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Community Health Centers: Health Care as It Could Be

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COMMUNITY HEALTH CENTERS: HEALTH CARE AS IT COULD BE

JUNIPER LESNIK¹

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INTRODUCTION

This Article explores the potential of community health centers (CHCs) to become a central component providing health care in America. It focuses on health centers as a proposed solution to the dual national problems of access to care and the shortage of primary care doctoring. It argues that CHCs have the capacity to address the problem of access to health services and to provide a vibrant model for the revival of primary care. Part I deals with the history, structure, current scope, and funding of CHCs. Part II looks at national health care goals and how CHCs are uniquely poised to actualize those goals. The demonstrated successes and potential growth of the CHC model are viewed against the backdrop of national health care priorities established through the *Healthy People 2010* report. Part III looks at physician workforce issues, Graduate Medical Education (GME), and efforts to extend residency programs to ambulatory settings, including CHCs. State initiatives to reform GME so that it will produce a physician workforce better adapted to meet local health care needs are discussed, and the needs for federal action are identified. The role of the GME funding structure is examined as a key component in shaping potential reforms. Finally, the conclusion summarizes the benefits delivered by CHCs and notes the need for systemic shifts to help facilitate the growth of this successful health care model. The broader policy questions of how CHC expansion fits into health care policy reform as a whole will be left to another Article.

Nonetheless, a brief overview of the current state of the U.S. health care crisis helps place the expanded need for CHC services in perspective. In August 2000, a groundbreaking World Health Organization (WHO) survey evaluating national health systems worldwide ranked the United States 37th in overall health system

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performance -- sandwiched between Costa Rica and Slovenia.² This dismal showing occurred despite the fact that the United States spends more on health care than any other of the 191 WHO nations.³ In 2004, U.S. health spending rose to a whopping 15 percent of the gross domestic product, a higher percentage than any other nation, including those that provide universal coverage to all residents and those with much more modest Gross Domestic Products (“GDP”).⁴ WHO Director-General Dr. Gro Harlem Brundtland says: “The main message from this report is that the health and well-being of people around the world depend critically on the performance of the health systems that serve them.”⁵ Though the methodology of the WHO study has been criticized, it illuminates the areas in which the U.S. health system clearly falls short.⁶ The factor that had the greatest negative impact on the U.S. ranking was access to care.

The most basic requirement of a successful health care system is that people have access to care when they need it. Health care is not a luxury good, reserved for the rich. It is a fundamental need, a precondition to being able to do virtually anything else—work, play, love, serve. In fact, the majority of Americans view health care as a “right and not a privilege.”⁷ This view reflects the American commitment to equality of opportunity, which logically leads to a social obligation to meet health care needs.⁸ For a nation that prides itself on “equal opportunity for all,” the United

²See Susan Lander, *The World's Health Care: How Do We Rank? The United States Spends a Great Deal on Health Care but Gains Too Little, Says the World Health Organization*. AMA, A.Med. News (Aug. 28, 2000), available at <http://www.ama-assn.org/amednews/2000/08/28/gvsa0828.htm> (last visited March 29, 2004). (In designing the framework for health system performance, WHO broke new methodological ground. It compares each country's system to what the experts estimate to be the upper limit of what can be done with the level of resources available in that country. It also measures what each country's system has accomplished in comparison with those of other countries.); see also WHO, *THE WORLD HEALTH REPORT 2000, HEALTH SYSTEMS: IMPROVING PERFORMANCE*, June 21, 2000 [hereinafter WHO Report].

³See Lander, *supra* note 2.

⁴See, e.g., Robert Pear, *Health Spending Rises to Record 15% of Economy*, N.Y. TIMES, Jan. 9, 2004, at A16, available at http://reclaimdemocracy.org/articles_2004/us_recordhigh_healthcare_spending.html (“[h]ealth spending accounts for nearly 15 percent of the nation's economy, the largest share on record, the Bush administration said on Thursday. The Department of Health and Human Services said that health care spending shot up 9.3 percent in 2002, the largest increase in 11 years, to a total of \$1.55 trillion. That represents an average of \$5,440 for each person in the United States”).

⁵WHO, *Press Release, THE WORLD HEALTH REPORT 2000 – HEALTH SYSTEMS: IMPROVING PERFORMANCE*, June 21, 2000 (WHO Geneva, Switzerland), available at <http://www.who.int/inf-pr-2000/en/pr2000-44.html> (last visited June 7, 2004).

⁶See Lander, *supra* note 2 (“[h]ow are these findings possible? After all, foreign heads of state who could get health care anywhere choose the United States. . . . But one of the problems is, while we have health care at the very best, we don't have all of our citizens covered for health care when they should be”).

⁷NORMAN DANIELS, DONALD W. LIGHT, & RONALD L. CAPLAN, *BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM* 18 (Oxford University Press, 1996).

⁸*Id.* at 19-21.

States is failing to provide the necessary baseline to enable all citizens to operate on a level playing field. If the disruptions of disease and injury are not met with the appropriate medical responses, these events can derail even the most determined of citizens. As the U.S. health care system stands today, tens of millions of Americans are living without a doctor to call if they are in pain or a medical office to accept them if they show up sick.

Why does the United States lag behind the rest of the industrialized world in health care, despite our wealth and technological prowess? Central to this failure is the consistent political failure in the U.S. to provide basic health care access to all Americans. This lack of commitment is spurred on by rising costs. To contain spiraling health care expenses, access is restricted in blatant and subtle ways.⁹ Limiting medical care to those who can pay for it (in one way or another) backfires both on an economic and on a human level. According to the U.S. Census Bureau, a staggering 45 million Americans—or 15.6 percent of the population—permanently live without any form of health insurance.¹⁰ This creates serious barriers to care, which lead to unnecessary illness and death. It is increasingly clear that, for individuals and their families, the financial burden of medical expenses is unmanageable without insurance. If anyone doubts, pause on this fact: medical debt is now the leading cause of personal bankruptcy in this country.¹¹ The position of the uninsured leads to dire national consequences as well. According to a 2004 Institute of Medicine (IOM) report, *Insuring America's Health*, 18,000 deaths occur each year because of lack of health insurance, and the U.S. loses around \$65 to \$130 billion annually as a result of the poor health and early deaths of uninsured adults.¹²

Lack of health insurance, however, is not the only significant factor affecting individuals' access to health care. Race and geography count, too. The system currently does very little to ensure that medical resources are evenly distributed according to health care needs or official national health priorities. Hidden doors

⁹*Id.* at 4.

¹⁰See, e.g., Jeanne Lambrew, *45 Million Uninsured Americans*, Center for American Progress, Aug. 26, 2004, available at <http://www.americanprogress.org/site/pp.asp?c=biJRJ8OVF&b=173900> (“[t]oday, the Census Bureau reported that 45 million Americans lacked health insurance in 2003, up by 1.4 million from 2002 and 5.2 million from 2000. The report states that this increase is “statistically significant.” As the statistics in this article show, “45 Million uninsured Americans is more than all Americans age 65 and older, all African-Americans, 12 million more than the population of Canada. . . . There are nearly 150 uninsured Americans for each physician in America, and nearly 7,500 uninsured Americans for each hospital in America. . . . There are over 84,000 uninsured Americans for each Member of Congress”).

¹¹Nearly half of all personal bankruptcies are caused by health problems or a large medical debt - even though 79% of the families filing for bankruptcy had at least some health insurance coverage. This staggering statistic provides some indication of the high failure rate of the current insurance system to cover a catastrophic illness. The numbers are quite large; 326,000 families identified illness/injury as the main cause of bankruptcy and an additional 270,000 had large medical debts at the time of bankruptcy. (Norton's Bankruptcy Advisor, May 2000).

¹²Institute of Medicine (IOM), *Insuring America's Health: Principles and Recommendations*, Jan. 14, 2004; see also IOM, *Hidden Costs, Value Lost: Uninsurance in America*, 106-107 National Academy of Sciences, Washington D.C. (2003).

keep some patients out. Health disparities based on race stubbornly persist in the U.S., creating significant access problems for people of color. There are proven racial and ethnic disparities in health status and levels of care among the general population even after controlling for socio-demographic factors.¹³ Additionally, there is a geographic maldistribution of health care workers, limiting access for those in rural and poor communities.

The access problem has not sparked adequate changes in the way young doctors are trained. Graduate Medical Education (GME) continues to produce an oversupply of specialists and a glaring undersupply of primary care and family doctors. This places ambulatory settings under strain when it comes to recruiting top medical school graduates. Despite the fact that a significant percentage of medical students enter medical school with the intention of going into general practice, many are ultimately lured into specialties by higher incomes and institutional pressures. The days of the family doctor who knows all of her patients by their first names are quickly disappearing. Well over 40 million Americans do not have a particular doctor's office, clinic, health center, or other place where they regularly seek health care or advice.¹⁴ This indicates an erosion of the doctor-patient relationship on an unprecedented scale. Unfortunately, access is largely determined by what serves the medical business model instead of by doctors serving patients.

There is little reason to believe that the forces currently in control of our health care system will independently act to address these inequities. Like so much else in American life, medicine has gone "big business" and the delivery of health care has relied on the market model, a blunt instrument notoriously unaccountable to equity

¹³See HEALTH, UNITED STATES, 2003: CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS, HHS, Centers for Disease Control and Prevention (CDC) (National Center for Health Statistics, 2003). In terms of general population, a few illustrative examples of health disparities are: overall mortality was 31 percent higher for black Americans than for white Americans in 2001; the 5-year survival rate for black females diagnosed in 1992-98 with breast cancer was 15 percentage points lower than the 5-year survival rate for white females; in 2001 the breast cancer mortality rate for black females was 37 percent higher than for white females; HIV death rates are much higher for Hispanic and black males than for non-Hispanic white males ages 25-44.

See also CDC Fact Sheet, *Racial/Ethnic Health Disparities* (Apr. 2, 2004), <http://www.cdc.gov/od/oc/media/pressrel/fs040402.htm> (last visited June 15, 2004); Bureau of Primary Care, *Minority Health Research and Evaluative Studies: Gender, Race, and Ethnicity Study*, http://bphc.hrsa.gov/OMWH/minority_health.htm ("[d]espite significant progress in societal attitudes and laws regarding racial and gender discrimination over the last century, national health statistics continue to show a disproportionate number of low-income people of color and women experience limited access to health care and present poor health outcomes, compared to the general population of the United States").

¹⁴Nat'l Assoc. of Community Health Centers (NACHC), *Health Center Expansion Has Helped Millions, Says HHS Secretary*, Jan. 15, 2004, available at <http://www.nachc.com/press/thompsonpress2004.asp> ("[a]n estimated 50 million people in the U.S. are 'unserved,' meaning they have no access to regular health care because of a shortage of providers in their communities. The number of unserved would be even higher were it not for health centers, which serve as the usual source of care and medical home for over 14 million people, more than five million of whom are uninsured. Low income, uninsured health center users are also generally much more likely to have a usual source of care than the uninsured").

concerns.¹⁵ It appears the system is steered more by profit motives than by health outcomes, by managing costs and not by care.¹⁶ At the same time, costs continue to spiral out of control. As fiscal pressures mount, it is increasingly difficult to sell reform measures that carry big price tags, though everyone may agree that reform is needed. To make things more difficult, the health care system involves multiple disjointed sectors that rarely work in a coordinated effort to meet the nation's health care needs. Surely, the system we now have does not reflect healthcare as we want it to be. Too many Americans are shut out, health care is too expensive, and the system is too disjointed. Better than asking how we got here is asking: what can we do about it?

Amidst these shocking failures, there is one underreported success: the Community Health Center. A federally-funded program begun in the mid-1960s, community health centers (CHCs) "provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities regardless of their ability to pay. Health centers overcome economic, geographic, and cultural barriers to primary health care, and they tailor services to the needs of the community."¹⁷ As far as existing health care delivery institutions go, CHCs are the nation's best shot at putting a deliberate step forward to improving the unsatisfactory patchwork system that marks U.S. health care. They are one of the few places where the uninsured have access to non-emergency and preventive care; they virtually eliminate racial disparities in care; and they provide a setting for the practice of quality, cost-effective primary care.

I. COMMUNITY HEALTH CENTERS

Community health centers present a model of health care that is an anomaly in the U.S. system.¹⁸ They acknowledge that health involves more than medical diagnosis and procedures. At a time when public health and related services were being institutionally segregated from specialized medical care, CHCs bucked this trend of bifurcated services in favor of a more holistic approach to improving the

¹⁵See John Spritzler, *Market Driven Health Care and Social Control*, New Democracy Newsletter, (Nov.-Dec. 2000) available at <http://www.newdemocracyworld.org/health.htm> ("health care is being turned into just another commodity for sale in the marketplace").

¹⁶*Id.* "So-called 'Health Maintenance Organizations' and hospitals, whether they are 'for-profit' or not, are driven by market competition to keep their costs low and sell their 'product' for as much as the market will bear. Because the central values of the marketplace are self-interest and the 'bottom line,' market-driven health care is in fundamental contradiction to the best values of the health professions expressed in the Hippocratic Oath, the Samaritan tradition, and the legacies of Florence Nightingale and Lillian Wald. All these affirm that medicine and health care should be driven not by self-interest but by that most humane of values – a commitment to each other's well-being." *Id.*

¹⁷U.S. Dept. of Health and Human Services (HHS), Health Resources and Services Admin. (HRSA), & Bureau of Primary Health Care (BPHC), COMMUNITY HEALTH CENTER PROGRAM INFORMATION, *Mission Statement*, available at <http://bphc.hrsa.gov/programs/CHC/Programinfo.asp> (last visited Oct. 18, 2005).

