The Role of Public Health in Providing Primary Care for the Medically Underserved

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This paper is an expression of the authors' views and does not necessarily reflect opinions of the Health Resources and Services Administration or the AmHS Institute.

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Synopsis

Strategies designed to meet the health care needs of Americans should include the issues of access as well as financing. And primary care and clinical preventive services should receive as much national attention as acute care and long-term care. The public health system at the Federal, State, and local levels with its mandate to assure conditions in which people can be healthy must also be incorporated into the national debate. Publicly funded infrastructures for delivering primary health care have become a significant element of assuring access at the community level.

This paper examines the expanding role of public health in assuring access to the delivery of primary health care and clinical preventive services to vulnerable populations within the larger issue of who should have access to care and how it should be made available. Special attention is paid to the part played by the Health Resources and Services Administration (HRSA) of the Public Health Service, which, in the Federal fiscal year that began on October 1, 1989, administered some $1.8 billion worth of programs for health care of targeted populations and for the support of training in the health professions.

ESTIMATES VARY as to the number of Americans without health insurance—either public or private—but the consensus is that it exceeds 30 million and has increased significantly over the past decade.

Quite often, the uninsured "fall between the health care cracks" because even though they are employed with incomes exceeding the Federal poverty level, they lack the economic resources for private health care.

It can be unavailable to the uninsured and, in many cases to the insured as well, because they live in areas where practitioners are scarce and health care services are nonexistent, limited, or sporadic in nature. A substantial number of the uninsured are poorly educated, live in substandard housing, lack job skills, and belong to racial minorities. For these people, health problems become just one more burden along with personal limitations and inadequacies of community systems.

In many cases and many places, publicly supported health care systems are providing needed primary and preventive health services for people with or without health insurance who are prevented from getting them.

In its landmark report on "The Future of Public Health" (*1*) the Institute of Medicine (IOM) concluded that "... the ultimate responsibility for assuring equitable access to health care for all, through a combination of public and private sector action, rests with the Federal Government." IOM also concluded that, until adequate Federal action is forthcoming, public health agencies must continue to serve, with quality and respect and to the best of their ability, the priority personal health care needs of the uninsured, the underinsured, and Medicaid clients.

In addition to the problem of access to health care for the indigent, several other current public health problems which "can be averted or lessened only through collective actions aimed at the community in contrast with personal medical services initiated by patients or individual practitioners" were identified by the IOM report. Included on the IOM list were the AIDS epidemic, injuries, teen pregnancy, control of high blood pressure, smoking, and substance abuse.

In concluding that public health agencies must continue to serve the priority personal health care needs of vulnerable persons "until adequate Federal action is forthcoming," the IOM report raises some interesting questions:

"If there is adequate Federal action—meaning a new financing arrangement for an insurance strategy—will the function of State and local public health departments for personal health care no longer be needed? What of the public health functions for community assessment, comprehensive policy development, and

assurance of health benefits?''

Declaring that the ultimate responsibility for assuring access to health care rests with the Federal Government, the IOM report raises interesting constitutional point on the ultimate responsibility of the individual States for assuring access to health care.

Operation of the Public Health System

The public health infrastructure operates directly or through the subsidization of facilities and staff. The maternal and child health clinic operated by a county is part of the public health infrastructure as is the private nonprofit migrant health center funded primarily by government monies or a National Health Service Corps physician assigned to a frontier community. The fees for services are usually flexible, based on a patient's available financial or insurance resources. Recipients often pay nothing if the service provides a community benefit such as prevention of certain diseases through immunization.

Because public health is part of government, health services can be incorporated with other public social services such as housing, transportation, employment counseling, and other nonhealth assistance required by multi-problem population groups. Unfortunately, such coordination of needed services does not always occur.

The Institute of Medicine report describes the American system of public health activities as being in ''disarray'' because the nation has lost sight of its public health goals. The report states:

> An impossible responsibility has been placed on America's public health agencies: to serve as stewards of the basic health needs of entire populations, but at the same time avert impending disaster and provide personal health care to those rejected by the rest of the health system. The wonder is not that American public health has problems, but that so much has been done so well, and with so little.

