[Mr. SMITH of Michigan addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from California [Ms. PELOSI] is recognized for 5 minutes.

[Ms. PELOSI addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Pennsylvania [Mr. WELDON] is recognized for 5 minutes.

[Mr. WELDON of Pennsylvania addressed the House. His remarks will appear hereafter in the Extensions of Remarks].

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Connecticut [Ms. DELAURO] is recognized for 5 minutes.

[Ms. DELAURO addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Connecticut [Mrs. JOHNSON] is recognized for 5 minutes.

[Mrs. JOHNSON of Connecticut addressed the House. Her remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Minnesota [Mr. GUTKNECHT] is recognized for 5 minutes.

[Mr. GUTKNECHT addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

ON SOCIAL SECURITY

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from South Carolina [Mr. SANFORD] is recognized for 5 minutes.

Mr. SANFORD. Mr. Speaker, I have before you a bill that I introduced today. It is a bill that would put the worst insomniac in the world to sleep. I look here at 160 or 170 pages that by themselves are long and boring pages. And yet what this bill is about is, in essence, I think something that is very exciting. That is, I think that this bill, which is a bill to save Social Security, is a bill about the American dream.

Because if you were to stop and think about it, I think that what we would all agree upon is that a part of the American dream is tied to ending a lifetime of work with something more than just memories. And yet for many Americans, in fact, we pulled the number at home in my State of South Carolina.

Last year, about 38,000 people died and only about 243 filled out Federal estate tax returns, which says to me that something is wrong, because clearly for that small a number, 38,000 people died but 243 filled out Federal estate tax returns, which means in the eyes of the Federal Government they had accumulated enough in the way of assets to hold an estate that ought to be taxed. It says that something is wrong in fulfilling that part of the American dream that ties straight to ending a lifetime of work with more than something other than just memories.

What is interesting about that is that a lot of people are beginning to recognize it. It has been constantly something that comes up in my congressional district back in South Carolina. Folks say to me, both young and old, the young folks say, I do not think I am going to get my Social Security when I grow up or when I finish working or when I retire. Older folks are saying, what I am hearing from my grandson or my granddaughter is that they do not think they are going to get their Social Security. And not only is it being heard in essence from the right, I guess is where I come from, but from the left.

I mean somebody like Sam Beard, a person who I have been working very hard on this idea of saving Social Security. Sam Beard comes from the opposite political philosophy of my own. He was a staffer for Robert Kennedy. He spent his entire lifetime working, trying to do something about the inner cities. He thinks that one of the only ways that you save the inner city is with this idea of personal savings accounts, which is what is talked about in this bill.

Because right now, though April 15 is a big day, April 15 is really an insignificant day when you think about overall tax rates in this country, because for 70 percent of Americans, the largest tax that they will pay is not income tax but payroll tax. And with Social Security 12 percent or, to be exact, 12.4 percent comes right off the top, not on April 15 but on every single working day.

What the trustees have said is with that 12 percent that is going toward one's retirement plan, what they have said is that if we do nothing to save Social Security, it goes bankrupt in about 30 years and it begins running structural deficits in about 15, such that either you have to look at cutting benefits by about 14 percent or raising payroll taxes by about 16 percent.

Both young people and old people that I talked to at home in South Carolina say neither of those are great options. What the trustees have also said is that the overall rate of return for everybody working and paying into Social Security today is 1.9 percent. And that everybody born after 1948 will get a negative rate of return on their Social Security investment. Again, these are not numbers that tie to people being able to live out the American dream in their retirement years.

So either you can wait and do nothing, which might be the conventional political wisdom in Washington, or you can look at cutting benefits, which I do not think is acceptable, or you can look at raising payroll taxes, which I do not think is acceptable, or you can try one other thing. It has been tried around the world.

That is, letting people earn more than this 1.9 percent or more than this negative number on their Social Security investment. That is what this bill does. What it does is simply offers people a choice. Everybody above the age of 65 would simply stay on Social Security as we know it. But people below that age would simply have a choice. That is, if they thought Social Security made more sense for themselves and their families then they could continue to stay on Social Security as we know it. But if they thought it did not, they could, instead of having their payroll tax go to Washington, it could be redirected into their own personal savings account that they owned and controlled and got a monthly statement on.