¹⁸See RAND E. ROSENBLATT, SYLVIA A. LAW, & SARA ROSENBAUM, *LAW AND THE AMERICAN HEALTH CARE SYSTEM* 104 (University Casebook Series, Foundation Press, 1997).

health of individuals.¹⁹ This approach presents a model of unified medicine that counteracts the increasing fragmentation found in the modern landscape of U.S. medical care. The unique delivery model of CHCs is largely attributable to the circumstances that originally inspired the development of health centers.

The Federal Community Health Center program began in 1965 as a pilot program of the Office of Economic Opportunity (OEO) and was granted statutory authority under the Economic Opportunity Act of 1966.²⁰ CHCs were originally funded by the Federal Government as part of the War on Poverty.²¹ Since 1969, the CHC program has been a federal grant program, funded under Section 330 of the Public Health Service Act (PHSA), to provide primary and preventive health care services in medically underserved areas throughout the U.S. and its territories.²² CHCs also provide essential ancillary services, such as lab tests and pharmacy services, links to Medicaid, substance abuse treatment and related services, access to a full range of specialty care services, health education, translation services, transportation, mental health services, dental service, and prenatal services.²³ Health centers are overseen by the Bureau of Primary Health Care (BPHC), located within the Department of Health and Human Services. The vast majority of CHCs are Section 501(c)(3) tax-exempt non-profit organizations.²⁴ The values originally embodied by the health center initiative have not only survived, but have become codified as legal requirements to the receipt of federal grant money.

To be eligible for funding under Section 330 of the PHSA and to be designated a “Federally Qualified Health Center” (FQHC) the applying center must meet five requirements defined by the federal government. These five legal requirements require all federally-qualified CHCs to:

- Be located in areas that have been identified as “medically underserved” by the Secretary of Health and Human Services.²⁵
- Provide comprehensive health and “enabling” services. These services include early and effective primary and preventative care, dental services, mental health services, X-rays and Lab services, pharmacy services, obstetrical and gynecological care, health education classes, transportation, outreach, interpretation/translation, and home visitation. These services must be delivered in a linguistically and culturally appropriate setting.²⁶

¹⁹*Id.* at 104-105 (citing KAREN DAVIS & CATHY SCHOEN, *HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL* (1978)).

²⁰*Id.* at 105.

²¹BPHC, PROGRAM INFORMATION, available at <http://www.bphc.hrsa.gov/programs/CHCProgramInfo.asp> (last visited June 9, 2004).

²²*Id.*

²³*Id.*

²⁴Michelle Proser, *The Role of Health Centers in Reducing Disparities*, Special Topics Issue Brief #2, 6 (NACHC, July 2003), available at <http://www.nachc.com/advocacy/HealthDisparities/index.asp>.

²⁵ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 106 (citing 42 U.S.C. § 254c(b)(3) (West 1995)). See definition in 42 U.S.C. § 254b(b)(3) (West 2003)).

²⁶42 U.S.C. § 254c(b)(1) (West 1995).

- Be open to all residents, and scale all out-of-pocket charges according to each patient's ability to pay. All patients seeking care will be served regardless of insurance status or inability to pay.²⁷
- Be governed by a consumer-run community board, consisting of at least 51 percent of the patients at the center.²⁸
- Follow rigorous performance and accountability requirements regarding their administrative, clinical, and financing operations.²⁹

From the start, CHCs were conceived to address severe problems in access to medical care.³⁰ In order to tackle the health needs of the medically underserved, the health center model built around the idea of providing quality ambulatory care to the general population.³¹ To achieve this goal, CHCs have always worked in conjunction with other service providers to address substantive issues affecting health status, such as environmental conditions and substance abuse. Physicians operate as part of clinical teams, emphasizing that doctoring is only one vital aspect of delivering health to the general population. It is not so surprising that this program arose in the mid-1960s, when support for national social programs was relatively strong. What is surprising is that they have survived, with steady growth in federal support, and are still considered vital today.

The health center program is generally thought to include community, migrant, homeless, and school health centers, which together constitute a primary and preventive care network that spans urban and rural communities in all 50 states, the District of Columbia, and all U.S. territories.³² Health centers are the medical home for over 14 million Americans, 9 million of them people of color.³³ In 2003, there were approximately 890 federally-funded health centers, operating in 4990 sites, in addition to 97 non-federally funded centers certified as meeting all federal grant requirements.³⁴ According to the National Association of Community Health

²⁷ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 106.

²⁸*Id.* (citing 42 U.S.C. § 254c(e)(3)(G) (West 1995)).

²⁹*Id.* (citing 42 U.S.C. § 254c); *see also* Proser, *supra* note 24, at 7.

³⁰*Id.* at 104-105 (citing Larry T. Patton, *Community Health Centers at 25: A Retrospective Look at the First 10 Years*, 13 J. AMBULATORY CARE MGMT. 13 (Oct. 1990). In 1965 there were only 4 physicians to serve 35,000 residents in the Bronx. The 6,000 residents of Columbia Point public housing project in Boston had to travel 90 minutes by bus and subway to the nearest charity clinic).

³¹*Id.* at 104.

³²Nat'l Ass'n of Cmty. Health Ctrs. [hereinafter NACHC], *Mission Statement*, available at <http://www.nachc.com/about/mission.asp> (last visited June 8, 2004).

³³NACHC, *Fact Sheet: Health Centers' Role in Reducing Health Disparities Among Hispanics and Latinos* (Sept. 2003), available at <http://www.nachc.com/research/HealthDisparities/index.asp> (last visited Dec. 28, 2005).

³⁴NACHC, *Health Center Fact Sheet: United States*, (NACHC, 2004) (based on BPHC, HRSA, DHHS, 2003 Uniform Data System) [hereinafter NACHC, *Fact Sheet*]; *see also* Peter Shin, Karen Jones, & Sara Rosenbaum, *Reducing Racial and Ethnic Health Disparities: Estimating the Impact of High Health Center Penetration in Low-Income Communities*, at 4, George Washington University Medical Center, Center for Health Services and Research

Centers (NACHC), the entire health center network includes over 3,500 centers nationwide, inclusive of school, migrant, and homeless health centers.³⁵ The focus of this Article is on expanding federal support for the community health center model. Thus, the abbreviation CHC is used to indicate all health centers that meet the FQHC guidelines described above.

When looking at the sizable number of uninsured in America, the question naturally arises: what do people do if they know they are sick but do not have health insurance? It is widely understood that many uninsured Americans are left to rely on hospital emergency rooms as their primary source of medical care.³⁶ In 2002, there were 110.2 million visits to hospital emergency rooms, up from 89.8 million in 1998.³⁷ The uninsured depend on emergency rooms for medical care because, legally, they cannot be turned away.³⁸ This solution is ineffective and costly, especially when it comes to routine medical services. It is also unsustainable. Emergency rooms increasingly are being forced to close because they are overwhelmed by uninsured patients. There were 15 percent fewer emergency rooms in 2002 than in 1998, and since 2002 the number of uninsured Americans has drastically increased.³⁹ It is clear that the nation needs alternative places where the health needs of the uninsured and medically underserved can be addressed.⁴⁰

The state of Arizona provides a good illustration of the problem. Twenty percent of Arizonans do not have health insurance, and almost half are medically underserved.⁴¹ In 2002, approximately 2 million people were treated in emergency

Pol'y (Sept. 2003), available at http://www.gwhealthpolicy.org/downloads/GWU_Disparities_Report.pdf (last visited Oct. 19, 2005).

³⁵See Proser, *supra* note 24, at 3.

³⁶See Reuters, *Uninsured Patients Flood Emergency Rooms: Some Clinics Seeing 'Explosion' in People Seeking Care*, MSNBC, Aug. 9, 2004, at <http://www.msnbc.msn.com/id/5651738/> (patients lacking health insurance are flooding U.S. emergency rooms, many seeking routine care that they should get elsewhere) [hereinafter Reuters, *Uninsured Patients*].

³⁷*Id.*

³⁸See, e.g., ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 63-70 (the Emergency Medical Treatment and Active Labor Act [EMTALA] of 1986, 42 U.S.C. § 1395dd (West 1995), is a federal law requiring all hospitals receiving Medicare payments to provide treatment to all emergency room patients regardless of their ability to pay or their Medicare status).

³⁹See Reuters, *Uninsured Patients*, *supra* note 36; see also NACHC, *With New Census Figures, Community Health Centers Brace for More Uninsured Patients: Health Centers Shoulder Growing Need on Tight Resources* (Aug. 26, 2004), <http://www.nachc.com/xxnewsitelpress/census.asp> (last visited Oct. 19, 2005) (“[a]ccording to a new U.S. Census report released on August 26, 2004, the number of Americans without health insurance increased to 45.0 million, up from 43.6 million in 2002”).

⁴⁰Reuters, *Uninsured Patients*, *supra* note 36 (the situation is further exacerbated by the fact that many doctors close their doors on Medicaid patients and that one-fifth are not accepting any new Medicaid patients).

⁴¹See The Arizona Association of Community Health Centers, *Program Overview*, <http://www.aachc.org/programs.html> (last visited Oct. 18, 2005).

rooms in Arizona.⁴² According to the Arizona Association of Community Health Centers, national estimates indicate that as many as 40 percent of these emergency room visits could have been adequately addressed by primary care providers.⁴³ Doing so would have saved the state millions of dollars, and the patients would have received equal or better treatment if they could have been diverted to a CHC.⁴⁴ Hospitals would also have saved millions of dollars, potentially alleviating some of the pressure that places them under mounting financial distress.⁴⁵

Community health centers offer a viable solution. This has been recognized at the federal level. As stated by President George W. Bush on January 28, 2004:

[o]ne of the ways to help make sure health care functions better is to help people who can't afford health care to have access to health care . . . other than emergency rooms and hospitals. And so I'm a big proponent of what's called community health centers. . . . This is a smart way to make sure that people get health care. It's more cost-effective that people are able to go to these centers and not go to an emergency room, which is, by far, the most expensive way for somebody to get health care.⁴⁶

Addressing basic health care needs through CHCs serves the dual goals of economic efficiency and patient care.⁴⁷ CHC costs of care rank among the lowest of all medical service providers and they reduce the need for expensive hospital and specialty care, reducing overall costs to taxpayers.⁴⁸ People who have knowledge of and access to a CHC can go there to seek top quality care regardless of their ability to pay. CHC patients consistently report far higher satisfaction ratings than patients in other settings.⁴⁹ The model of health care delivered through CHCs is one that actually has the potential to address health as part of a community's mission, not a good to be sought through waiting in line at a big hospital far away. The health centers' consumer-controlled boards assure that the care each CHC delivers is community-specific and that preventive programs are tailored to the articulated needs of patients.⁵⁰

⁴²*Id.*

⁴³*Id.*

⁴⁴*Id.*

⁴⁵*Id.*

⁴⁶Office of the Press Secretary, *President Bush Discusses Quality, Affordable Health Care: Remarks by the President on Access to Health Care* (Jan. 28, 2004), available at <http://www.whitehouse.gov/news/releases/2004/01/20040128-2.html> (last visited Oct. 18, 2005).

⁴⁷ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 107 (“[n]umerous studies of the [health center] program over the past three decades have found that health centers furnish health care of high quality and operate in a cost-efficient fashion”).

⁴⁸NACHC, *Fact Sheet*, *supra* note 34.

⁴⁹NACHC, *National Health Center Week 2004*, available at http://www.nachc.com/about/nhcw_2004.asp (last visited Oct. 18, 2005) (“[a]t a time when Americans are paying more for less, health centers still receive patient satisfaction levels of up to 99 percent”).

⁵⁰Proser, *supra* note 24, at 8.

CHCs are at the center of the healthcare safety net that catches those excluded from the patchwork U.S. system of employer-sponsored medical coverage and hard-to-qualify-for federal programs. Data collected in 2001 showed that 40 percent of CHC patients were uninsured, 37 percent were insured through Medicaid/SCHIP, 7 percent were on Medicare, and 14 percent had private insurance.⁵¹ As the number of uninsured Americans continues to rise, the need for CHCs grows at a similar rate. In fact, in 2003 there was an 11 percent increase overall in the number of uninsured patients who received health care through CHCs; some centers saw increases as high as 73 percent in their uninsured patient rolls.⁵² With increases of this magnitude, there are simply not enough health centers to go around. Unfortunately, the current funding scheme does not provide a health center in every community that needs one.

According to the Bureau of Primary Health Care (BPHC), an estimated 50 million Americans do not have access to a primary health care provider, not even a community health center.⁵³ In 2004, the NACHC issued a more moderate state-by-state report confirming the same problem. That NACHC report found that 36 million Americans do not have access to basic health care.⁵⁴ The report, *Nation's Health At Risk*, exposes the stark reality often obscured by the focus on the 45 million Americans without health insurance. Insurance clearly is not the only substantial barrier to care - location counts, too. Approximately 12 percent of the population lack healthcare simply because there is no available doctor where they live, whether or not they have insurance or the means to pay.⁵⁵ Among Americans with an average income, 13 percent say it is difficult to get care; for those with below average income, the number rises dramatically to 48 percent.⁵⁶ According to Dan Hawkins, Vice President for policy at NACHC, "[t]hey live in inner-cities and in isolated rural communities. But no matter where they live, the story is the same: they can't get health care because there aren't enough doctors in their communities

⁵¹*Id.* at 5.

