The Use of Community Health Centers In Countries with National Health Insurance: Evidence from the Literature

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Abstract

Objectives: To explore the use of dirctly financed, publicly supported community health clinics in countries with national health insurance.

Methods: A literature search for studies of community health center services in nations with national health insurance.

Results: Most countries with national health insurance make use of community health clinics organized and staffed in a manner similar to the U.S. community health centers program in order to achieve population health goals, correct problems related to the maldistribution of health resources, and ensure that isolated populations receive care.

Conclusions: Health centers remain a basic element of the health system even in countries with national health insurance. While they cannot substitute for insurance coverage publicly supported health centers should be viewed as part of any overall national health policy.

Introduction

The original policy architects of the Medicare and Medicaid programs understood that even with expanded health coverage, large numbers of individuals living in medically underserved communities would continue to face significant barriers to healthcare. To address these concerns, the Johnson Administration in 1965 launched a demonstration program to establish Community Health Centers (CHCs) in urban and rural communities with significant health care underservice. The purpose of the program was to bring ñboth newly-insured low income people and those who remained uninsured into the health care system, educating patients on how to gain access to and utilize careò (Hawkins et al, 1997). The program was also viewed as a means for addressing the range of medical and health problems associated with deep impoverishment and isolation. Officials anticipated that by providing care in strategic locations with extended office hours, and by offering patient support services such as transportation and translation, heath centers would improve access to care and health outcomes.

Following its initial successes, documented in numerous studies of health center impact and effectiveness, the program was codified in law in 1975 as part of the Public Health Service Act. By 2000, the program operated clinical sites in more than 3,000 urban and rural medically underserved communities. Federal appropriations for FY 2001 stand at $1.169 billion, and health centers currently serve over 12 million patients, 40 percent of whom are completely uninsured and virtually all of whom have low family incomes.

The high number of uninsured Americans (in 1999 the number of uninsured stood at more than 42 million persons) (U.S. Census Bureau, 2000) makes the need for a program such as health centers relatively obvious, particularly in a highly competitive health care climate in which financial pressures have had a documented impact on the availability of uncompensated and charitable care (Institute of Medicine [IOM], 2000). At the same time, a question that has been posed with some frequency in a variety of policy settings is whether programs such as health centers and other safety net providers (such as public health agencies and clinics) would be necessary for insured populations, particularly under a universal health insurance scheme in which the types of differentials in access that are associated with a separate public insurance program such as Medicaid are minimized. While this question may seem somewhat academic in the current environment, it is a significant one that merits consideration. Were the prevailing judgment to be that universal coverage would obviate the need for health centers and similar programs, then a powerful argument could be made that even the limited incremental federal health insurance reforms for children and families enacted over the past decade[1] would have substantially reduced the need for increased direct operating subsidies for publicly assisted health care providers, on the assumption that individuals who gain coverage would move into private sector care settings, leaving those providers with additional capacity within current budget levels to care for the remaining uninsured.[2] Indeed, this critical tension can be seen in modern literature on the subject of health centers and other safety net providers (IOM, 2000).

[1]Kaiser Family Foundation, 1999.

[2] Of course, this assumption at least implicitly reflects a belief that the new coverage would be permanent and thus would support a permanent alteration of health care utilization patterns. In fact, however, studies of coverage under Medicaid and its companion, the State Children's Health Insurance Program, suggest that coverage tends to be episodic and unstable with lapses in eligibility resulting from problems in program administration and even slight changes in family income (See, e.g., Kaiser Commission, 2000).