That is not such a crazy idea because it has been a well-tested idea. It has been an idea that Great Britain has moved toward. It has been an idea that seven countries down in South America have moved toward. It has been an idea with 3.5 million workers in our own country that has been in essence tested. This is the beginning of a conversation about the American dream.

ACCOMPLISHMENT OF THE HEALTH CENTER PROGRAMS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 7, 1997, the gentleman from Illinois [Mr. DAVIS] is recognized for 60 minutes as the designee of the minority leader.

GENERAL LEAVE

Mr. DAVIS of Illinois. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my special order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Illinois?

There was no objection.

Mr. DAVIS of Illinois. Mr. Speaker, about 30 years ago, there emerged on the American scene, as a result of the civil rights movement, demonstrations, marches, protests, action on the part of the United States Congress, initiation of the war on poverty, there emerged a new set of health service delivery mechanisms, something that we today know as community health centers. They started out with the name neighborhood health centers as part of the OEO antipoverty program.

Every community that OEO would go into, making an assessment to look at the issue of poverty, there would always emerge the issue of a lack of

health care resources, the issue of there not being services available to the people who lived in inner cities and rural communities. As a result of that, these pioneering centers came on the scene.

Today I rise to underscore that they are indeed a vital component of our health care system and one that focuses on providing the access to primary and preventive health care services that coverage alone cannot assure. As we all know too well from our experience over the years with Medicaid, the possession of an insurance card will not necessarily guarantee Americans access to health care. Nowhere is this more true than in our inner city and rural, medically underserved communities.

I had the good fortune of taking a job at the Martin Luther King, Jr. Neighborhood Health Center in the City of Chicago as its director of training, which sharpened my interest in health care, and ultimately continued to work in that area and had the good fortune to see the emergence and development of this group of inner-city, rural migrant health programs throughout the country, got involved and eventually became, after the group had developed, a national association which even to this day still exists, is very vibrant, viable and a valuable part of the American health care delivery system.

Every place that we went we found that underserved communities desperately need the health care system to deliver three things:

One, the presence of a medical home that offers high quality care regardless of a person's health or social status or his or her ability to pay for services and that is accessible in terms of location of hours of service for those who do not have private transportation or cannot take time off from the workday.

Second, adequate numbers of highly trained, culturally competent health professionals to staff these facilities; and, thirdly, the assurance that their medical home will not be driven out of business due to excessive financial risk or inadequate reimbursement simply because they care for those who are the sickest and hardest to reach.

I strongly believe that our health system should be built and should build on what works. Among the programs that have worked best for the underserved are the community migrant and homeless health center programs. Over the past 30 years, these centers have established an unparalleled, uniquely successful record of providing quality, cost-effective primary and preventive care to the hardest-to-reach populations across the Nation, recruiting and retaining health professionals where they are most needed and empowering communities to develop long-range solutions to their health needs.

Health reform should invest in such success by preserving and building upon these programs in preparation for the implementation of reform so that universal coverage will truly guarantee access to quality care for everyone.

One of the things that I liked best about the community health center movement is that they have spurred the development of so many individuals. I am certain without a doubt that I would not be standing here today as a Member of the United States Congress had I not gotten involved with the community health center movement in my community that not only brought services, but also provided opportunities for individuals to be trained, for individuals who had never been in the health business to develop careers.

I remember some of the great training programs that the association developed where individuals could go off to the University of Michigan and acquire a master's degree in public health on the weekends while working in their local centers.

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Or they could go out to the University of California for six-week periods at a time and acquire Master's degrees in health administration while retaining the job that they had back in their local communities.

So I am so pleased that one of the real people who have seen these developments is also here to join with me this evening, in the person of the esteemed Representative from the State of South Carolina [Mr. CLYBURN]. We will be delighted to have him join and share with us.

Mr. CLYBURN. Mr. Speaker, I am pleased to be here this evening with my good friend, the gentleman from Illinois [Mr. DAVIS] and to thank him for all of his historical work in the field of community health centers.

I want to say to him tonight that one of the most pleasant things for me to find out was, as I was working my congressional district a few months ago, to find out from so many of my constituents that he is considered a real hero among the people in this field. I am honored that he has asked me to join with him tonight in this special order.

Community health centers have long been the sole means of medical attention for millions of Americans. For that reason alone, we should be very careful to afford them the resources needed to continue their services. Community health centers offer a wide range of services, including dental care, health education, community outreach, transportation, and various support programs. In many communities, health centers work in collaboration with other organizations such as the local schools, Head Start programs, and homeless shelters, just to name a few.