⁵²Reuters, *Uninsured Patients, supra* note 36; see also NACHC, *With New Census Figures, Community Health Centers Brace for More Uninsured Patients: Health Centers Shoulder Growing Need on Tight Resources* (Aug. 26, 2004), available at <http://www.nachc.com/press/census.asp> (last visited Oct. 18, 2005).

⁵³NACHC, *NACHC Reach 2000*, at <http://www.nachc.com/research/reach2.asp> (last visited Oct. 18, 2005).

⁵⁴NACHC, *36 Million Americans Lack Access To Basic Health Care State-by State Report Shows That Low-Income Families, Minorities Hardest Hit* (Mar. 23, 2004), available at <http://www.nachc.com/press/March23.asp> (last visited Oct. 18, 2005) [hereinafter NACHC, *36 Million Americans*].

⁵⁵*Id.*

⁵⁶See FRIED VM, PRAGER K, MACKAY AO, & XIA H, CHARTBOOK ON TRENDS IN THE HEALTH OF AMERICANS, HEALTH, UNITED STATES, 2003, 10 (National Center for Health Statistics, 2003), available at <http://www.cdc.gov/nchs/data/hvs/hvs03.pdf> (last visited Oct. 20, 2005); see also Robert J. Blendon et al., *Inequities in Health Care: A Five-Country Survey*, 21 J. OF HEALTH AFFAIRS 182, 186 (May-June 2002), available at <http://content.healthaffairs.org/cgi/reprint/21/3/182> (last visited Oct. 20, 2005) (while 52 percent of below-income uninsured Americans find it very or extremely difficult to get care, only 7 percent of above-income insured Americans find the same).

who are willing or able to care for them.”⁵⁷ Health centers, which laws require to be located in medically underserved areas, make a vital contribution to the high-risk situation faced by many Americans who would otherwise be stranded without health services. The BPHC research indicates that CHCs are prepared to expand their capacity to address unmet needs, but they lack the resources to do so.⁵⁸

Providing these additional resources is vital to creating a functional health care system in the United States. This role is particularly vital when it comes to health care for racial minorities. Minorities are disproportionately represented among the uninsured and those lacking access to health care. In 2000, while Latinos represented less than 13 percent of the U.S. population, they made up 30 percent of the uninsured;⁵⁹ African-Americans made up 12 percent of the population and 17 percent of the uninsured.⁶⁰ CHCs serve a disproportionate number of these minorities. Two thirds of all health center patients in 2001 were members of minority groups.⁶¹ Racial and ethnic minorities are projected to grow from 28 percent of the U.S. population in 1998 to 40 percent by 2030.⁶² Without increasing the scope of CHCs, the percentage of Americans who lack access to efficient medical coverage threatens to climb at proportionally high rates.

The vital role that CHCs play in providing equitable care to those left out by the current health delivery system is of growing national importance. Yet, as with all aspects of health care policy, arguing for CHC expansion requires close attention to the matter of dollars and cents. CHCs are funded by a combination of federal and state grants, Medicaid and Medicare reimbursement, patient fees, private insurance, and donations.⁶³ Federal appropriations to health centers have steadily increased, from \$802 million in 1997 to \$1.3 billion in 2002.⁶⁴ Federal grants are the most important source of CHC funds, and it is hard to imagine a significant growth in CHCs that does not originate from increased federal support.

The current administration has not overlooked this. President George W. Bush has called for a doubling of health centers across the nation, and the federal Congress approved a FY 2004 increase of \$113 million.⁶⁵ The proposed FY 2005 Budget

⁵⁷NACHC, *36 Million Americans*, *supra* note 54.

⁵⁸NACHC, *NACHC Reach 2000*, *supra* note 53.

⁵⁹See Proser, *supra* note 24, at 8.

⁶⁰*Id.*

⁶¹*Id.*

⁶²*Id.* (citing U.S. Census Bureau, National Population Projections, “NP-T4. Projections of the Total Resident Population by 5-year Age Groups, Race, And Hispanic Origin with Special Age Categories: Middle Series, 1999 to 2100,” available at <http://www.census.gov/population/www/projections/natsum-T3.html>).

⁶³Mark Lurtz, *Strengthening the Health Care Safety Net through Financing and Technical Assistance*, Community Investments Online (Jan. 14, 2004), at <http://www.frbsf.org/publications/community/investments/0405/article1pf.html> (last visited Oct. 19, 2005).

⁶⁴BPHC www.bphc.hrsa.gov/programs/CHCPrograminfo.asp (last visited June 9, 2004).

⁶⁵Shin, Jones, & Rosenbaum, *supra* note 34, at 4; see also NACHC, *Congress Approves FY2004 Budget Health Center Funding Increases by \$113 Million* (Jan. 22, 2004), at <http://www.nachc.com/lawsregs/congressapprovesbudget.asp> (last visited Oct. 18, 2005).

request includes a boost of \$219 million to fund the community health center program, a 13.5 percent increase in funding.⁶⁶

President Bush's five-year plan calls for an additional \$2.2 billion in federal dollars to the CHC program. This would enable health centers to provide health care access to 1.6 million people, in addition to the 15 million they already serve.⁶⁷ Federal support is particularly vital now, as state budget crises decrease the availability of the primary alternative-funding source.⁶⁸ Those working on the ground verify the immediacy of the crisis. "Even with the presidential initiative . . . health centers around the nation will be challenged to provide that care because of state budget crises," says Benjamin Pettus Jr., Executive Director of the Samuel Rodgers Community Health Center in Kansas City, Missouri.⁶⁹

The proposed funding increases may be a good start, but they are not enough. The numbers reveal the inadequacy of current fiscal support. Growth in health centers in 2002-2003 did reduce the number of Americans without a source of care by 2.4 million. However, if all qualified applications for new sites had been funded, an additional 4 million Americans would currently have access to health care.⁷⁰ Furthermore, even if the number of uninsured Americans froze at the 2004 levels, the projected capacity for CHCs under the proposed funding scheme is only about one quarter of what would be needed.⁷¹ Taking full advantage of what community health centers provide requires a more significant expansion of the program. If the federal government is serious about its claim of extending fiscal support to CHCs as an alternative to nationalizing the health system the funding levels must substantially increase.⁷² As Dan Hawkins states:

[t]he President's plan to expand health centers is a vitally important step in efforts to meet the needs of the uninsured. At the same time, the number of people and communities who need a health center and don't have one continues to grow more rapidly than the amount of new funding available. And even with the extra dollars the Administration has very generously committed, health centers are struggling to keep pace with

⁶⁶NACHC, *FY 2005 Budget Includes Increase for Community Health Centers Health Centers Say Funding Increase Will Help Keep Pace with Growing Patient Population*, (Feb. 2, 2004), available at <http://www.nachc.com/press/fy2005budget.asp> (last visited Oct. 18, 2005).

⁶⁷*Id.*

⁶⁸See Lurtz, *supra* note 63 ("[s]tate budget deficits force reductions in entitlement programs").

⁶⁹NACHC, Press Briefing, *A New NACHC Report: Economy, State Budget Deficits Put Health Care At Risk Low-Income Families, Children Are Casualties In U.S. Health Care Crisis*, 2 (Mar. 21, 2003), available at <http://www.nachc.com>.

⁷⁰Dan Hawkins, *A Nation's Health at Risk: A National and State Report on America's 36 Million People Without a Regular Healthcare Provider* (NACHC, Mar. 2004), at <http://www.nachc.com/pubmgr/Catalog.sp?cn+PubCategory=2> (last visited June 5, 2004).

⁷¹IOM, *A Shared Destiny: Community Effects of Uninsurance* 46 (National Academies Press, 2003).

⁷²James G. Lakely, *Bush Pushes Health Centers*, WASH. TIMES, May 26, 2004, at A3.

rising health care costs and Medicaid cutbacks in some states, which is fueling the growing uninsured population.⁷³

Meeting the needs of CHCs is not a matter of doling out tax dollars to help the poor. It would be uncharacteristic of the socially conservative Bush administration to extend fiscal support if this were merely public charity. The fact is that community health centers present an important opportunity for major cost savings, particularly in Medicaid spending. It is estimated that health centers already save almost \$3 billion annually in combined federal and state Medicaid expenditures—1.2 billion in state spending alone.⁷⁴ That amount is four times the current national total of state-appropriated funding provided to health centers.⁷⁵ Moreover, in FY 2000, the CHC investment generated over \$3 billion in revenues for impoverished underserved communities across the country.⁷⁶

CHCs are in the unique position of achieving unrivaled success when it comes to meeting the nation's health goals. Expanding the CHC network holds the promise of a successful remedy to two of the biggest gaps in our current health care system: access to care and the shortage of primary care doctors. By striving to provide health care access to all, CHCs will also provide fertile training ground for medical students and employment opportunities for licensed physicians.

II. COMMUNITY HEALTH CENTERS AND NATIONAL HEALTH GOALS

If CHCs are worthy of expanded federal support, they must first be shown to further the nation's health goals. Fortunately, these goals are clearly articulated in a federal report. *Healthy People 2010: Understanding and Improving Health* is an initiative sponsored by the U.S. Department of Health and Human Services (HHS) establishing 10-year health objectives for the nation. The Healthy People Consortium—an alliance of more than 350 national organizations and 250 State agencies—conducted three national meetings to develop these objectives.⁷⁷ The drafting process included ample individual testimony at regional meetings and more than 11,000 comments on draft materials from citizens.⁷⁸ The finalized report is thus the culmination of professional and public opinions on national health care priority setting.

The central theme of *Healthy People 2010* is “Healthy People in Healthy Communities.”⁷⁹ The final report identifies two primary goals as a roadmap to move

⁷³NACHC, *With New Census Figures, Community Health Centers Brace for More Uninsured Patients: Health Centers Shoulder Growing Need on Tight Resources*, (NACHC, Aug. 26, 2004), at <http://www.nachc.org/press/census.asp> (last visited Oct. 18, 2005).

⁷⁴Proser, *supra* note 24, at 14.

⁷⁵*Id.* (based on calculations by NACHC, 2003).

⁷⁶BPHC, *Program Information*, <http://bphc.hrsa.gov/programs/CHCPrograminfo.asp> (last visited Oct. 18, 2005).

⁷⁷U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH*, 2 (2d ed., U.S. Government Printing Office, Nov. 2000) [hereinafter HP 2010].

⁷⁸*Id.*

⁷⁹*Id.* at 3.

the nation toward better health.⁸⁰ The first goal is to increase the quality and duration of healthy life, which includes helping individuals gain the “knowledge, motivation, and opportunities they need to make informed decisions about their own health” and encouraging state leaders to develop community efforts that promote healthy behaviors and create healthy environments.⁸¹ The second goal is to eliminate health disparities.⁸² *Healthy People 2010* is “firmly dedicated to the principle that every person in every community across the Nation deserves equal access to comprehensive, culturally competent, community-based health care systems that are committed to serving the needs of the individual and promoting community health.”⁸³ The pronouncement of a national commitment to the *HP 2010* goals is difficult to map on a health care landscape that is being increasingly populated by the institutional towers of managed care. However, there is an existing health care delivery institution that has already proven its success at making significant headway toward the priorities set by the federal government through the *HP 2010* program: the Community Health Center.

The alliance between CHCs and the national health agenda is underscored by considering how the mainstream health care system fails to meet these goals. According to the *HP 2010* report, the strongest predictors of access to quality health care are having health insurance, having a higher income level, and using a regular primary care provider or other source of ongoing care. *HP 2010* seeks to advance its objectives by increasing the proportion of Americans with health insurance, especially minorities, who are overrepresented among the uninsured. Mainstream medicine has produced a steady increase in the number of uninsured Americans and a steady decline in the number of primary care doctors per capita. Noting these deficits, *HP 2010* aims to overcome the access problem that leaves millions of Americans bereft of health care providers. According to the *HP 2010* report, there are three kinds of barriers to access: financial, structural—including lack of primary doctors and health facilities, and personal—including language barriers, lack of knowledge regarding where to seek care, and concerns about discrimination.⁸⁴

The CHC commitment to improving health care access is reflected in health center efforts to overcome all three of the access barriers identified in *HP 2010*. As to personal barriers, both cultural and practical obstacles are actively addressed. In a 2001 survey of health center patients, 95% reported their doctor speaks the same language as they do and over half of the remaining 5% state that someone at the health center translates for them.⁸⁵ Community outreach programs act as information sources for notifying potential patients how to access the CHC. Consumers are encouraged to take an active role in their health care, thus reducing the “one size fits

⁸⁰*Id.* at 2; *see also* CDC, National Center for Health Statistics, *The Healthy People 2010 Database*, at <http://www.edc.gov/nchs/about/otheract/phdatat2010/abouthp.htm> (last visited Oct. 18, 2005).

⁸¹*HP 2010*, *supra* note 77, at 10.

⁸²*Id.* at 2.

⁸³*Id.* at 16.

⁸⁴*Id.* at 45.

⁸⁵*See* Proser, *supra* note 24, at 7.

all” model of medical paternalism. As to structural barriers, CHCs are ambulatory settings that provide quality primary care services. Not only do they help address the problem of unavailable facilities by locating in medically underserved areas, but they also frequently provide transportation to ensure that patients are not deterred from seeking health care.⁸⁶ On the financial side, the CHC sliding scale charges patients on a fee-for-service basis that is based on income and ability to pay.