To better understand the role of health centers and similar programs in an environment of expanded coverage, the National Association of Community Health Centers, in collaboration with the George Washington University School of Public Health and Health Services, undertook a review of the literature during the spring and summer of 2000 that was designed to examine the role of health centers in countries with national health insurance systems. The results of this literature review suggest that even countries with advanced health insurance schemes continue to provide direct and ongoing support for clinical health services in high need communities, as a component of their overall national health policies. Most countries with national health insurance maintain programs of directly supported community clinical service providers that appear to deal with the same types of needs and system limitations as those addressed by publicly assisted clinics in the U.S. The continued existence of such a clinical scheme is an indication of the inevitable limits of market power under even the broadest national health insurance scheme. The literature also suggests that even full national health insurance appears to have a lesser impact for certain patients and communities and that the use of a primary health delivery system that is tailored to addressing these issues can help close remaining health status and access gaps that transcend the financial and organizational impact of even the broadest national health insurance scheme.

This paper presents findings from our literature review and concludes with an assessment of the major policy issues that would arise in the reconfiguration of the U.S. health centers program were public policy makers to pursue significant health insurance expansions.

Methods

An extensive review of the literature on health centers in countries with national health insurance was undertaken. Results yielded a series of relevant documents, predominantly published under the auspices of the World Health Organization (WHO).

The WHO defines community health centers as frontline institutions that engage in the identification of community health needs, and the provision of medical care and prevention activities (WHO, 1994). The WHO has organized conferences and forums to discuss the role of health centers in different countries and has created Study Groups to examine experiences of different health center systems and make policy recommendations related to the needs of nations (WHO Forum, 1998; WHO, 1994). The WHO also has published literature on the role of health centers in urban areas and in district health care systems (WHO, 1997; WHO, 1992).

Community health centers are generally discussed in the literature irrespective of whether or not they operate in countries with or without national health insurance. To that end we identified 11 nations whose economies resemble those of the U.S. and that, according to studies of national health insurance, maintain universal, or near-universal, coverage systems. We then reviewed the literature on the extent to which these countries maintain programs of health centers for which they provide direct operating support[3].

Findings

[3] Limited reference to the use of community health centers in both South Korea and South Africa was also found in the literature; however, these countries were omitted from this review becasue of differences in those nations' health systems or general economies.

Use of health centers by countries with national health insurance

Table 1 displays findings regarding the use of health centers in countries with national health insurance that were selected for review. Among the 11 countries that were identified as candidate nations, 9 appear to concurrently maintain health center-style programs of direct service delivery supported with direct revenue allocations as well as other sources of income.

Community health services and community medicine have a particularly long history in the United Kingdom. The historic so-called Peckham experiment, conducted in the UK at the Pioneer Health Center between 1935 and 1950, produced findings on health care access and positive health outcomes that, while decades old, remain part of the policy framework for health care in that nation (Pepper, 1998).

Use of Health Centers in Countries with National Health Insurance

Country	Evidence of Direct Support for Health Centers
United Kingdom	Yes
Canada	Yes
Spain	Yes
Australia	Yes
New Zealand	Yes
Sweden	Yes
Finland	Yes

Switzerland	Yes (limited)
Japan	Yes
France	No
Germany	No

We could find no evidence in the literature that either France or Germany maintained a formal program of community health centers as a matter of national health policy. However, at least one analysis has identified the lack of such a program as a factor underlying the nationôs inability to adequately address the health needs of populations, such as refugees, that may be marginalized by the general health care system. (Gardemann et al, 1998).

In Scandinavian countries, although health care services are very evenly distributed, health centers are viewed as efficient ways to provide primary care for a variety of reasons, including geographic accessibility and a more holistic approach to primary care (Hansagi, 1993; Marklund, 1989). In England, health centers provide the central means by which a community defines its own health needs, considers how those needs can be met and decides collectively on priorities of action (McNaught, 1991). In Finland, health centers are principally responsible for the organization of local primary, secondary, and tertiary healthcare services (Vehvilainen, 1999). In Canada, following that nation's health care reform, community health centers were given lead responsibility for home care, postoperative care, post-hospital follow-up and other tasks, and are credited with carrying out all of the vaccination campaigns and 90% of home care today (Blair, 1999). In Spain, the competence of health center professionals and their impact on health outcomes were recently identified as among their strongest points, giving the public care model an

advantage over the private one (Rodriguez PMA et al, 1999). In Australia, health centers are more likely than private physicians to report involvement in group health promotion activity and broader community development initiatives (Baum et al, 1998). In New Zealand, researchers have found that taking health care into communities both enhances the wellness of the population and positively enhances the experience of place for local residents (Kearns, 1991).

