Health Centers and the American Academy of Family Physicians estimated last year that 56 million people were "medically disenfranchised" because they lived in areas with inadequate primary care.

President-elect Barack Obama has said little about how the centers may fit into his plans to remake American health care. But he was a sponsor of a Senate bill in August that would quadruple federal spending on the program — to $8 billion from $2.1 billion — and increase incentives for medical students to choose primary care. His wife, Michelle, worked closely with health centers in Chicago as vice president for community and external relations at the University of Chicago Medical Center.

And Mr. Obama's choice to become secretary of health and human services, former Senator Tom Daschle of South Dakota, argues in his recent book on health care that financing should be increased, describing the health centers as "a godsend."

The federal program, which was first championed in Congress by Senator Edward M. Kennedy, Democrat of Massachusetts, has earned considerable bipartisan support. Leading advocates, like Senator Bernie Sanders, independent of Vermont, and Representative James E. Clyburn, Democrat of South Carolina, the House majority whip, argue that any success Mr. Obama has in reducing the number of uninsured will be meaningless if the newly insured cannot find medical homes. In Massachusetts, health centers have seen increased demand since the state began mandating health coverage two years ago.

At $8 billion, the Senate measure may be considered a relative bargain compared with the more than $100 billion needed for Mr. Obama's proposal to subsidize coverage for the uninsured. If his plan runs into fiscal obstacles, a vast expansion of community health centers may again serve as a stopgap while universal coverage waits for flusher times.

Recent job losses, meanwhile, are stoking demand for the clinics' services, often from first-time users. The United Neighborhood Health Services clinics in Nashville have seen a 35 percent increase in patients this year, with much of the growth from the newly jobless.

"I'm seeing a lot of professionals that no longer have their insurance or they're laid off from their jobs," said Dr. Marshelya D. Wilson, a physician at the center's Cayce clinic. "So they come here and get their health care."

Studies have generally shown that the health centers — which must be governed by patient-dominated boards — are effective at reducing racial and ethnic disparities in medical treatment and save substantial sums by keeping patients out of hospitals. Their trade association estimates that they save the health care system $17.6 billion a year, and that an equivalent amount could be saved if avoidable emergency room visits were diverted to clinics. Some centers, including here in Nashville, have brokered agreements with hospitals to do exactly that.

Many centers are finding that federal support is not keeping pace with the growing cost of treating the uninsured. Government grants now account for 19 percent of community health center revenues, compared with 22 percent in 2001, according to the Health Resources and Services Administration, which oversees the program. The largest revenue sources are public insurance plans like Medicaid, Medicare and the State Children's Health Insurance Program, making the centers vulnerable to government belt-tightening.

The centers are known for their efficiency. Though United Neighborhood Health Services has more than doubled in size this decade, Ms. Bufwack, its chief executive, manages to run five neighborhood clinics, five school clinics, a homeless clinic, two mobile clinics and a rural clinic, with 24,391 patients, on a budget of $8.1 million. Starting pay for her doctors is $120,000. Patients are charged on an income-based sliding scale, and the uninsured are expected to pay at least $20 for an office visit. One clinic is housed in a double-wide trailer.

Because of a nationwide shortage of primary care physicians, the clinics rely on federal programs like the National Health Service Corps that entice medical students with grants and loan write-offs in exchange for agreements to practice as generalists in underserved areas. Of the 16 doctors working for United Neighborhood, seven are current or former participants.

Dr. LaTonya D. Knott, 37, who treated Ms. Ridley for her bronchitis, is among them. Born to a 15-year-old mother in south Nashville, she herself had been a regular childhood patient at one of the center's clinics. After graduating as her high school's valedictorian, she went to college on scholarships and then to medical school on government grants, with an obligation to serve for two years.

She said she now felt a responsibility to be a role model. "I do a whole lot of social work," she said, noting that it was not uncommon for children to drop by the clinic for help with homework, or for a peanut butter sandwich. "It's not just that we provide the medical care. I'm trying to provide you with a future."

Despite such commitment, national staffing shortages have reinforced concerns about the quality of care at health centers, notably the management of chronic diseases. This year, the government started collecting data at the centers on performance measures like cervical cancer screening and diabetes control.

"The question is not just, 'Are you going to have more community health centers?' " said Dr. H. Jack Geiger, founder of the health centers movement and a professor emeritus at the City University of New York. "It's,

‘Are you going to have adequate services?’ ”

A deeper frustration for health centers concerns their difficulty in securing follow-up appointments with specialists for patients who are uninsured or have Medicaid. All too often, said Ms. Bufwack, medical care ends at the clinic door, reinforcing the need to expand both primary care and health insurance coverage.

“That’s when our doctors feel they’re practicing third world medicine,” she said. “You will die if you have cancer or a heart condition or bad asthma or horrible diabetes. If you need a specialist and specialty tests and specialty meds and specialty surgery, those things are totally out of your reach.”