As events of the past few days have proven, many of us are driven by numbers, so let me share some numbers with you concerning community health centers of the last year alone. Nine hundred forty community health centers served almost 10 million people nationwide. In my home State of South Carolina, there are 17 community health centers which are private, not-for-profit businesses owned and run by the local communities.

In 1996 they provided primary and preventive health care services at more than 60 locations. These health clinics served more than 152,000 patients, many of whom would not have otherwise received medical care. More than 50,000 children, 85,000 adults, and 15,000 elderly South Carolinians depended on the health professionals in their community health centers for their medical care and made over a half million visits to them.

In the Sixth Congressional District, which I am proud to represent, there were over 68,000 people in community health centers last year. Many of these people are children, some pregnant women, many uninsured, many minorities, many from rural areas, many from low-income households, and many Medicaid recipients.

In my district, the Franklin C. Fetter Family Health Center in Charleston County had over 100,000 visits last year, the highest in the State. Another center in my district, the Family Health Center, Incorporated, in Orangeburg, served over 34,000 individual patients, another record high in the State.

Now, I share these numbers with my colleagues to illustrate the value my constituents place on these local health centers. Nationwide, over 50,000 people are employed in community health centers. In South Carolina, that translates into more than 900 jobs and over $53 million being pumped into the State's economy. There is tremendous return on our investment in health centers. Every $100 million invested brings an additional $200 million in other resources into our communities. I think that my colleagues will agree with me that that is an investment worth making.

Mr. Speaker, community health centers play a vital role in our Nation, our States and, more importantly, in our local communities. I am pleased to join tonight with my good friend the gentleman from Illinois [Mr. DAVIS] to ask that this Congress continue to work toward the adequate funding of these unique and vital community institutions.

I thank the gentleman for allowing me the time.

Mr. DAVIS of Illinois. Thank you so much. I really appreciate your being here.

You mentioned Franklin C. Fetter. I remember when that center started, and I remember that it had a director who was there for a long period of time, just an outstanding gentleman. I am thinking of people that I knew then in South Carolina, like Georgia Goode and Tom Barnwell, I mean, people who were so committed and so dedicated and gave so much of themselves to make sure that these centers got started and that they continue.

Who was the gentleman I am trying to think of?

Mr. CLYBURN. Mr. Speaker, if the gentleman will yield, he may recall that that movement in South Carolina started with an effort in Beaufort County, the Beaufort-Jasper Comprehensive Health Care Center. That occupied significant amounts of our time trying to pull all of that together, and it finally got put together. Tom Barnwell, as you know, for many, many years directed that effort. It came about because Senator HOLLINGS took it upon himself to go and visit rural Beaufort County and drew the Nation's attention to the health care problems in rural South Carolina.

When that attention was focused, a lot of people were a bit upset, thinking that this was a negative for Beaufort. But when the Congress saw, it responded, and what looked like a negative turned out to be a tremendous positive not just for Beaufort County, but then it moved from there to Franklin Fetter.

I think my colleague may be talking about Dr. Leroy Anderson.

Mr. DAVIS. Dr. Leroy Anderson.

Mr. CLYBURN. He directed that for a long period of time, and of course the Franklin Fetter Center started out working with migrants. It was my opportunity to serve for a number of years as the director of the South Carolina Commission for Farm Workers, and of course part of our work was on James Island and Johns Island and Yonges and Edisto Islands, trying to work with migrants who came into the area following the stream up from Florida, as well as seasonal farm workers. We found tremendous health needs among this rural part of Charleston county.

Of course, Franklin Fetter was born there, and from there it has moved to Charleston's east side to focus on the urban aspects of these problems. The center is still there, enjoying a tremendous work and, of course, working with us now, we are about to establish a similar center in north Charleston. Thanks to the mayor and the council of north Charleston there, they have come forward to provide the building for us to put the center in.

When we see these kind of efforts, it is not just about health care, it is about getting communities to work together, getting people to focus on needs that go beyond health, health being the method by which we get them organized. I think that your work with my friends in South Carolina, and of course I better mention, because also in my district, in fact, I spent last Saturday afternoon with the people in Eastover, where we have a similar center. Mr. Brown, who directs that, they were very pleased with the recent grant they got to help with their work.

So I want to thank my colleague because, as I move throughout the district, I am amazed at the number of people. I am glad he lives in Illinois. Do not move to South Carolina, because I find it a little bit difficult, people think so much of you there for the work that you have done in this field.