Strategic use of health center programs

The literature indicates that even in countries with national health insurance schemes, community health centers are viewed as one of the most important health agencies to work with populations such as the urban poor, the homeless, the disabled, alcoholics, and drug addicts. In some countries, such as Australia and Canada, health centers also play an important role in the provision of family planning and maternal and child health care (Broom, 1997; Blair, 1999).

Countries with national health insurance tend to have a well developed and widespread network of health centers that are part of community (frequently referred to as district) health systems (WHO, 1997; McNaught, 1991; Vehvilainen, 1990). This is consistent with the trend toward decentralization within many national health systems (Kahssay, 1998; WHO, 1997). Because they shape their services on a community-wide rather than individual patient basis, health centers are viewed as more efficient in the administration of health promotion and disease prevention activities (Rodriguez PMA et al, 1999; Baum et al, 1998; Ejlertsson et al, 1985).

Several studies suggest that community health centers are typically designed to serve targeted populations that have unique and special health needs, such as the homeless, the disabled, the elderly, the mentally ill, persons with substance abuse-related health problems and other individuals whom health professionals in private practice either may resist serving or be not sufficiently experienced in the care of particularly high health risk populations to serve adequately (Power et al, 1999; Lanz et al, 1996; WHO, 1992; McNaught, 1991; Snowdon, 1987). Indeed, the literature suggests that it is both accepted and customary for private phsycians to formally refer certain classes of patients to health centers (Blair, 1999).

The literature also suggests that health centers are used to provide access to basic health care to populations that are not considered citizens of the specific country they reside in, and thus are ineligible for the health insurance schemes made available to the rest of the population (WHO, 1992). In addition, several studies indicate that health centers play an important role in health systems for culturally distinct population sub-groups, such as aboriginal populations, whose health care traditions differ from the rest of the country and whose health needs and preferences require specific customization of medical care (Kent, 1999; Mackenzie, 1999; Wakerman et al, 1998; Kearns, 1991).

Specific organizational and functional dimensions of health centers

The literature indicates that, as in the U.S., health centers tend to be structured in certain distinct ways. In some countries health center staff function on a medical team basis in order to make services more comprehensive and resposive to community-wide issues rather than simply

the needs of individual patients (Blair, 1999; Kahssay, 1998; WHO, 1997). Emphasis is placed on integrated medical records in order to promote continuity of care and as a means of supporting multidisciplinary teams (Rodriguez PMA et al, 1999; Ejlersson et al, 1985).

The literature also suggests that a specific purpose of health centers is to link health care with social services and to provide a single location for the provision of a broad range of interventions that transcend traditional medical care and that reach into the worlds of nutrition, social services, educational services, recreation, and other interventions that promote overall health rather than simply diagnosing and treating disease (Kahssay, 1998; WHO, 1997; McNaught, 1991). Studies indicate that health centers can take on a social function as a place where people meet and that they promote dialogue on community health issues that cut across multiple sectors (Pepper, 1998; Campbell Forester, 1998; Lennie et al, 1990).

Studies suggest that increasing community involvement in decision making around health and health care is a specific aspect of the work of health centers in other countries. Health centers are used to generate participation by all segments of a community in public policy questions related to the nature and structure of the health system. In addition, health centers in some other countries play an important role in promoting access among underserved populations to emerging health care research that otherwise might elude populations whose status and health needs might be perceived as placing them beyond the reach of emerging therapies. For example, in South Africa, mobile health teams are directly linked to academic health centers and district decision-makers, while in Sweden, nearly one-third of all health centers participate in ongoing research

projects in the fields of epidemiology, preventive medicine and health services research (Tolman, 1998; Haglund, 1985).