CHC performance in the area of racial equity is particularly noteworthy in light of the failures of mainstream medicine. Not only do CHCs help alleviate the access problem by extending themselves to the underserved, but they are also curative of the far subtler access problems exposed by uneven levels of care according to race. In 1994, a Health Center User Survey and a National Health Interview Survey found that while there were significant racial and ethnic disparities in health factors among the general population, even after controlling for socio-demographic factors, these disparities did not exist among health center users.⁸⁷ These longstanding results have received national attention. Tommy Thompson, HHS Secretary, acknowledged that “one of our top priorities at the Department of Health and Human Services is to reduce racial disparities in health care. Community health centers are among the very most effective tools at accomplishing that goal.”⁸⁸

The problem of racial inequity persists despite the conclusive findings over ten years ago. The Institute of Medicine’s (IOM) 2002 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, concluded that American minorities receive lesser health care than whites, even when income, insurance status, and medical conditions are part of the equation.⁸⁹ The IOM found that unequal treatment in the quality of healthcare is the result of racial or ethnic differences rather than access-related factors, clinical needs, preferences, or appropriateness of intervention.⁹⁰

According to the report, a consistent body of research demonstrates that unequal treatment continues, even when insurance status, income, age, and severity of conditions are comparable.⁹¹ This research indicates that racial and ethnic minorities in the U.S. are less likely to receive even routine medical procedures and experience a lower quality of health services overall. For example, minorities are less likely to be given appropriate cardiac medications or to undergo bypass surgery and are less likely to receive kidney dialysis or transplants.⁹² On the other end of the spectrum,

⁸⁶See Shin, Jones, & Rosenbaum, *supra* note 34, at 5.

⁸⁷See Proser, *supra* note 24, at 6.

⁸⁸*Id.*; see also Tommy Thompson, Sec’y of Health and Human Services, *Compassion and Service: The Importance of Community Health Centers to America’s Health Care Future*, (Speech at the NACHC Policy & Issues Forum, Washington, D.C., Mar. 20, 2002).

⁸⁹See IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, Mar. 20, 2002, at <http://www.iom.edu/report.asp?id=4475> [hereinafter IOM, *Unequal Treatment*].

⁹⁰*Id.*

⁹¹*Id.*

⁹²*Id.*

minorities are more likely to receive certain less desirable procedures, such as lower limb amputations for diabetes and other conditions.⁹³

Many of the 2002 IOM recommendations for addressing these health disparities have been put into practice by CHCs, serving as an example to others.⁹⁴ CHCs participate in the Health Disparities Collaboratives program, a nationwide initiative aimed at improving health outcomes for chronic conditions among the medically vulnerable.⁹⁵ Due to the successful results of CHC participation, the 2002 IOM Report commended health centers, recommending them as models for reforming primary care.⁹⁶

These accolades are well earned. The racial disparities in health among the general population *are significantly reduced or completely eliminated among health center users*.⁹⁷ A Georgetown University study of health centers showed that, when CHCs penetrate states' medically underserved communities, disparities in health indicators significantly decline.⁹⁸ For example, the overall black/white mortality rates drop from 286 additional black deaths per 100,000 lives to 166 deaths, and the disparities in Hispanic/white tuberculosis cases decline from 8.5 additional Hispanic tuberculosis cases per 100,000 lives to 6.7 cases.⁹⁹ Considering the biases that have been documented in mainstream medical care, the health disparities that exist among the general population will likely escalate at marked rates without the corrective intervention of CHCs.

CHCs are diligent in charting the correlation between race and care, underscoring their reliability in serving as a model in this area. BPHC collects this data annually from health centers through the Uniform Data System ("UDS") reporting system.¹⁰⁰ Absent this system, there is simply very little information collected regarding race and healthcare. Mainstream health care providers do not collect such data and have

⁹³*Id.*

⁹⁴Proser, *supra* note 24, at 2. These recommendations include: increasing awareness; strengthening the stability of patient-provider relationships; supporting the use of interpretation services where the community needs them; supporting use of community health workers and preventive care teams; collecting and reporting data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and primary language by OMB categories; monitoring progress toward disparity elimination; and conducting research on causes and possible interventions for disparities.

⁹⁵*Id.* at 1 ("[it is a]n initiative that aims to improve health outcomes for chronic conditions among the medically vulnerable, particularly minorities. [It is] overseen by the federal Bureau of Primary Health Care and was designed to improve the skills of clinical staff, strengthen the process of care through the development of extensive patient registries that improve clinicians' ability to monitor the health of individual patients, and effectively educate patients on self-management of their conditions").

⁹⁶*Id.* at 11; *see also* IOM, *Unequal Treatment*, *supra* note 89.

⁹⁷Proser, *supra* note 24, at 6.

⁹⁸*See* Shin, Jones, & Rosenbaum, *supra* note 34, at 3.

⁹⁹*Id.* at 13, 15.

¹⁰⁰Federally funded health center data are recorded in the 2002 Uniform Data System, Health Resources and Services Administration, HHS. *See* NACHC, *Fact Sheet*, *supra* note 34.

vigorously resisted federal efforts to require them to do so.¹⁰¹ This makes progress toward the national goal of reducing racial disparities in healthcare difficult to measure. Thus, CHCs provide an information service that is absent from the health care system at large, placing them in position to be uniquely accountable to national health goals.

Not only do CHCs successfully address the issue of health disparities, but they also work toward the second *HP 2010* goal: increasing the quality and duration of a healthy life. CHCs provide an ideal conduit for the goal of increasing citizen involvement in making healthy lifestyle choices regarding diet, exercise, smoking, and use of other substances. This is one of their greatest values, as a November 2000 study shows that decisions involving these factors have the single greatest impact on health and mortality.¹⁰² In 2001, 96 percent of CHCs provided some type of health education program.¹⁰³ “Uninsured adults at health centers were more likely than other United States’ uninsured adults to be counseled on nutrition (54 percent vs. 43 percent), physical activity (57 percent vs. 49 percent), smoking (75 percent vs. 64 percent), drinking (68 percent vs. 52 percent), drug use (55 percent vs. 39 percent), and sexually transmitted diseases (54 percent vs. 36 percent).”¹⁰⁴ This integrated treatment of the patient is mirrored by the delivery structure employed by CHC staff.

CHCs use a team-effort approach to care, incorporating the work of physicians, social workers, dieticians, and case managers to address health issues. By working in non-hierarchical “clinical teams” of physicians, nurses, community outreach workers, physician assistants, and quality managers, health outcomes are improved.¹⁰⁵ This “clinical professional” model is cost-effective and efficient, particularly when compared with the bureaucratic corporate model that dominates much of the U.S. health care delivery system.¹⁰⁶ Mainstream medicine has become increasingly fragmented as privately managed care providers undermine physician autonomy and increasingly dominate decisions about service utilization.¹⁰⁷ Health centers, on the other hand, work with extended networks including local and state public health departments, other social service organizations, schools, and

¹⁰¹ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 111 (“[a]s of 1996, no agency in the U.S., public or private, regularly collected data on race and ethnicity in health care. The Uniform Institutional Provider Claim Form, popularly known as UB-82 and now UB-92, is a critical document in health care. All health care institutions claiming reimbursement under Medicare and Medicaid use this uniform billing form, as do many private insurers. Despite urging by a coalition of health care advocates, the form solicits no information on the race or ethnic identity of the patient, seriously limiting the governments’ ability to enforce the nation’s civil rights laws in the health care system”).

¹⁰²HP 2010, *supra* note 77, at 18 (individual behaviors and environmental factors are responsible for about seventy percent of premature deaths in the United States).

¹⁰³Proser, *supra* note 24, at 8; *see also* NACHC, *Fact Sheet*, *supra* note 34.

¹⁰⁴Proser, *supra* note 24, at 13.

¹⁰⁵*See* Louise Trubek & Maya Das, *Achieving Equality: Healthcare Governance in Transition*, 29 AM. J.L. & MED. 395, 415 (2003).

¹⁰⁶*Id.* at 415-16.

¹⁰⁷*See* ROSENBLATT, LAW, & ROSENBAUM, *supra* note 18, at 20-1.

community groups.¹⁰⁸ These are not empty gestures; these practices yield real results.

CHCs score high on outcomes achieved through preventive health initiatives. “For mammograms, clinical breast examinations, and up-to-date Pap smears health center women have far exceeded the national rate for comparable women, and then have met or exceeded the *Healthy People 2000* goal for those categories.”¹⁰⁹ Rates of hospitalization are lower in communities served by CHCs than in communities not served by these centers.¹¹⁰ This is likely connected to the fact that, according to a recent study, “CHCs provide better continuity of care than in either hospital outpatient departments or physician offices.”¹¹¹ Continuity is essential in the management of chronic diseases, and CHCs score high on this front. For example, “ninety percent of African American and Hispanic health center patients with hypertension reported that their blood pressure is under control.”¹¹² “This is more than triple that of a comparable national group and nearly double the *Healthy People 2000* goal of fifty percent.”¹¹³ These results clearly bespeak ongoing care that works.

This effective patient care is protected by an integrated reporting system. Community health centers at the local level are held accountable through interaction with regional and national supervisors, transmission of data, and national training programs.¹¹⁴ CHCs serve as a reliable provider of data on the patients they serve. “Section 330 grantees are required to report information each year on utilization, patient demographics, insurance status, managed care, prenatal care and birth outcomes, diagnoses, and financing.”¹¹⁵ Not only does this make their own successes and failures transparent, but it also acts as a valuable body of information for the study of effective health practice generally. Patients and community members are an integral part of the outcome and accountability system.¹¹⁶

All of these impressive facts are not a mere litany of numbers that look good on paper. Patients served at CHCs are both healthier and more satisfied with the health care they receive. The influence of consumer-controlled boards is that health services are able to respond to the health care needs expressed directly by patients, thereby producing higher patient satisfaction ratings.

CHCs are, in short, a demonstration of what health care should be. There is no existing model in a better position to make significant progress toward meeting the national goals of eliminating health disparities and improving quality of life. So why are CHCs not on center stage of debates on health care reforms? Alice Sardell

¹⁰⁸See Trubek & Das, *supra* note 105, at 405.

¹⁰⁹See Proser, *supra* note 24, at 12.

¹¹⁰*Id.* at 8.

¹¹¹*Id.*

¹¹²*Id.* at 13.

¹¹³*Id.*

¹¹⁴See Trubek & Das, *supra* note 105, at 411.

¹¹⁵Proser, *supra* note 24, at 6.

¹¹⁶See Trubek & Das, *supra* note 105, at 417.

examined this question nearly twenty years ago in her comprehensive analysis of CHCs from 1965 through 1986. In her resulting book, she concluded:

The fact that the neighborhood health center program did not fulfill its original objective to serve as a model for health care delivery for the whole population was not because the model was inadequate, but rather because of the nature of the American policy process itself.¹¹⁷

“More recently, it has been suggested that though CHCs remain structurally marginalized, they may be the crucible of reforms yet to come.”¹¹⁸

This marginalization is complex, and several factors contribute. First, the population that CHCs primarily serve is associated with second-tier care – “charity medicine” - what is given to those who can’t afford to choose.¹¹⁹ Second, the complicated financing scheme of Graduate Medical Education (GME), Medicaid/Medicare reimbursements, and the increasing influence of managed care have created significant obstacles to the growth of CHCs. Third, the need for more CHCs has coincided with a general decline in U.S. doctors choosing primary care specialties. The health center model represents everything the technological world of sub-specialty medicine rejects, and CHCs cannot compete with the physician reimbursement levels received in sub-specialized fields.¹²⁰ CHCs must be incorporated into the training model for young physicians in order to create the exposure and incentives medical students need to elect primary care careers.

The federal government can afford these reforms based on the benefits that CHCs already deliver. CHCs have proven to provide substantial cost savings. As previously mentioned, the CHC cost savings in Medicaid dollars alone is four times the amount of national funding currently provided to health centers.¹²¹ At the same time, health centers achieve health outcomes for patients that surpass those of the general population. Renewed federal support does reflect a continuing

¹¹⁷ALICE SARDELL, *THE U.S. EXPERIMENT IN SOCIAL MEDICINE: THE COMMUNITY HEALTH CENTER PROGRAM, 1965-1986*, at 4-5 (University of Pittsburgh Press 1988).

¹¹⁸See Donald W. Light, *The Rhetoric and Realities of Community Health Care: The Limits of Countervailing Powers to Meet the Health Care Needs of the Twenty-First Century*, 22 J. HEALTH POL. POL’Y & L. 105, 138 (1997).

¹¹⁹See Shin, Jones, & Rosenbaum, *supra* note 34, at 4 (“[d]ata collected annually from all federally funded health centers show that in 2002, two-thirds of all health center patients were members of racial and ethnic minority populations; 86 percent of all persons served were low income. Approximately 40 percent of all health center patients have no health insurance and approximately one-third speak a primary language other than English”).