I think that health care is so fundamental to everything that we do, so I want to just thank my colleague for all that he has done.

Mr. DAVIS of Illinois. Mr. Speaker, reclaiming my time, the gentleman from South Carolina [Mr. CLYBURN] is just so on target, and again, I want to compliment him. I also want to compliment him because we recently just finished an outstanding legislative weekend of the Congressional Black Caucus, and he was the chairperson of that activity. Every place that I go back in my district in Chicago and out in the suburban areas and throughout the country, there are people who tell me what an outstanding weekend they thought it was, and I always say to them, ''Well, one the reasons is the fact that we had an outstanding chairman.'' So I commend him for that.

Mr. CLYBURN. Thank you.

Mr. DAVIS of Illinois. My colleague jogged my memory, he started talking about Dr. Anderson and I remembered other people, like Dr. Stephen Joseph; Jack Geiger; Count Gibson; Jerry Ashford out of Boston, who became the first director of the association; Dr. Sam Rodgers from Kansas City, where they eventually named a center there for him; Dr. Charles Swett out of Chicago; Clifton Cole out of Los Angeles, who became the first president of our association; Dr. Batcheler from Detroit; a woman named Earline Lindsey out of Chicago; another lady, Delores Lindsey out of Cincinnati; and Pepper Jacques out of Detroit; and Eloise Westbrook from out in San Francisco; and Harvey Holzberg out of New York; and Tom van Koffenen, who now directs the association, who came on and has been there I guess now 25 years or so, continuing to advocate, continuing to develop, to plan, to orchestrate and to provide technical assistance and help these centers to grow.

Because even though we have experienced a tremendous amount of success, there are still 43 million medically underserved people in this country, and these are people who do not have adequate access to health care services and often have poor health status. It is critical that health reform include special measures to meet their needs if our goal of cost containment is to be realized.

The underserved are exactly the ones who end up on emergency room doorsteps. Studies have shown, for example, that up to 80 percent of emergency room visits in underserved visits are non-urgent care. If the underserved do not have their preventive and primary health care needs met in health reform, then our goal of cost containment will be unattainable.

Health centers have shown that we give top quality care and constrained cost for our communities. For example, inpatient hospital admission rates for health center patients have been up to 67 percent lower than for those served by other providers, including hospital outpatient departments or private physicians. I do not know if you can get much better than that.

The length of stay for hospital patients served by health centers has been found to be only one-third as long as that for patients who are seen by outpatient departments and half as long as that of outpatients served by private physicians. Studies have also shown that regular use of a health center has produced a 33-percent savings to Medicaid on both per case and per person yearly basis. This is for total costs for all services.

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Health centers are among the few Federal programs that empower communities to craft long-range solutions to their health problems. By law, of course, health centers must be governed by a board of directors, a majority of whom must be patients of the facility. Only through the health center programs are consumers in the driver's seat of their primary care delivery site. And only through health centers are underserved communities assured that their primary care provider will respond to their specific needs. It is for these reasons and others that health centers have attracted such broad bipartisan support.

Virtually all major health reform proposals introduced in the Congress over the past few years have included funding and other provisions for community health centers. That means that a majority of the Members of this House, whether they be Democrats or Republicans or Independents, have stated that they think health centers are the best hope for addressing the needs of the underserved populations. When it comes to access to care, health centers are something we can all support.

Most of these legislative proposals have called for efforts to respond to the needs of underserved Americans in 3 very important ways. First, they have called for an expansion of the community health center program, including flexible authority to make grants to other community based providers and to establish community owned and operated networks and plans consistent of safety net providers.

Secondly, they have included provisions encouraging managed care plans to include health centers in their provider networks and to make sure that these providers are not put at undue risk. This will preserve the existing safety net primary care infrastructure in underserved areas and assure their full participation in the new health system.

Thirdly, they have encouraged the inclusion of health centers in health professions education and training. This will ensure that primary health care professionals are trained and practice in underserved areas where they are most needed. This is a critical point in the history of the health center movement. It demonstrates that to get health care to the people who cannot afford it, the Federal Government

must chip in a critical share. It comes in the form of health center operating grants. The best action we can take for those health professionals who want to give something back to their communities is to ensure a broad base of federally assisted community based providers in underserved areas. This will give these professionals a place to train and practice with the quality care environment and all the supports they will need.