Challenges facing Health Centers

Notwithstanding the acceptance of community health centers in countries with national health insurance schemes, health centers throughout the world share similar difficulties. The most important one appears to be a constant lack of financial resources (Blair, 1999; Kahssay, 1998; WHO, 1997). This funding shortage shows up in two respects. First, studies suggest that, as is the case in the U.S., [4] the number of health centers is inadequate to meet the basic needs for which health centers are used.

Second, in view of the expanded health needs of health center patients, centers frequently report that their current funding levels are inadequate to provide the level of services (both medical and health and health-related) that their patients require, even in a national health insurance environment. This is particularly true in the case of those patients whose status may disqualify them from eligibility under the countryøs national health scheme (e.g., immigrant populations).

A third issue facing health centers is retention of staff. As is the case in the U.S., health centers in many countries see the poorest and sickest patients. As a result staff frequently feel

[4] One study that used medical underservice formulas to calculate the number of health centers in the U.S. in relation to need found that at the funding levels in place at the time, health centers were able to serve only 15 percent of all persons in the U.S. at risk for medical underservice (Hawkins et al, 1993). Since that time funding levels have increased, but in real dollar terms, current health center grant funding levels stand at the same point at which the program was funded 20 years ago (Rosenbaum et al, 2000)

overworked and subject to high levels of stress. Moreover, the demanding nature of the care and relatively low pay makes retention of physicians and other clinical professionals difficult (Blair, 1999; WHO, 1997; Aoyama, 1996).

A fourth problem that is evident in the literature -- and again, one that is not uncommon in the U.S. -- is the limited understanding among the general public (and often among policy makers) of the role of community health centers in the health system, and inadequate cooperation from local and central governments. The literature suggests that health officials view this lack of political support at the community level as one of the signficant causes of the under-financing of health centers (Blair, 1999; WHO, 1997).

Implications and Conclusion

In the U.S., where the number of uninsured persons remains extremely high, health centers are widely viewed as an efficient means of underwriting the cost of basic health care for an uninsured population. Although there is extensive literature on health centersô impact on health care access and health outcomes among lower income and vulnerable populations generally, the primary focus of American policy makers is on the role of health centers as a form of health care financing support for the uninsured. Consequently, less attention has been given to their impact on health care access and quality, which, in a context of health services research, is a separate matter.

As a result of this emphasis on the financial underwriting role of health centers, a somewhat strange dynamic has developed in public policy debates in the U.S. On the one hand, proponents of national health insurance frequently tend to perceive programs such as public clinics and hospitals as undermining, rather than enhancing a national health reform effort because as a source of financial support for the uninsured, they may diminish policy makersô perceptions of the importance of a national health scheme. Ironically, those who work at or advocate for health centers or similar entities in the U.S. have historically been among the strongest proponents for insurance coverage expansions. Persons who see the struggle to secure adequate health care for uninsured persons are, if anything, particularly aware of the inability of modest grant-based funding to make more than the most limited incursions into financial barriers, particularly with respect to inpatient and specialty care, which are utterly beyond the financial capabilities of even the largest health centers. For proponents of health centers, improved health insurance remains a primary, not a secondary, U.S. policy goal.

At the other end of the spectrum in the national health policy debate are representatives of some (but by no means all) organizations representing private practitioners and health care institutions, as well as advocates of market remedies to social problems. These two groups, for different but related reasons, perceive health centers as no longer necessary in a world of expanded health coverage. Both groups tend to see health insurance as a complete correction for diminished access, because their analysis of the problem identifies financial barriers as the sole impediment to care. In addition, of course, professional societies with a natural interest in the economic opportunities of health care, do not want to lose insured business to competitors whenever they can avoid it.