¹²⁰Pay, *Working Conditions for Rural Docs Vary by Practice*, Physician Compensation Report, December 2003, at http://www.findarticles.com/p/articles/mi_m0FBW/is_12_4/ai_110675318 (last visited Oct. 18, 2005) (“[d]ata from the National Association of Community Health Centers (NACHC) suggest that adult Primary care practitioners who work in rural community health centers (CHCs) earn perhaps 9% to 12% less than similar doctors do nationally, using Medical Group Management Association for national comparison. The national medians for CHC family practitioners and internists both are close to \$135,000, while the MGMA national medians for family practitioners with obstetrics and for internists are \$157,000 and \$155,000, respectively”).

¹²¹Proser, *supra* note 24, at 14 (based on calculations by NACHC, 2003).

acknowledgment that CHCs play a necessary role in providing health services to U.S. citizens. However, the extent of the support does not match the potential for CHCs to help remedy the U.S. health care crisis.

CHCs may be the most useful tool the nation has to ensure the majority of Americans have access to medical care when they need it. This is particularly vital so long as the current political resistance to universal health coverage persists in this country. Expanding CHCs would not only bring the nation in line with its own stated national health goals, it would likely help lift some of the ever-increasing financial burden of having 45 million citizens forced to rely on expensive emergency room care as their sole source of legally guaranteed treatment.¹²²

The primary goal for enlarging the health center program should be to provide a federally qualified health center to every underserved area in the country. *Healthy People 2010* recognizes that “the health of every community in every State and territory determines the overall health status of the Nation.”¹²³ Once this is accomplished, the health center model may be adjusted to serve more mixed income communities and may eventually become the primary seat of primary care services, saving hospitals for the specialized procedures that they are best equipped to perform.

III. GRADUATE MEDICAL EDUCATION: TRAINING DOCTORS TO FILL NATIONAL HEALTH CARE NEEDS

Expanding the role of community health centers is not simply a matter of increased federal funding. Both existing centers and new centers will require professional medical staff. This requires organized efforts to ensure that the medical system is training sufficient numbers of skilled primary care physicians who are committed to employment in CHCs. In short, if gifted young doctors are going to elect a practice in medically underserved areas, they must first be exposed to what community-based medicine has to offer. This involves both the opportunity to elect primary care residencies and the location of at least some of those residencies in ambulatory settings. Supporting this transition will require financing reforms alongside renewed institutional commitment to the value and importance of steering top students toward primary care doctoring.

One of the key factors in shaping the physician workforce is the Graduate Medical Education program (GME). GME is the prerequisite training and sole entryway for students to become licensed physicians in the United States.¹²⁴ Both United States and foreign medical school graduates (FMGs) enter the profession through the GME residency program.¹²⁵ GME determines the style and setting for

¹²²See Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (West 2003); see also HEALTH, UNITED STATES, 2003, *supra* note 13, at 10 (expenditures for hospital care accounted for 32 percent of all national health expenditures in 2001. Use of hospital inpatient care among the poor is greater than that among the nonpoor; in 2001, among those under 65 years of age, the hospital discharge rate was almost twice the rate for nonpoor (168 and 87 per 1,000 population)).

¹²³HP 2010, *supra* note 77, at 3.

¹²⁴See Katherine Huang, *Graduate Medical Education: The Federal Government's Opportunity to Shape the Nation's Physician Workforce*, 16 YALE J. ON REG. 175, 176 (1999).

¹²⁵*Id.*

medical training and gives medical students the experiential basis on which career decisions will be made. As the doorway into medical practice, GME has a key role in shaping the size and distribution of the physician workforce.¹²⁶ Residency training is conducted through a variety of settings: teaching hospitals, academic health centers, and ambulatory settings.¹²⁷ Because the health care that the nation receives is dependent on the professionals available to provide it, GME plays a crucial role in determining the landscape of national health care. Residency experience has been shown to be a key determinant of the practice areas that medical graduates will pursue upon licensure.¹²⁸

The primary purpose of GME is professional training. However, teaching occurs in tandem with patient care and research.¹²⁹ Thus, medical residents double as a valuable workforce, performing a significant percentage of patient care in the settings where they work.¹³⁰ Despite this contribution, educating young doctors still imposes financial costs on the institutions that host them. The costs involved include the direct costs of resident salaries and additional overhead (DME) and the indirect costs of increased use of testing and technology as part of resident training (IME). Because the value of training the nation's doctors has long been seen as a public good, GME is funded largely by federal dollars.¹³¹ In FY1999, the federal government contributed \$6.8 billion to GME through Medicare, and additional funds through the Departments of Defense and Veterans Affairs.¹³² By FY2000, Medicare funding levels alone reached \$7.8 billion - \$2.7 billion in direct GME payments and \$5.1 billion in indirect payments.¹³³ Second to Medicare, Medicaid is the largest GME payer, contributing between \$2.5 and \$2.7 billion to teaching hospitals in 2002.¹³⁴

As the primary fiscal backer of GME, the federal government presumably has the leverage to steer residency distribution in order to provide practitioners the training to execute the national health goals established in *HP 2010*. Professional education has a substantial effect on physicians' behavior and values, where they practice, and what is generally considered a prestigious use of a medical degree. It is because doctoring overlaps with such a compelling social need that medical education and

¹²⁶*Id.*

¹²⁷*Id.*

¹²⁸*Id.*

¹²⁹COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME), U.S. DEPT. OF HEALTH & HUMAN SERVICES, *FINANCING GRADUATE MEDICAL EDUCATION IN A CHANGING HEALTH CARE ENVIRONMENT*, FIFTEENTH REPORT, at 1 (2000).

¹³⁰Huang, *supra* note 124, at 176.

¹³¹National Health Policy Reform, *Federal and State Perspectives on GME Reform*, Issue Brief #764, 3, George Washington Univ. (2001) ("the concept of GME being a public good remains"); *see also*, Huang, *supra* note 124, at 175.

¹³²Huang, *supra* note 124, at 176-77.

¹³³COGME, FIFTEENTH REPORT, *supra* note 129, at 3 (citing HCFA 2000).

¹³⁴COGME Resource Paper, U.S. DEPT. OF HEALTH & HUMAN SERVICES, *STATE AND MANAGED CARE SUPPORT FOR GRADUATE MEDICAL EDUCATION: INNOVATIONS AND IMPLICATIONS FOR FEDERAL POLICY*, at 7 (2004) [hereinafter COGME, *STATE SUPPORT*].

medical care are heavily subsidized by federal and state governments. In exchange for this fiscal support comes a certain degree of social responsibility to meet national health needs. Implementing the *HP 2010* agenda calls for increased emphasis on producing community-based primary care physicians prepared to work in conjunction with public health and community organizations. Instead, GME has produced an undersupply of generalists, an oversupply of specialists, and no solution for the geographical misdistribution of doctors.¹³⁵ According to the American Academy of Family Physicians, any attempt to contain costs and ensure quality in the American health care system will be frustrated by this structural problem: there simply aren't enough primary care physicians.¹³⁶

This imbalance can be directly linked to the locations where young doctors are trained. Medical students are more likely to work in settings similar to those in which they did their residencies.¹³⁷ On a more subtle level, the settings within which medical students are trained communicate what it is to be a doctor and prepare residents for a particular kind of practice. Although residency programs span a range of settings - an overwhelming majority of residency opportunities are limited to tertiary care hospitals. There is a marked shortage of residencies in ambulatory settings, the training most conducive to producing general practitioners.¹³⁸ At the same time, since 1998 there has been a steady decline in the number of U.S. medical school seniors who choose primary care residencies.¹³⁹ Yet, the demand for family physicians, from both the population and the health care delivery system, remains great.¹⁴⁰

Medical care may be reaching ever-increasing technological heights, but the health needs of the average citizen remain fairly basic. General practitioners—internists, pediatricians, and family doctors—are fully equipped to handle the majority of medical complaints. The family physician can manage 90 percent of patients' health problems, consulting colleagues or referring patients to specialists as necessary.¹⁴¹ In spite of this, the lure of high salaries and the glorification of

¹³⁵See Huang, *supra* note 124, at 177 (citing Pub. L. No. 105-33, 111 Stat. 251, codified as amended in scattered sections of Title 42 U.S.C., *infra* Section II).

¹³⁶American Academy of Family Physicians (AAFP), *Graduate Medical Education*, Statement to the Senate Finance Committee (May 12, 1999), <http://www.aafp.org/x1126.xml?printsm1> [hereinafter AAFP, *Statement to Senate*].

¹³⁷Huang, *supra* note 124, at 176.

¹³⁸See COGME, FOURTEENTH REPORT, *Physician Workforce Policies: Recent Developments and Remaining Challenges in Meeting National Goals*, at 3 (1999).

¹³⁹See Jay Greene, *Match Day 2000: Primary Care Still Passed Over*, AMA, *The Newspaper for American's Physicians* (Apr. 3, 2000), <http://www.ama-assn.org/amed news> (last visited Oct. 18, 2005).

¹⁴⁰*Id.* (citing AAFP, *Family Physician Workforce Reform: Recommendations of the American Academy of Family Physicians*, (Kansas City, MO: The Academy, 1995; AAFP reprint no. 305a)).

¹⁴¹Julea G. Garner, M.D. et. al, *Responses to Questions about the Specialty of Family Practice as a Career*, Amer. Fam. Phys., (AAFP, July 1999), available at <http://www.aafp.org/afp/990700ap/167.html>; see also IOM, Division of Health Manpower and Resources

technologically advanced specialties that are practiced in relatively controlled settings pull increasing numbers of medical students away from the once honored image of general practice. As Allan Goroll, author of the most widely used textbook in primary care medicine, observes, “[w]hen students come to medical school, being somebody’s doctor is really what they want to do. Somehow, by the time they leave, we’ve changed their minds; they’d rather do just about anything but that.”¹⁴²

The American Academy of Family Physicians (AAFP) has analyzed the physician work force and called for U.S. family practice residency programs to graduate 3,700 to 4,100 family physicians each year in order to meet the need for these physicians in the United States.¹⁴³ A total of 3,380 family physicians graduated in 1998, and approximately 3,570 to 3,580 family physicians graduated in 1999 and in 2000.¹⁴⁴ These numbers, which fell far short of the projected need, include all general internists and general pediatricians, as well as the growing number of physician assistants and nurse practitioners.¹⁴⁵ Family physicians are historically the most needed physicians, as they are recruited more than any others by managed care systems, rural providers, and inner-city practices.¹⁴⁶ Despite this fact, family physicians make up a mere 13 percent of America’s physician workforce.¹⁴⁷ Under these conditions, it is hard to imagine meeting the goal of distributing family physicians on a per capita basis so that every American has access to cost-effective, comprehensive, continuous primary care services.¹⁴⁸ CHCs are working toward this goal. GME clearly is not.

GME is doing little to facilitate *HP 2010* national health goals. If anything, the system that trains the physician workforce is working against the priorities of closing the access gap and improving the quality and length of life for all. According to the National Resident Matching program, the organization that coordinates placement for post-graduate medical training, the number of primary care residency programs has dropped by more than a third over the past decade.¹⁴⁹ Most of those remaining

Development, *A Manpower Policy for Primary Health Care: Report of a Study* (Washington, D.C.: National Academy of Sciences).

¹⁴²Lisa Sanders, M.D., *The End of Primary Care*, N.Y. TIMES MAGAZINE 52, 54 (Apr. 18, 2004).

¹⁴³AAFP, *Delegates Support Board Report G, "Family Physician Workforce Reform,"* 1998 Congressional Summary, at [http://www.aafp.org/MEMBERS /congress/1998/index.html](http://www.aafp.org/MEMBERS/congress/1998/index.html) (last visited Oct. 18, 2005).

¹⁴⁴*Id.*

¹⁴⁵*Id.*

¹⁴⁶Seifer SD, Troupin B, & Rubinfeld GD, *Changes in Marketplace Demand for Physicians: A Study of Medical Journal Recruitment Advertisements*, 276 JAMA 695, 695-99 (1996); see also Miller RS, Dunn MR, & Whitcomb ME, *Initial Employment Status of Resident Completing Training in 1995*, 277 JAMA 1699, 1699-704 (1997).

¹⁴⁷AAFP, *Statement to Senate*, *supra* note 136.

¹⁴⁸*Responses to Questions about the Specialty of Family Practice as a Career*, AMERICAN FAMILY PHYSICIAN, July 1999.

¹⁴⁹Sanders, *supra* note 142, at 54.

are smaller than they once were.¹⁵⁰ Estimates indicate that a physician workforce of at least 50 percent generalists and 50 percent sub-specialists would be the needed distribution to meet America's health care needs, as compared to the 70 percent sub-specialists and 30 percent primary care doctors recorded in 1999.¹⁵¹

In response to the imbalanced workforce that GME was producing, in 1986 Congress established the Council on Graduate Medical Education (COGME) to examine workforce demands in current and future health care environments.¹⁵² Since its inception, COGME has issued yearly reports on GME issues, particularly those affecting the physician workforce. In 1996, COGME compared forecasted need with available supply and concluded that the nation has "a moderate need for more generalists and a substantial surplus of specialists."¹⁵³ The American Academy of Family Physicians (AAFP), Physician Payment Review Commission (PPRC), the Pew Health Professions Commission, the Institute of Medicine, the American Medical Association, and the Association of American Medical Colleges, all of whom support increasing the supply of primary care physicians, corroborate this conclusion.¹⁵⁴ In 2000, the COGME annual report addressed the financing of GME, and concluded that the current GME funding structure constrains medical training and creates barriers for reform, particularly when it comes to training in ambulatory settings.¹⁵⁵ Together these findings show that correcting the physician imbalance requires direct fiscal reforms.