The health centers in my home State are all jewels. As a matter of fact, they are indeed worth their weight in gold. They are cost effective, responsive to community needs, and the patients just love them. I cannot think of much more that we could ask of a group of providers. And so I would certainly want to urge this Congress and all of my colleagues to continue to provide the support that has been provided over the years and let us continue with one of the most effective programs that we have ever seen for the provision of quality comprehensive health care to large numbers of poor people in this country.

I really thank the gentleman from South Carolina [Mr. CLYBURN] for sharing. It is also an indication of caring. If the gentleman has got some other comments, please go right ahead.

Mr. CLYBURN. I thank the gentleman so much. I am just pleased to be a part of this because, as we have discussed in passing, this is something I very much have been involved in over the years. I was just so pleased to find that the gentleman had such a rich and hands-on involvement. To have someone like the gentleman as an advocate in this area is something that makes me feel much more comfortable with our efforts. I just want to thank the gentleman for letting me be here tonight to join with him and to call upon our colleagues to continue this great work.

Mr. DAVIS of Illinois. I thank the gentleman. I will just make a little special recognition to a few of the community health centers that operate in my district. I always say that I have the most fascinating district in the United States of America. These people have simply gone above and beyond being just good providers of primary care.

For example, under the tireless leadership of Berniece Mills-Thomas, executive director of the Near North Health Service Corporation which provides primary care to women, infants, school age children and their parents, we have seen that infant mortality has gone down significantly in the area that they service around Cabrini Housing Development. Actually they have reduced infant mortality over the years from 26.6 per 1,000 live births to now 12.8 per 1,000 live births. That is an outstanding indicator of the impact, of the effectiveness.

The Winfield Moody, I can remember traveling around the country with Mrs. Moody as they were getting that community's health center started. And we have the Erie Family Center under the strong leadership of Rupert Evans, who is the executive director. This center has done an outstanding job of providing care to the communities in and around it, Humboldt Park, West Town. Plus the Erie integrated care program is the only bilingual primary care provider serving HIV and HIV/AIDS infected patients in the city of Chicago. They have a great pediatric program.

We also have a number of other centers, such as the Daniel Hale Williams Center, the Mercy Diagnostic, the Sinai Family Centers, which just received a substantial grant of $8 million not very long ago to continue its great work, the Alivio Medical Center, Circle Family Center, the Mill Square Health Center, Komed, New City, the Cook County Network. All of these are centers that provide not only the best of care but also opportunities for people to work, for people to have jobs, for people to plan, for people to serve on the boards of directors, to make decisions, to decide what their neighborhoods and communities will be.

And so in its 30th year, I just thought that this would be an excellent time to stop and pause and pay tribute to this great group of centers that are operating and remember some of the individuals who made it happen, people out of New York like Paul Mejias and Janice Robinson, Curtis Owens from Philadelphia, Dan Cantrell from Chicago, Dave Simmons from Boston, Aaron Shirley from Jackson, Mississippi, Melba McAfee from Jackson, Mississippi, and other people from all over the country. I just hope that some historian who has been involved in the efforts is writing a history so that 100 years from now when we look back and look at where health care has come and look at our health care delivery systems, we will recognize the tremendous role that the community health center movement has played.

Mr. Speaker, I would like to include some additional documents here that I would like to insert:

''The American Health Care Revolution and the Critical Role of Health Centers.''

''Health Centers Are Unique in Structure and Mission.''

''Why Health Centers Work for the Nation.''

''Community, Migrant & Homeless Health Centers.''

''And from the Bureau of Primary Health Care, its depiction of what the health center movement has meant to primary care services in the country.''

''The material referred to is as follows:

THE AMERICAN HEALTH CARE REVOLUTION AND THE CRITICAL ROLE OF HEALTH CENTERS

A revolution in the American health care system is well underway and by all accounts will dramatically transform that system over the next few years. More than two-thirds of privately-insured individuals, or 120 million people, are already enrolled in some form of managed care, with continuing substantial annual increases in managed care enrollment.[1] This revolution has been driven by employers' and insurers' demands that costs be held down or even reduced, and that providers share financial risk. Managed care plans have willingly complied with those demands, bargaining for significant reductions in provider charges or rates. Though doubts continue to persist as to the long-term ability of managed care systems in holding down health care costs, data from 1994 and 1995 show medical cost inflation rates in the single digits for the first time in over a decade. Clearly, the era of open-ended, fee-for-service medicine is over.