Furthermore, certain health professionals view continued support for health centers and similar entities as a professional issue, since the existence of this alternative approach to the organization and delivery of medical care can be understood as an admission of the weaknesses of ñmainstream medicineò in the case of populations whose health status, place of residence, cultural identity, and other attributes, place them outside the ñnormò as defined by organized medical societies. The history of the U.S. health centers program is replete with examples from the field of organized professional opposition to health centers. Moreover, the literature on the existence of these programs in countries with national health insurance constitutes a powerful reminder of the fact that these problems do not disappear under national health insurance. They are the product of the human frailties that produce exclusionary and discriminatory attitudes and conduct and are not a function of money alone. One need look no further than the history of racial segregation in health care in the U.S., as well as a multitude of studies of racial disparities in health care within insured populations in the modern health system, to understand why insurance alone is not the cure.

The studies identified in this literature review underscore the ongoing need for health centers and similar programs, not as diversions from but as a means of enhancing and securing the promises of, a national health insurance scheme. To be sure, the expansion of insurance raises significant budgetary and practical issues for the operation of health centers that would merit resolution. Do higher levels of third party coverage diminish the need for direct operational subsidies for the uninsured? Should these funds remain for reinvestment in uninsured services or investment in additional communities with inadequate sources of care? How does the role of

publicly supported health care providers change in the context of expanded insurance coverage? Can these providers take on additional responsibilities that enhance access and health status and that would have been impossible in the absence of improved coverage (for example, closer collaboration with health professionals in private practice settings)? These are all legitimate and necessary questions that would arise in the context of insurance expansion. Yet none of them suggests that there is no need for health centers and similar providers ï only an evolving role in a changing health system.

Producing a well functioning ï and more importantly, perhaps, a just ï health system goes beyond the extension of insurance coverage. The development and operation of primary health clinics ï even high quality programs ï can never substitute for comprehensive coverage and should not be put forth as a substitute. At the same time, the studies examined in this synthesis underscore the continued role of publicly supported programs, even in nations with universal health coverage, an indication of the fact that health care financing alone is a critical, but not the only, determinant of health care access.

References

AbelinT., Ackermann U., The Role of Local Health Departments in Reducing Inequalities in Health in Switzerland, Gesundheitswesen, 1998, 60(11):622-625

Aoyama H., Background and Prospects of the Community Health Act, Japanese Journal of Hygiene, 1996, 50(6):1026-1035

Balliss E., Logan P., Primary Health Care for Homeless Single People in London: A Strategic Approach, Working Party on Single Homelessness in London Health Sub-Group, 1987

Baum F., Kalucy E., Lawless A., Barton S., Steven I, Health Promotion in Different Medical Settings: Womenôs Health, Community Health and Priavate Practice, Australian and New Zealand Journal of Public Health, 1998, 22(2):200-205

Blair L., Cutting and Pasting in Quebec, Canadian Family Physician, 1999, 45:261-264

Brand H., Schmacke N., Social Inequalities and Health: The Role Played by Local Health Departments in Germany, Gesundheitswesen, 1998, 60(11):626-631

Broom D.H., The Best Medicine: Women Using Community health centers, Australian and New Zealand Journal of Public Health, 1997, 21(3):275-280

Campbell Forester S., Health Centers as Community Development Centers, World Health Forum, 1998, 19:353-354

Ejlertsson G., Berg S., Continuity of Care in Health Care Teams. A Comparison of Continuity Measures and Organizational Solutions, Scandinavian Journal of Primary Health Care, 1985, 3(2):79-85

Gardemann J., Mashkoori K., Health Situation of Refugee Children in Munster, Gesundheitswesen, 1998, 60(11):686-693

Haglund B.J., Research and Development Work in Primary Health Care in Sweden, Scandinavian Journal of Primary Health Care, 1985, 3(2):107-112

Hawkins, D., and Rosenbaum, S., *Lives in the Balance* (National Association of Community Health Centers), Washington DC, 1993

Hawkins, D., and Rosenbaum, S., "The Challenges Facing Health Centers in a Changing Healthcare System," in The Future U.S. Healthcare System: Who Will Pay for the Poor and Uninsured, Health Adminisration Press, Chicago, 1998