To understand the COGME conclusions, it is important to have a brief understanding of how the GME funding scheme works. Medical Education is funded through multiple sources. The federal government, through Medicare, is the single largest supporter of GME, directly bearing 34 percent of the program's costs.¹⁵⁶ Private payers and Medicaid combined contribute 57 percent; the Department of Defense and Veterans Administration contributes 13 percent, and the remaining 9 percent comes from other sources.¹⁵⁷ Private insurers make no direct contribution, though they do contribute through higher fees-for-service paid to

¹⁵⁰*Id.*

¹⁵¹*Id.*

¹⁵²Title VII of the Public Health Service Act; *see also* COGME Resource Paper, STATE AND MANAGED CARE SUPPORT FOR GRADUATE MEDICAL EDUCATION: INNOVATIONS AND IMPLICATIONS FOR FEDERAL POLICY, at V (HRSA, July 2004); *see also* Huang, *supra* note 124, at 182.

¹⁵³*See* Marc L. Rivo & David A. Kindig, *A Report Card on the Physician Work Force in the United States*, 334 NEW ENG. J. MED. 892, at 893, note 21 and 895 (1996).

¹⁵⁴*See* AAFP, *Statement to Senate*, *supra* note 136.

¹⁵⁵*See generally*, COGME, FIFTEENTH REPORT, *supra* note 129.

¹⁵⁶Huang, *supra* note 124, at 186.

¹⁵⁷*Id.*; *see also id.* at 178, note 8 (Medicare [health insurance program for aged persons] and Medicaid [funds for the medical care of certain low-income persons] were established by Titles XVIII and XIX, respectively, of the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C., *supra* Section II); *see also* Randall L. Braddom, *A Review of Graduate Medical Education Funding, 1997*, 76 AM. J. PHYSICAL MED. REHAB. 340, 340 (1997).

teaching hospitals, marking the built-in additional expense of operating a teaching program.¹⁵⁸ GME payments are received through both direct and indirect funding streams.¹⁵⁹

Medicare's direct medical education (DME) payments cover residents' stipends and fringe benefits, a portion of teaching faculty salaries, administrative expenses, costs of sleeping rooms and supplies, and other overhead costs attributed to residency programs.¹⁶⁰ Medicaid dollars are distributed to GME on a state-by-state basis, with states retaining discretion on how to apply these funds.¹⁶¹ Indirect medical education (IME) payments are received through generally higher fees, paid to the physicians who supervise residents, and to the teaching hospitals where residents work. IME compensation recognizes the fact that teaching hospitals care for sicker patients, with less staff productivity, and use more diagnostic tests as part of the residents' learning process.¹⁶²

Until the passage of the Balanced Budget Act (BBA) of 1997, federally funded training programs went unregulated.¹⁶³ This unrestricted financing scheme created a potentially lucrative incentive for hospitals to create additional residencies. Residents provided care at a low cost while garnering federal dollars, which hospitals could use to subsidize unrelated expenses.¹⁶⁴ There were no restrictions on residency types, "so hospitals were free to accommodate student interest in specialization."¹⁶⁵

¹⁵⁸Huang, *supra* note 124, at 186.

¹⁵⁹*Id.* at 186, note 67 (PHYSICIAN PAYMENT REVIEW COMM'N, 1997 ANNUAL REPORT TO CONGRESS 387 (1997)) (adjusting for differences in case mix, labor costs, and location, the costs of teaching hospitals are approximately 25% higher than those of nonteaching hospitals). See Kenneth E. Thorpe, *The Health System in Transition: Care, Cost, and Coverage*, 22 J. HEALTH POL. POL'Y & L. 339, 353 (1997). The approximate annual cost of teaching, research, and clinical innovation at academic health centers and teaching hospitals is \$18.1 billion and accounts for 28% of their total costs.

See Samuel Thier & Nannerl Keohane, *How Can We Assure the Survival of Academic Health Centers?*, CHRON. OF HIGHER EDUC., Mar. 13, 1998, at A64; see also JAMES REUTER, THE FINANCING OF ACADEMIC HEALTH CENTERS: A CHART BOOK 12 (1997) (noting that in comparison to large urban nonteaching hospitals, the indirect costs of teaching add about \$2,681 per case, or 27.7 of total cost per patient, in academic health centers and \$706 per case, or 10.6% of total cost, in all other teaching hospitals); see also James Reuter & Darrell Gaskin, *Academic Health Centers in Competitive Markets*, 16 HEALTH AFF. 242, 247 (1997) (finding that academic health centers are approximately 30% more expensive than their nonteaching competitors, even after the patient case-mix differential has been removed)).

¹⁶⁰Huang, *supra* note 124, at 186 (citing Braddom, *supra* note 157, at 340).

¹⁶¹*Id.*

¹⁶²*Id.* at 186-87.

¹⁶³See Pub. L. No. 105-33, 111 Stat. 251 (codified as amended in scattered sections of 42 U.S.C., *supra* Section II).

¹⁶⁴See generally John K. Iglehart, *The American Health Care System: Teaching Hospitals*, 329 NEW ENG. J. MED. 1052, 1052-53 (Sept. 30, 1993) (discussing how teaching hospitals use revenues from patient care and GME payments to cross-subsidize their multiple missions, such as patient care, indigent care, research, and physician training).

¹⁶⁵Huang, *supra* note 124, at 187.

It is no wonder that the GME system has failed to train a physician workforce appropriate for the nation's needs. The result of the current funding scheme is that the distribution and type of residencies are shaped by financial incentives and not by public need. Not surprisingly, calls for massive reform can be heard from virtually every corner.

This gap between the kinds of doctors needed and the kind of doctoring that students choose to pursue has not always been so apparent. "In the 1930s, more than 80 percent of practicing physicians were general practitioners."¹⁶⁶ In 1949, 59.1 percent of active doctors in medicine were in primary care; by 2001, that percentage had dropped dramatically to 34.6.¹⁶⁷ However, this decline does not match a change in need from the population. With the advances of medical technology came an increasing reliance on, and intrigue with, more specialized forms of medical services. These professional and structural factors are responsible for the disconnect between the nation's health needs and the way physicians are trained.

The shape of our physician workforce is not determined solely by the preferences of young students in training. There are institutional mechanisms that have a significant influence on how aspiring physicians ultimately practice medicine. The decline in primary care doctors is partially due to increasing professional and educational emphasis on specialization, which is reinforced by the funding structure of GME. On the other hand, decreasing numbers of primary care residency programs have also been attributed to a lack of student interest, making these spots harder and harder to fill.¹⁶⁸

In either case, neither professional fads nor student self-interest should be the sole determinant of the kind of medical care the national system provides. The advancement of medicine as a profession cannot be pursued to the neglect of "prevention, public health, and primary care."¹⁶⁹ To correct the current imbalances, the medical profession must look at how students are being prepared to practice medicine and must be willing to embrace reforms that will serve the nation's need for more primary care doctors.

¹⁶⁶Jennifer Devoe, M.D., *My Experiences at an Orphan School: The Importance of Finding Parents*, AMERICAN FAMILY PHYSICIAN, Jul. 1, 2000 (citing VR Hunt, *The Unifying Principles of Family Medicine: A Historical Perspective*, R. I. Med. (July 1993) 76:351-60, at 351).

¹⁶⁷See HEALTH, UNITED STATES, 2003, *supra* note 13, at 293 (National Center for Health Statistics, 2003); see also SR Lawson & JD Hoban, *Predicting Career Decisions in Primary Care Medicine: A Theoretical Analysis*, 23 J. CONTIN. EDUC. HEALTH PROF. 68, 68-80 (Spring 2003) ("[e]ntering the 1960s, more than half of the medical doctors in the United States were family physicians, pediatricians, or general internists. Today, about one-third of all U.S. physicians are primary care practitioners").

¹⁶⁸See, e.g., Thomas Rowley, *A Family (Doctor) Affair*, 8 RURAL HEALTH NEWS 2 (Summer 2001), <http://www.nal.usda.gov/ric/richs/RHNsum01.htm> (last visited Oct. 18, 2005) ("beginning in 1997, the percentage of family practice residency positions filled in the National Resident Matching Program . . . declined each year").

¹⁶⁹Donald W. Light, *The Rhetorics and Realities of Community Health Care: The Limits of Countervailing Powers to Meet the Health Care Needs of the Twenty-First Century*, 22 J. HEALTH POL'Y & L. 105, 116 (1997).

A look at the historical relationship between primary and specialty care is instructive in understanding the current imbalance. Failed prior attempts to correct a similar problem may have contributed to institutional resistance to act now. In 1992, the United States had the lowest proportion of primary care physicians out of 10 Western industrialized countries.¹⁷⁰ The U.S. system at that time was becoming more dominated by specialty and tertiary care.¹⁷¹ At the same time, the value of a primary care-oriented health system was being championed. A wave of studies generated empirical data showing that primary care doctors delivered care that was, in many measurable ways, better than that of specialists.¹⁷² The United States made an attempt to respond to this data and to change course. As recently as 1996, more than half of medical school graduates entered a primary care residency: family medicine, pediatrics, or internal medicine.¹⁷³ The image of being “somebody’s doctor” was being backed by substantial information valorizing the value of choosing primary care. Why, then, did this movement derail?

As with so many problems in the health care system, the answer may be financial. The success of primary care made it a sitting duck for the financial marksmen aiming at ways to keep quality up and costs down. Perhaps one of the most direct hits came in the mid-1980s, when HMOs decided to enlist primary care doctors as “gatekeepers,” controlling patient access to more expensive specialty care.¹⁷⁴ This idea was well-intentioned. Generalists would be granted the freedom to practice “big doctoring”—taking care of patients over time—with a glowing institutional stamp of approval.¹⁷⁵ HMOs would reap the cost and quality benefits that primary care had empirically demonstrated.¹⁷⁶ Instead, the plan backfired. It ate away at the very essence of primary care’s value: the doctor-patient relationship.¹⁷⁷ Patients grew suspicious of whether their doctors were acting in their best interest; the role of keeping costs down by limiting access to specialty care was too transparent for American consumers.¹⁷⁸ Egged on by the financial incentives of primary care doctoring, HMOs framed general practitioners, by transforming their

¹⁷⁰See BARBARA STARFIELD, *PRIMARY CARE: CONCEPT, EVALUATION, AND POLICY* 213-35 (Oxford University Press, 1992) (the United States had a primary care score of 0.2, the lowest of 10 industrialized nations).

¹⁷¹See Zohreh Ajdari Oliver Fein, *Primary Care in the United Kingdom and the United States*, 7 *ARCH. FAM. MED.* 311, 311-14 (1998).

¹⁷²Sanders, *supra* note 142, at 54.

¹⁷³*Id.*

¹⁷⁴*Id.* at 55.

¹⁷⁵See generally FITZHUGH MULLAN, *BIG DOCTORING IN AMERICA: PROFILES IN PRIMARY CARE* (University of California Press 2002); see also Sanders, *supra* note 142, at 55.

¹⁷⁶See Sanders, *supra* note 142, at 54 (“[t]he [IOM] report cited research showing that people treated by primary care physicians spent less time in the hospital, had fewer visits to the E.R. and had fewer procedures and tests. Yet they were healthier and happier with their care than those without these doctors”).

¹⁷⁷*Id.* at 55.

¹⁷⁸*Id.*

public image of advocate into the unfortunate image of pawn (or worse, a Benedict Arnold) to their own sick patients.

This indicates that, in terms of medical markets, American consumers react poorly to limits, if those limits are perceived as holding them back from otherwise available and desired care. This lesson will have to be considered in the larger policy analysis of expanding CHCs, particularly if expansion includes broadening the patient base to include the middle class. But there is another important lesson here: nothing in this story undermines the proven fact that primary care works. It was the misguided HMO attempt to wield primary care as a sword to cut costs that made gatekeeping a failed experiment.

At the same time that economic motives corrupted the primary care movement, GME financing fell under increasing pressures of its own. Privately managed care payers grew resistant to paying the higher fees, which taught hospitals to compensate for their educational expenses.¹⁷⁹ The Balanced Budget Act of 1997 (BBA) reduced Medicaid payments by \$10.4 billion for hospitals that served a disproportionate number of low-income patients, affecting the indirect teaching adjustment that had long been a part of accounting at teaching hospitals.¹⁸⁰ These financial pressures and the institutional failings of GME have forced it to center stage in dialogues about how to address the dysfunctions of the U.S. health care system.¹⁸¹

The BBA tried to solve the problem through Medicare policy reforms that allowed funding for some residency training in ambulatory settings.¹⁸² Although the intention was to foster a more structural emphasis on primary care, the provisions in the Act failed to provide specific protections for primary care.¹⁸³ The results of the BBA have been mixed. The detrimental effects include unintended harmful effects on family medicine training programs, caused by restrictions such as capping hospital funding on the basis of residents in training as of 1996 and setting a restrictive cut-off date for new residents.¹⁸⁴ This failed experiment raised serious questions about continuing reliance on Medicare as the biggest sole supporter of GME.

COGME's Fifteenth Report, published in December 2000, addresses the question of GME financing in a changing health care environment. The report advocates for major reforms, citing the fact that the "uncertainties of continued reliance on Medicare, Medicaid and private pay revenues have reinforced conclusions held by COGME and others that major changes are needed in the way GME is financed."¹⁸⁵

Perhaps the most significant barrier to much-needed GME reform is the pathway through which federal money is received.¹⁸⁶ Reliance on Medicare money as the

¹⁷⁹Huang, *supra* note 124, at 177.