While public insurance programs have moved more slowly, they too—especially Medicaid—are now outpacing the private sector in their rates of managed care enrollment. In 1990, a little over 2 million Medicaid beneficiaries were enrolled in managed care plans; that number jumped to an estimated 11 million by the end of 1995[2]. Most of that growth has been accomplished through the use of Medicaid waivers, which the current Administration has granted to more than a dozen states under Section 1115 of the Social Security Act, allowing those states to bypass Medicaid law requirements in establishing state managed care initiatives and other reforms. The recently-enacted Balanced Budget Act of 1997 contains far-reaching provisions that give states substantial flexibility to re-structure their Medicaid programs in order to enroll most of their Medicaid populations in managed care plans.[3]

Under the right circumstances, the American health care revolution can significantly improve both the availability and quality of health care for most Americans while containing costs by reducing the provision of unnecessary or inappropriate care. However, the success of both private market and public financing reforms could be significantly undermined if adequate attention is not given to two other key factors:

The recent acceleration in the use of Medicaid managed care raises questions as to whether the managed care industry has the capacity and infrastructure to absorb millions of patients who differ dramatically in socioeconomic and health status, education and health care needs from their traditional enrollees, and experience numerous barriers to access to health care services—making them among the most difficult-to-reach and needy patients in the health care system.[4] Medicaid beneficiaries and other low income Americans have higher rates of illness and disability than other Americans, and thus accumulate significantly higher costs of medical care.[5] By contrast, most managed care organizations have, until recently, principally focused their enrollment and infrastructure in reasonably affluent, healthy, well-educated suburban patient bases. Therefore, in implementing Medicaid managed care programs, states are moving millions of individuals into health care delivery systems which have had little experience in providing care to them. Without an adequate infrastructure, this difficult-to-reach and needy population may be denied access to basic health care.

At the same time, more than 43 million Americans have no health insurance and that number is rising by more than 100,000 each month.[6] A recent report found that the uninsured are almost twice as likely to lack a regular source of care, have fewer ambulatory visits, and have a higher rate of medical emergencies, than those who have insurance. They frequently depend on hospitals and emergency rooms for even basic care often due to severe shortages of appropriate primary health services in their communities[7].

Footnotes at end of article.

As more privately-insured Americans join managed care plans, and as plans increasingly demand maximum cost-efficiency from their providers, providers will be less able to provide care to individuals who are uninsured or whose insurer pays less than the cost of care that is provided (as is true of both Medicare and Medicaid today).

Clearly, the long-term success of the American health care revolution will depend upon steps to assure the availability, and encourage the use, of cost-effective preventive and primary health care for uninsured low income working families; and the key to the longer-term survival of managed care organizations will be the adequacy of their Medicare and Medicaid enrollees' access to lower-cost primary and preventive care, as well as their expertise in managing enrollee costs. To be successful in these efforts, the new American health care system and its managed care plans will need the resources and know-how of providers that have a history of cost-effective, quality service to Medicaid beneficiaries and other low income populations—providers such as America's Health Centers.

WHY HEALTH CENTERS?

For more than 30 years, Health Centers have served as ''managed care'' providers for publicly-insured and uninsured families. Nationwide, 2700 local health center service sites currently deliver preventive and primary health care to more than 10 million people—including 3.8 million Medicaid recipients, 1 million Medicare beneficiaries, and 4.2 million people who have no health insurance—in urban and rural underserved communities across the country. The underlying goal of the health center programs has been to help communities and their people to take responsibility for their health; toward that end, the programs have facilitated the flow of public and private resources, enabling the communities themselves to establish and operate health centers and to develop innovative programs to meet their health needs.

Health Centers have historically operated with very limited budgets and have developed considerable expertise in managing patients with significant health needs in low cost settings, providing access to primary and preventive health services. With literally thousands of communities across the country suffering from acute shortages of cost-effective preventive and primary health care service providers, with the numbers of uninsured Americans rising each month, and with cost controls making it increasingly impossible for other providers to continue offering care to those without coverage, health center programs are today, more than ever, critical to the success of the new American health care system. This is especially true because health centers:

Are, by law, located exclusively in rural and inner city communities that have been designated as ''medically underserved,'' because they have far too few ''front-line'' providers and poor health status indicators. I these communities, health centers are frequently the only available and accessible primary care provider.