Hansagi H., Calltorp J., Andreasson S., Quality Comparisons Between Privately and Publicly Managed Health Care Centers in a Suburban Area of Stockholm, Sweden, Quality Assurance in Health Care, 1993, 5(1):33-40

Institute of Medicine (IOM, America's Health Care Safety Net: Intact but Endangered, Washington, DC, 2000

Kahssay H.M., Health Centers - the Future of Health Depends on Them, World Health Forum, 1998, 19:341-347

Kaiser Commission on Medicaid and the Uninsured, Enrollment in Medicaid and S/CHIP: A 50-State Report, 1997 - 1999, Washington, DC, 2000

Kaiser Family Foundation, Options for Expanding Health Insurance Coverage: Report on a Health Policy Roundtable, Menlo Park, CA, 1999

Kearns R.A., The Place of Health in the Health Place: The Case of the Hokianga Special Medical Area, Social Science and Medicine, 1991, 33(4):519-530

Kent H., The Yukon Takes Native Health a Step Further at Whitehorse Hospital, Canadian Medical Association Journal, 1999, 161(10):1312-1313

Lanz A., Sempach R., Scholz G., Evaluation of Contact and Care Centers, a Low-Threshold Daytime Source in the City of Zurich, Sozial ï und Praventivmedizin, 1996, 41(1):S35-43

Lennie I.G., Conpeman R.C., Sangster A., Factors Enhancing and Inhibiting the Development of Primary Medical Care in Community Health Centers, Community Health Studies, 1990, 14(2):108-117

Mackenzie G., Currie B.J., Communication Between Hospitals and Isolated Aboriginal Community Clinics, Australian and New Zealand Journal of Public Health, 1999, 23(2):204-206

Marklund B., Bengtsson C., Medical Advice by Telephone at Swedish Health Centers: Who Calls and What are the Problems?, Family Practice, 1989, 6(1):42-46

McNaught A., Managing Community Health Services, Chapman and Hall, 1991, London

Pepper A.D., Health Centers as Healthy Living Centers, World Health Forum, 1998, 19:354-357

Power R., French R., Connelly J., George S., Hawes D., Hinton T., Klee H., Robinson D., Senior J., Timms P., Warner D., Health, Health Promotion and Homelessness, BMJ, 1999, 318(7183):590-592

Rodriguez P.M.A., Cerda M.J.C., Femandez L.L.A., The Quality perceived by the Users of Health Centers and by Private Insurance Companies, Atencion Primaria, 1999, 24(5):259-266

Rodriguez R., Frohlich K.L., The Role of Community Organizations in the Transformation of the Health Services Delivery System in the Montreal Metropolitan Area, Canadian Journal of Public Health, 1999, 90(1):41-44

Rosenbaum, S., Shin, P., and Markus A., Health Centers' Role as Safety net Providers for Medicaid Patients and the Uninsured, Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 2000

Snowdon J., Uncleanliness Among Persons Seen by Community Health Workers, Hospital and Community Psychiatry, 1987, 38(5):491-494

Tollman S., Health Centers as Part of a Learning System, World Health Forum, 1998, 19:357-360

U.S. Bureau of the Census, Report on Health Insurance Coverage for all Americans, Washington, DC, 2000

Vehvilainen A., Kumpusalo E.A., Takala J.K., Drinking Problems Load Health Center Hospitals in Finland, Scandinavian Journal of Public Health, 1999, 2:143-147

Wakerman J., Field P., Remote Area Health Service Delivery in Central Australia: Primary Health Care and Participatory Management, Australian Journal of Rural Health, 1998, 6(1):27-31

World Health Organization, World Health Forum, 1998

World Health Organization, Improving the Performance of Health Centers in District Health Systems, WHO Technical Report Series, 1997 No. 869

World Health Organization, The Health Center in District Health Systems, Geneva, 1994 (unpublished document WHO/SHS/DHS/94.3)

World Health Organization, The Role of Health Centers in the Development of Urban Health Systems, WHO Technical Report Series, 1992 No.827