¹⁸⁰COGME, FIFTEENTH REPORT, *supra* note 129, at 3.

¹⁸¹Huang, *supra* note 124, at 177.

¹⁸²See AAFP, *Statement to Senate*, *supra* note 136, at 2.

¹⁸³*Id.* at 2-3.

¹⁸⁴*Id.*

¹⁸⁵COGME, FIFTEENTH REPORT, *supra* note 129, at 3.

¹⁸⁶*Id.* at 1.

primary federal funding mechanism creates three major concerns for the settings that ultimately house residency programs.¹⁸⁷ First, restricting payments to teaching hospitals for educational costs hinders the development of residency programs in non-hospital ambulatory settings, including CHCs.¹⁸⁸ Before the BBA, federal legislation authorized direct GME Medicaid payments to go *only* to hospitals.¹⁸⁹ Although other entities are now eligible to receive payments, the specific amounts lack historical precedent and are thus more vulnerable to fiscal constraints.

Second, linking GME payments to Medicare patients concentrates GME on providers with high Medicare utilization and offers very limited federal support to providers with relatively low Medicare utilization, such as CHCs.¹⁹⁰ This limitation is even more absolute when it comes to residency programs that do not involve direct patient care services, including preventive medicine. Finally, relying solely on patient care reimbursements is not an effective mechanism for achieving specific workforce goals, such as correcting the geographic and specialty imbalances high on the national radar.¹⁹¹ Thus, forcing GME through the eye of the Medicare needle prevents GME from functioning in accordance with its supposed mission: to train the doctors who will attend to the nation's health.

The need for reform has been suggested for years as the centerpiece for correcting well-recognized defects in how GME currently operates. It is increasingly clear that accomplishing reform will likely require government regulation. Because the benefits of GME cannot be charged to future beneficiaries, the private market alone would under-produce GME as a resource.¹⁹² A natural place to begin reform measures is the financing scheme and incentive structure of GME. This will require continued government support, both fiscally and programmatically.

The need for regulation is not new to the medical profession. The number of medical schools, the quality and training provided at those schools, and the standards for students admitted to medical school have been carefully managed by the AMA, and other professional organizations, for nearly 100 years.¹⁹³ This is because of the nature of the medical profession—in order to ensure quality and affordable care, the balance of supply and demand requires careful monitoring. The AMA was initially founded to define, control, and limit the parameters of the medical profession.¹⁹⁴ Although professional self-regulation is a valid enterprise, one must not forget the unique nature of the service that physicians provide. After a century of professional self-regulation, an imbalance has evolved that places the ambition of doctors ahead

¹⁸⁷*Id.* at 3.

¹⁸⁸*Id.*

¹⁸⁹*Id.* at 4.

¹⁹⁰*Id.* at 3.

¹⁹¹*Id.*

¹⁹²COGME, *STATE SUPPORT*, *supra* note 134, at 9.

¹⁹³*See, e.g.*, American Medical Association History, *AMA History*, available at <http://www.ama-assn.org/ama/pub/category/1854.html> (last visited Oct. 18, 2005); *see generally* PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 90-91* (Basic Books, 1982).

¹⁹⁴*See* STARR, *supra* note 193, at 90-1.

of the service they provide. The abandonment of primary care for the sake of high-tech specialization must be contained. This is a crucial step in readying the system to support the expansion of CHCs, thus reaping the value of a primary care model that works.

The most direct way to do this is by extending GME funding to host more residencies in CHCs and other ambulatory settings. Because of the current GME funding scheme, this change will require major reforms. The BBA recognized that the hospital-centered Medicaid reimbursement formula was preventing the development of residencies in ambulatory settings and thus constraining the growth of primary care.¹⁹⁵ The BBA attempted to promote ambulatory residencies by including provisions to support training in underserved non-hospital settings.¹⁹⁶ For example, the BBA did allocate DME payments to select ambulatory settings including CHCs.¹⁹⁷ Yet, because most CHCs are not linked to a teaching hospital, they earn no Medicaid revenues to cover the additional IME costs of teaching, making it difficult for CHC residency programs to survive financially.¹⁹⁸

The constraints on training in CHCs and other ambulatory settings are readily visible, though numerous programs strive to fill the gap. Most GME resident exposure to community settings currently occurs through an affiliation with a teaching hospital. A classic example is the Residency Program in Social Medicine (RPSM), sponsored by the Department of Family and Social Medicine at the Albert Einstein College of Medicine. The RPSM began in 1970 because medical faculty saw that traditional programs were not adequately training students in ambulatory and community medicine.¹⁹⁹ The RPSM integrates community care experience at a CHC in the Bronx with in-hospital experiences at the Montefiore Medical Center and affiliated hospitals.²⁰⁰ Similarly, the Harvard Combined Program in Medicine and Pediatrics is a four-year residency program that offers combined training through hospitals and two affiliated CHCs.²⁰¹ With slight variations, this structure is found in numerous primary care residencies: a teaching hospital operates as host and the CHC acts as a means for residents to get exposure to community-based practice.

¹⁹⁵See Huang, *supra* note 124, at 195.

¹⁹⁶University of California, Office of Federal Governmental Relations, *Graduate Medical Education: Volunteer Faculty and Community Support* (Health Forum 2004), <http://csd.vcop.edu/documents/gradmed.pdf> [hereinafter University of California].

¹⁹⁷See Huang, *supra* note 124, at 195-96; see also John K. Iglehart, *Medicare and Graduate Medical Education*, 338 NEW ENG. J. MED. 402, 403 (1998).

¹⁹⁸COGME, *STATE SUPPORT*, *supra* note 134, at 8.

¹⁹⁹Albert Einstein College of Medicine, Department of family and Social Medicine, available at <http://www.aecom.yu.edu/family/rpsm.htm> (last visited Oct. 18, 2005).

²⁰⁰*Id.*

²⁰¹See Brigham and Women's Hospital, available at <http://www.bwh.partners.org/residency/Medical/pediatrics.asp> (last visited Oct. 18, 2005). The Brigham and Women's Hospital, Massachusetts General Hospital, and the Children's Hospital Medical Center (CHMC), sponsor a four-year training program, known as the Harvard Combined Program in Medicine and Pediatrics. In addition to the facilities of these university hospitals, training experiences at our affiliated community health centers provide opportunities to deal with the health of family units, as well as medical and social problems unique to these settings.

Creative programs such as these cannot be expected to solve the problem. Much broader facilitative reforms are necessary. Programs that rely on hospitals partnering with CHCs fall short of a systemic solution on several fronts. First, the portion of the training conducted in CHCs is performed almost completely by physician faculty who volunteer their support.²⁰² This results in lowered IME reimbursements to hospitals for residents training in non-hospital settings, creating a fiscal disincentive.²⁰³ Second, these programs are selective and limited by nature. Most CHCs lack such a formal affiliation with a hospital and thus remain isolated from the GME network of young physicians and excluded from the valuable framework within which doctors begin their professional careers.²⁰⁴

Interestingly, individual states have taken the lead in GME innovation. States have launched a number of programs aimed at aligning medical education with public need by requiring expanded training in community-based care. In the late 1990s, eleven states directed medical schools to produce more primary care practitioners or to alter medical student training to make careers in primary care more appealing to students.²⁰⁵ These state initiatives reveal the urgent need to expand primary care residencies and ambulatory training sites. State legislatures have thus harnessed their leverage to create GME environments that serve state needs. These mandates recognize that medical schools and residency programs are a part of the distributional problem of health care delivery and can be held legislatively accountable for fulfilling their social responsibility to train the doctors that the population needs.²⁰⁶

Among the more adventurous states to advance new GME initiatives are Arkansas, Texas, Michigan, and New York. These states have all implemented innovative approaches to GME financing, improving GME accountability to educational and workforce goals for State health needs.²⁰⁷ A brief examination of these policies serves as a guide in developing recommendations for GME reform on a national scale.²⁰⁸ These examples are merely representative of state efforts to reform GME. Most states now designate specific funds for the training of primary

²⁰²*Id.* For example, in family medicine data show that 85 percent of faculty in non-hospital settings is composed of volunteers.

²⁰³*Id.*

²⁰⁴This is partially due to the complicating factor that the vast majority of CHCs are 501(c)(3) federally tax-exempt, non-profit organizations, which introduces a fiscal structure not necessarily compatible with the current GME funding scheme. *See Proser, supra* note 24, at 7.

²⁰⁵Carol S. Weissert & Susan L. Silberman, *Sending a Policy Signal: State Legislatures, Medical Schools, and Primary Care Mandates*, 23 J. HEALTH POL. POL'Y & L. 743, 743 (1998).

²⁰⁶*Id.* at 743-44.

²⁰⁷COGME, MODEL STATE GME FINANCING INITIATIVES (2004), <http://www.cogme.gov/ManagedCare/8.htm> [hereinafter, COGME, *MODEL STATE*].

²⁰⁸National Health Policy Reform, *Federal and State Perspectives on GME Reform*, Issue Brief #764, 3 GEO. WASH. U. (2001).

care doctors, and more than 40 states offer special grant programs for family physician training.²⁰⁹

Texas and Arkansas structured their initiatives around state appropriation, partially based on the belief that training physicians equipped to handle the State's health needs will save the state money in the long run. In 1973, Arkansas state officials began demanding a new model that would better facilitate the distribution of physicians across needy areas of the state.²¹⁰ Between 1975 and 1980, the Arkansas legislature, in conjunction with the state's Area Health Education Centers (AHECs) created six new family residency programs, which have since made a significant impact on physician supply in Arkansas.²¹¹ In over 25 years of existence, the residencies produce the most rural physicians for the State and forty-five percent of graduating residents go on to practice in communities with populations less than 20,000.²¹² Additionally, Arkansas has implemented a "community match" program, in which a specific community makes an agreement with first-year medical students. The community agrees to pay half of the student's tuition, and, in exchange, the student agrees to select a primary care residency and to practice in that community for a designated period of time after licensure.²¹³ This program is partially supported by \$4 million of the state's tobacco settlement. It has been suggested that these funds be used to give premiums to hospitals affiliated with the community residency programs.²¹⁴

In 1977, Texas passed a law giving the Texas Family Practice Residency Program, administered by the Higher Education Coordinating Board (HECB), the authority to allocate state funds to family practice residencies on a contract basis.²¹⁵ By the late 1990s, this program provided approximately \$11 million to 26 Texas medical school programs, creating over 700 family practice residency positions.²¹⁶ As HECB only provides 35 percent of a given program's budget, additional funds—from patient revenue, hospital funds, or medical schools—are required. However, HCEB does collect information on the distribution of family doctors and the improvement of medical care in underserved communities.²¹⁷ A comprehensive 1989 law required the expansion of programs serving rural areas. This law also

²⁰⁹COGME, *STATE SUPPORT*, *supra* note 134, at 1.

²¹⁰COGME, *MODEL STATE*, *supra* note 207, at 1.

²¹¹*Id.*

²¹²*Id.*

²¹³*Id.*

²¹⁴*Id.*

²¹⁵*Id.* at 2.

²¹⁶*Id.*; see also Robert I. Summit, *Addressing a State's Physician Workforce Priorities Through the Funding of Graduate Medical Education: The TennCare Model*, 279 JAMA 10, 767-771 (1998) (under the new TennCare GME funding design, funds flow to the state's 4 medical schools and then to the sites of the residents' training. Allocation to the medical schools is based primarily on the number of primary care residents in residency programs under the sponsorship of each).

²¹⁷COGME, *MODEL STATE*, *supra* note 207, at 2.

mandated that all medical schools incorporate a third-year clerkship in family practice for *all* medical students and to report data on their renewed efforts to have at least 25 percent of their first-year primary care residents in family practice.²¹⁸ In 1991, these clerkships were given state funding through legislative order.²¹⁹ Then, in 1995, a follow-up law added several provisions, including support for an additional 150 community-based primary care residency positions phased in over 5 years, though the per-resident allotment stayed the same.²²⁰ Finally, in 1997 Texas opted to carve out Medicaid GME funds from the HMO capitation rates and to direct those funds toward teaching hospitals for primary care training.²²¹ Since the mid-1990s, there have been multiple proposals for additional reforms, including a proposal that the State cover the entire educational cost for primary care residents. Still looming are the concerns that funds for community-based faculty are limited and that the reduction of Medicare GME support, coupled with an increase in managed care enrollment, threatens the financial health of teaching programs.²²²

Michigan has reformed GME through significant changes in its Medicaid policies. In 1997, the state restructured GME payments to align physician education with three public policy goals: (1) to train appropriate numbers of primary care providers, (2) to enhance training in rural areas, and (3) to support programs of particular importance in the treatment of the Medicaid-eligible population.²²³ These accountability requirements were implemented through the creation of three funding pools. The first continues with hospital reimbursement at the 1995 level. The second, the primary care pool, provides payments to hospitals based on the institution's number of primary care residents and share of Medicaid patients. This pool seeks to advance the education in the primary care fields of general practice, family practice, preventive medicine, obstetrics, and geriatrics.²²⁴ Both of the hospital-based pools must submit detailed reports to the state, documenting how the funds are being applied to support the specific public policy goals mentioned above.²²⁵ The third pool, the Innovations in Health Professions Education Grant Fund, was established using GME funds and supports innovation in medical education and the acceleration of state health care delivery system reforms.²²⁶ Although Michigan is optimistic about the impact of this initiative on workforce

²¹⁸*Id.*

²¹⁹Tim M. Henderson, *State Efforts to Increase Community-Based Medical Education*, The Intergovernmental Health Policy Project, National Conference of State Legislatures (1994).