With all its perceived flaws, today's public health system has the capacity to reflect local and State problems, resources, and unique characteristics. Programs to assist the medically disadvantaged can be tailored to meet location-specific needs in a manner which is culturally and socially appropriate. Consequently, programs are likely to be better designed to meet the needs of those that they are intended to serve if decisions on implementation are left to those responsible at the local level. Ultimately, as part of government, the public health system can and should be accountable to all the people.

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Federal Role in Public Health Care Delivery

Federal involvement in the public health care delivery system is critical to provide resources and leadership for concerns that cross local boundaries and State lines. Federal resources have in the past and should continue to assist States and communities in efforts to expand their capacity to provide direct primary and preventive care for the medically underserved.

Although the Federal Government has been involved with the delivery of health care since the founding of the nation, this care had usually been directed at entitled groups (merchant seamen, Native Americans, military personnel, members of Congress, and so forth) and at controlling perceived epidemics, such as smallpox, tuberculosis, yellow fever, and, more recently, AIDS.

Substantial and categorical Federal support for the delivery of health care to poor and vulnerable Americans began 50 years ago with the enactment of maternal and child health legislation. In the intervening years, other Federal efforts to improve local health care capacity focused on facilities (Hill-Burton Program for hospital construction), systems (health maintenance organizations and community health planning) and financing (the Kerr-Mills Act, Medicare, and Medicaid).

In enacting the gigantic Medicare and Medicaid programs, the Federal Government assumed for the first time a major comprehensive role in American health care. This change seemed to inspire other national initiatives. Early programs of the War on Poverty, such as Head Start, found serious untreated health problems among the participants. Patton (2) describes how the neighborhood health center model grew in response to the needs of the poverty program participants. The federally funded centers were to provide comprehensive health, social, and environmental services, train and employ community residents in the centers, and involve local residents to the extent possible in community

development and policy making for the center. The special needs of migrants who had both untreated health problems and often lacked needed residential eligibility status stimulated the establishment of migrant health centers.

The Role of HRSA

Among the eight component agencies of the Public Health Service, the mission of the Health Resources and Services Administration (HRSA) is to assure the support and delivery of primary health care services and the development of qualified health professionals and facilities to meet the health needs of the nation. HRSA has the responsibility of managing most of the Federal efforts concerned with the provision of primary health care to vulnerable populations. These include the Maternal and Child Health block grants, the Community and Migrant Health Center Programs, the National Health Service Corps, the Comprehensive Perinatal Care Program, the Health Care for the Homeless Program, and the AIDS Prevention and Treatment Programs for HIV-infected persons.

The $1.8 billion annual funding level projected for these HRSA programs in Fiscal Year 1990 (*3*) provides a sense of the size and scope of this Federal effort. It is much more difficult to estimate how many people are served by HRSA programs. For instance, the Maternal and Child Health block grants, now funded at a level of more than half a billion dollars and administered usually through State and local health departments, is intended to serve at least 20 million people.

Almost 6 million people are seen annually in community and migrant health centers. In addition, it is estimated that 230,000 people were helped in the first year of operation of the Health Care for the Homeless Program.

Of equal importance to the numbers served has been the impact on the health care status of the persons served by these programs. A data book issued in 1989 by the National Association of Community Health Centers, Inc. (*4*) points out that community health centers

- promote the use of preventive health care and reduce reliance on emergency rooms,
- improve the health of communities they serve, and
- provide high quality care.

With responsibility for a complex array of multiple health services, programs for training health professionals, and State support programs, HRSA can be viewed as a "holding company" for disparate legislative initiatives in health care. In an effort to achieve efficiency and improve the quality of care to the medically underserved for whom most of its programs are intended, the Agency has undertaken a number of ventures to coordinate its various programs with other related Federal, State, and local efforts. Cooperative projects between community and migrant health centers and local and State public health programs are one way to build on what is in place and thereby offer a speedy and efficient channel for expanding health care for the growing number of medically underserved Americans.

Two principal HRSA tools which facilitate such coordination are grants to primary care associations and cooperative agreements with States and Territories. There are about 41 such agreements at present. Their purpose is to establish a relationship in which the State leads in promoting an integrated public health system that provides more comprehensive primary care services to greater numbers of medically underserved people than would be possible otherwise.