²²⁰COGME, *MODEL STATE*, *supra* note 207, at 3.

²²¹Stacey Silverman, Director, Medical Education Programs, Texas Higher Education Coordinating Board, presentation at Forum for State Health Policy Leadership, Lake Tahoe, California, Apr. 26, 2001.

²²²COGME, *MODEL STATE*, *supra* note 207, at 3.

²²³*Id.* at 4.

²²⁴*Id.*

²²⁵*Id.*

²²⁶*Id.*

goals, it acknowledges that a more comprehensive policy encompassing Medicaid, Medicare, and other payers would be more effective.²²⁷ Beginning in 2001, Michigan made some movement in this direction. Teaching hospitals are now required to submit annual data on interns and residents, with funds distributed based on actual documented costs, and with upweighting for Medicaid use and physician enrollment in Medicare.²²⁸

New York, on the other hand, based GME reform around pooling multiple payment sources from the start. The New York payer pool is comprised of commercial in-state insurers and Medicaid.²²⁹ This initiative was intended to protect teaching hospitals, which typically provide higher rates of uncompensated care, from financial collapse.²³⁰ All payers in the New York demonstration pay the same rates, but hospitals receive a stable form of payment through negotiated rates.²³¹ GME funds are weighted to the advantage of primary care and are distributed regionally based on a resident count.²³² The funds distributed are based on the receipts from individual institutions and are given directly to those institutions.²³³ New York also sets aside substantial funds to support GME reforms. These funds are distributed based on performance in furtherance of workforce goals established by the Commissioner, including increasing the percentage of residents trained in ambulatory settings and the number of primary care residencies.²³⁴

GME has been called one of the most challenging aspects of health policy due to the fact that GME payments are entrenched in law and practice.²³⁵ However, these varied state reform initiatives make clear that there *is* flexibility to restructure GME so that it deliberately serves the health needs of the nation's communities. At the same time, there are several reasons why the federal government cannot rely on the states to be the sole initiators of GME reform. First, the fiscal environments in most states have changed drastically since the initiation of these programs. Escalating costs of health care and a deteriorating tax base have led to major budget deficits in most states.²³⁶ Because health costs account for 30 percent of state spending nationwide, these fiscal dire straits have led to major reductions in state Medicaid

²²⁷*Id.*

²²⁸*Id.*

²²⁹*Id.*

²³⁰*Id.*

²³¹*Id.*

²³²*Id.*

²³³*Id.*

²³⁴*Id.*

²³⁵Sheila P. Burke, National Health Policy Reform, *Federal and State Perspectives on GME Reform*, Issue Brief No. 764, June 22, 2001, at 2, available at http://www.nhpf.org/pdfs_ib/IB764%5FGMERreform%5f6%2D22%2D01%2E.pdf (last visited Oct. 18, 2005).

²³⁶See COGME, *STATE SUPPORT*, *supra* note 134, at 3 (“[a]s of April 2003, 41 States and DC were projecting shortfalls that could exceed \$78 billion”).

spending and other health programs.²³⁷ Continued funding for GME innovations in most States is under fiscal pressure or has already been cut back.

Second, state programs are targeted to state health care needs. Many programs offer grants and loan repayments to medical students in exchange for an oath to practice primary care in that state after graduation. Currently, seventeen states retain over half of all physicians who complete their GME training in that state.²³⁸ The result is that poor states, those most in need of well-trained primary care physicians, are likely to suffer without the equalizing intervention of a federalized policy.

Third, state efforts are crippled by constraints in Medicaid policies. Although there is increasing flexibility for states to amend Medicaid administration, states still must seek federal approval to modify their programs.²³⁹ This can be cumbersome and create barriers to innovation. For instance, most states follow a Medicare methodology that limits reimbursement to clinical education in hospital settings.²⁴⁰ In order to extend GME payments to ambulatory training programs, each state would have to seek individual federal approval to modify. To make things more difficult, in 2003, the Center for Medicare and Medicaid Services (CMS) put a regulatory standard in place halting IME and DME reimbursements for non-hospital training, if at any point the program had been totally supported by non-Medicare funds.²⁴¹ This puts programs funded by state entities in jeopardy. It would be more efficient for the federal government to foresee the need for reform and make facilitative changes on a national scale.

If health care is truly a national goal, the federal government should tackle the reforms needed to extend GME more readily to CHCs, thus taking a crucial step in capitalizing on CHCs' untapped potential. It is time for Congress to demand accountability in return for the federal GME paycheck, even if this initially comes in the form of directing authority to state legislatures. Possible approaches to GME reform come from the state programs discussed above, which have tested multiple means of innovation. In learning from these initiatives, national policymakers can profit from the capacity for individual states to be the experimental legislators that eventually guide the approach taken by the federal government.

Several models emerge from these state legislative initiatives that provide structures within which to build national reforms. Each of these reforms could be deliberately tailored to facilitate CHC inclusion in the GME network. A proportion of GME funding could be earmarked for primary care residency programs. The distribution of GME dollars could be based on a more deliberate attempt to achieve balanced geographical distribution of doctors. To facilitate this, for example, the New York demonstration project of upweighting primary care residencies could be expanded to upweight Medicare dollars for GME time spent in ambulatory care settings and to double upweighting for public delivery sites.²⁴² Also, distributing

²³⁷*Id.*

²³⁸*Id.* at 5.

²³⁹*Id.* at 12.

²⁴⁰*Id.*

²⁴¹*See* University of California, *supra* note 196.

²⁴²David A. Kindig, *Residency Training in Community Health Centers—An Unfulfilled Opportunity*, 110 *Pub. Health Rep.* 300-301 (1995).

GME funds directly to medical schools, as do Texas and Tennessee, could be explored at the national level.

Alternately, the 1994 Health Security Act, COGME, the Association of American Medical Colleges, and the American Medical Association (AMA) all support an all-payer pool, which would receive contributions from all payers for health care, to fund GME.²⁴³ This would lift the constraints currently imposed by heavy reliance on Medicare. The argument for an all-payer fund was reinforced in a 1997 consensus agreement between COGME, the Pew Health Professions Commission, Commonwealth Fund, and associations representing major GME stakeholders.²⁴⁴ The proposal for an all-payer fund is based on the idea that, because medical care is a public good, the majority of the GME funding burden should not fall on the Medicare program alone. As COGME explains, relying on Medicare as the primary revenue stream creates distortions external to the needs served by GME. It limits which types of institutions are eligible for funding and creates a heavy bias toward teaching hospitals that serve high proportions of Medicare patients.

The AMA suggests an all-payer system take the form of a Graduate Medical Education Trust Fund.²⁴⁵ This fund would be administered by a public/private sector advisory body located outside of the regular government structure.²⁴⁶ This body would be responsible for developing a mechanism to distribute GME funds, as well as recommending the number and distribution of GME residencies.²⁴⁷ The AMA would allow for funds to follow residents to all educational sites.²⁴⁸ Creating an all-payer pool will require a more explicit accounting of GME costs.²⁴⁹ As state initiatives prove, this is entirely feasible, despite institutional resistance to documented costs. Ultimately, an all-payer trust fund that provides a stable and direct source of GME costs would make medical training publicly accountable and would help build a physician workforce that can further the nation's goals of providing access to quality, cost-effective health care.²⁵⁰

In terms of moving GME training to ambulatory settings, the question of the best way of structuring this expansion need not freeze the government in its tracks.²⁵¹ Although an all-payer fund may be the ultimate solution, there is no reason not to

²⁴³*Id.* at 301; see also AMA, *Graduate Medical Education Funding*, <http://www.ama-assn.org/ama/pub/category/2391.html> (last visited Oct. 19, 2005) [hereinafter AMA, *GME Funding*].

²⁴⁴Burke, *supra* note 235, at 11 (including the American Association of Colleges of Osteopathic Medicine, American Medical Association, American Osteopathic Association, Association of Academic Health Center, AAMC, and National Medical Association).

²⁴⁵See AMA, *GME Funding*, *supra* note 243.

²⁴⁶*Id.*

²⁴⁷*Id.*

²⁴⁸*Id.*

²⁴⁹*Id.*

²⁵⁰Huang, *supra* note 124, at 201-202 (suggesting that to avoid the political resistance to raising taxes, the trust fund could be generated through a minor tax on insurance premiums).

²⁵¹Burke, *supra* note 235, at 11.

initiate more modest beginnings. The federal government could sponsor residencies in existing CHCs, thus welcoming the CHC network into the ambit of GME training. Even if this were initially a symbolic gesture, it would pave the way for CHCs to take a more substantial role in the operation of the U.S. health care system. CHCs provide an ideal placement for training community-based primary care doctors - the physicians that the nation needs most. CHCs have a 30-year track record of providing quality care in underserved settings. They present a forum through which students can be trained in personal, community-based doctoring. And, although certain percentages of medical students will continue to seek the specialty with the highest income, there are surely a substantial number of medical students drawn to medicine as a healing profession, who retain a genuine desire to assist the basic health care needs of their fellow human beings. This desire deserves to be cultivated by educational institutions, not only because society needs this kind of doctor, but also because it is a valid professional impulse worthy of encouragement.

In fact, evidence shows that doctors who select general practice have impressively high satisfaction ratings. In a recent survey of young California physicians, 92 percent of family doctors expressed high levels of satisfaction with their choice.²⁵² But we need not rely solely on the altruism of medical students. With the amount of Medicare and Medicaid dollars that CHCs save, the federal government can afford to extend a premium to doctors who choose to work in health centers, thus providing an incentive that reflects the value of this delivery model.

Extending the GME program more deliberately to CHCs may be a significant step toward lifting the onus of CHC marginalization, but it is not the only obstacle. As with any aspect of the U.S. health care system, CHCs must contend with a complex web of fiscal arrangements and the ever-increasing pressure of consumer biases and demands. Due to the interconnectedness of virtually every aspect of the U.S. health care system, it is beyond the scope of this Article to design the comprehensive policy and economic reforms needed to facilitate CHC growth. However, through identifying some of the key issues and making a strong case for the value of CHCs, it is hoped that the larger questions of how CHCs will best function within the health care system at large will be taken up by the more economically inclined.

There will likely be challenges to expanding CHCs. All reforms involve careful maneuvering. In this case, the effort will likely be well compensated by the efficacy of its outcomes. The demonstrated success of CHCs is so strong that, whatever the obstacles, the nation must make every effort to capitalize on this effective model and take the necessary steps toward elevating their status.

IV. CONCLUSION

While the rest of the U.S. health care system has plummeted into disrepair, community health centers have quietly continued to grow, successfully meeting their mandate and exceeding all expected outcomes. The CHC model offers a healthy response to a system starving for solutions: put resources where we know they work; invest in preventive care, health education, continuity of care, and integrated

²⁵²Julea G. Garner et al., *Responses to Questions about the Specialty of Family Practice as a Career*, 60 AMERICAN FAMILY PHYSICIAN 167 (July 1999) (citing "California physician survey results of young physicians: more than 1100 young doctors reveal what they like and don't like about practicing medicine" Calif. Phys 1995;12:22-35).

services; break down barriers to access so that citizens receive quality medical attention regardless of their geographical location or skin color; make health a community goal by building bridges between health care providers and community groups, schools, and churches. These simple measures are a win-win on the health care see-saw: quality goes up, while costs go down.

The fact that U.S. health care needs reform is no secret. Massive attempts to reorganize the system have been engineered and have failed.²⁵³ Attempts at piecemeal solutions have the band-aid effect—they may stop the bleeding but they leave behind stubborn scars. All the while, our healthcare crisis continues to escalate. Expensive technology runs away with our immortal imaginations, luring disproportionate shares of medical resources with it. It is time to pay attention to a program that is known to deliver the needed result. If the nation is serious about putting its money where its mouth is when it comes to national health goals, it is time to move CHCs more into the provider limelight. Though current funding increases make a salutary nod to CHC success, more significant gestures are appropriate. Medical education must act to embrace CHCs as a crucial part of the delivery system. The CHC network is well prepared to receive the institutional and fiscal boost that will enable it to expand its services in accordance with the nation's needs. The nation would be foolish not to extend that support.

²⁵³The first legislation providing health insurance for all Americans was sponsored by John D. Dingell in 1943. His son, John D. Dingell, Jr., “sponsored a national health insurance bill in every Congressional session since 1955 when he filled the House seat left vacant by his father's death.” *Id.* Most memorably, President Clinton promised a bill in 1992—within 100 days of taking office—attempting to provide health care for all through an employer mandate. *Id.* The Plan began with 76 percent public support in September 1993, which dwindled to 47 percent public support by mid-August 1994. *Id.* at 84. In late August 1994, the Plan folded and with it the optimism of achieving major health care reform legislation any time that year. W. John Thomas, *The Clinton Health Care Reform Plan: A Failed Dramatic Presentation*, 7 STAN. L. & POL'Y REV. 83, 83 (Winter 1995-1996); see also NORMAN DANIELS, DONALD W. LIGHT, RONALD L. CAPLAN, BENCHMARKS OF FAIRNESS FOR HEALTH CARE REFORM 4-7 (1996).