Future Options for Public Primary Care

Even if the Congress adopts a broad national expansion of health insurance coverage, it is unlikely that all of the uninsured, underinsured, and the uninsurable will be covered. Important health care and related services are likely to remain uncovered, be too expensive (through high co-insurance or other insurance cost containment programs), and remain geographically distant from many in need. Services within this category include mental health and substance abuse treatment and clinical preventive services.

We are probably going to continue witnessing incremental expansion of current programs to serve those most in need. It makes sense that such expansion be based on what already exists and is working well. For this to happen, policy makers and the public need to understand what the government is already doing at the national, State, and local levels and then support the best efforts to assure delivery of health care to persons most in need. Expanded and new financing mechanisms alone are not sufficient. The public health approach, based on an understanding of community and individual needs and a legal responsibility to take action against barriers to good health, will be able to assure access to needed health care for all.

The various proposals for new Federal financing initiatives will not automatically make available the kind of managed care that is sensitive and cost-effective for certain vulnerable groups. They are likely to be best served by a protective health care system that is easily accessible, "user friendly," and reaches out to them. A look at today's homeless proves this point. Many of the homeless are eligible for a number of health programs. Their various personal, social, and health deficits, how-

ever, make it difficult for them to have access to customary systems of care. Often, health care literally has to be taken out on the streets to reach these alienated citizens.

Although State and local governments should carry the public sector responsibility for determining who is in need of what services and figuring out how to make them accessible, the Federal Government has a role to play in supporting States and localities to assure access to primary care for everyone. To accomplish this, further steps need to be taken to improve publicly provided primary health care. Two initiatives that have been advanced would involve new Federal legislation.

Some have proposed that the Congress call on States to establish a new health service authority which would take jurisdiction over several separate, pre-existing agencies. State programs for managing or funding health services would be placed within this new agency. It is argued that such an authority would provide incentives to the States to coordinate better the State and local traditional public health functions with federally supported providers such as Community and Migrant Health Center Programs and the National Health Service Corps.

Another proposal that would complement the authority idea is to bolster the capacity of States to address their basic health service needs. It envisions the creation of a Primary Care block grant, similar to the Maternal and Child Health, Preventive Health Services, and Alcohol, Drug Abuse, and Mental Health block grants. Created in 1981, these initiatives "bundled" multiple related Federal health programs and transferred management of them to the States. The intention was to locate management of federally-financed health services closer to the intended beneficiaries, delivery systems, and providers, as well as to regionally and culturally specific problems. By combining the management of related programs and reducing the number of burdensome Federal regulations, savings, efficiencies, and a higher quality of care were to be achieved at the State and local levels.

It is essential that a Primary Care block grant include provisions for community participation and sensitivity to local needs and characteristics that have been at the core of the success of the community and migrant health center program. In addition, sufficient funding should be available to allow States to maintain and increase levels of service where appropriate.

Conclusion

While others undertake the development of financing strategies for meeting the health care needs of Americans, it is important for public health—at the Federal, State, and local levels—to address the proper role of government in assuring access and delivery of health care to the medically underserved and to those persons whose health, finances, and other problems deter their taking advantage of private health care systems. So too is it government's role to address problems resulting from maldistribution of health care providers.

The ability and desire of States to be responsive to the health care needs of their most vulnerable citizens should not be underestimated in the national debate. The Public Health Foundation reports (*5*) that in Fiscal Year 1987 State health agencies spent $4 billion in State tax dollars on personal health services. The creativity and courage of State efforts within the last several years in addressing the issue of the uninsured is a firm foundation for future national efforts.

Strategies designed for meeting the health care needs of Americans should include access as well as financing issues. So too should primary care and clinical preventive services receive as much national attention as acute care and long-term care. Publicly funded infrastructures for delivering primary health care have become a significant element of assuring access at the community level. Public health is a partner to the private health care system that serves the majority of citizens with health insurance. It is essential that Federal policy makers work with State leadership in fully utilizing the public health primary care system as a unique, effective, and efficient means of reaching many of the Americans with the greatest health needs.

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