Care for those whom other providers do not serve because of their high costs and complex health needs.

Offer high quality preventive and primary health care under one roof, in a ''one-stop caring'' system.

Have had a major impact on the health of their communities and provide care in a highly cost-effective fashion.

HEALTH CENTERS ARE A PRIVATE SECTOR ALTERNATIVE

Although health centers have a broad, prevention-focused perspective on many health problems, they are much like private medical practices, staffed by physicians, nurses, and other health professionals. They differ from private medical practices, however, by their broader range of services, such as social service and health education, and by their management structure. Health centers are owned and operated by communities through volunteer governing boards composed of leaders and residents of the communities they serve. They function as non-profit businesses with professional managers; purchase goods and services; provide employment; and make an economic impact within their community.

Because they exist to serve their communities, health centers are committed to seeking out and combining resources from a variety of sources to ensure that access to primary health care services is made available to all community residents, regardless of their financial or insurance status. Patients who can afford to pay are expected to pay. Medicare and Medicaid patients are always welcome. And insurance companies are billed on behalf of patients with coverage. The centers' Board and staff also work to obtain support from other sources, such as local governments and foundations, to ensure that care is available for all patients based on ability to pay.

In order to maximize limited resources, these private, non-profit community practices have developed community linkages with local health departments, hospitals, nursing homes, pharmacists and others to ensure that services are coordinated and to eliminate duplication of effort. Although some services may not be available on-site, the health center does coordinate care and referrals to other providers in a way that assures true ''one stop caring'' for its patients.

HEALTH CENTERS ARE FOUND WHERE THEY'RE NEEDED MOST

By law, all Health Centers must be located in and serve medically underserved areas and/or populations—and their 2,700 sites are split evenly between rural and urban communities. The residents of these communities suffer from the most profound shortage of accessible primary health care services and, not surprisingly, exhibit some of the most severe health problems and the poorest health status of all American communities.

More than 43 million people, living in these inner-city and rural communities, remain seriously medically underserved because of special needs or circumstances[8]:

They are overwhelmingly members of low income families, and are disproportionately young.

Many are uninsured, but 60 percent of them already have some form of insurance (including Medicare and Medicaid).

Many live and work in areas with too few providers of care, while others face serious non-financial barriers to care (such as language or physical disabilities), or have complex health and social problems.

In simplest terms, the medically underserved are people who can't get care when they need it, and when it is most appropriate—to prevent the onset of a health problem or illness, or to diagnose and treat a condition in its earliest stages—because of who they are, where they live, or because of their health status. Two recent reports found that, even when insured, these Americans continue to face significant barriers to care, especially to primary and preventive health services, and as a result have measurably poorer health outcomes and overall health status.[9]

HEALTH CENTERS SERVE THE MOST VULNERABLE OF ALL

Health center patients are almost universally among the most vulnerable of all underserved people in America today—persons who even if insured, nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, and their frequently far greater levels of complex health care needs:

Fifty percent reside in isolated rural areas; the other half live in economically depressed inner city communities.

Virtually all patients have family incomes below 200 percent of the federal poverty level ($28,700 annually for a family of four in 1994).

Nearly one in two is completely uninsured, either publicly or privately, and more than one-third depend on Medicaid.

44 percent of all patients are children under 18, and thirty percent are women of childbearing age (nearly one in ten is pregnant). Health centers delivered over 400,000 babies last year—10 percent of all births and 1 in 5 low income births[10].

Because of factors such as poverty or homelessness, and other social-environmental threats that permeate low income/underserved communities, health center patients are at higher risk for serious and costly conditions (such as asthma, tuberculosis, or high-risk pregnancies) than the general population, and require unique health services not typically offered by traditional providers, including most managed care entities.

HEALTH CENTERS ARE CLINICALLY EFFECTIVE

Health centers provide more than just care for illness or episodic conditions. They offer a ''health care home'' for all residents of an underserved area. Like any good family doctor's office, they provide ongoing care and health management for families and individuals through all life stages. Care is provided in the office whenever possible; physicians are on the medical staffs of their local hospitals; and referrals to other providers are made whenever needed.

Health center practices are staffed by a team of board certified or board eligible physicians, physician's assistants, nurses, dentists, social workers and other health professionals. In rural areas, physicians are typically family practitioners, while larger urban centers are usually staffed with interdisciplinary teams of internists, pediatricians, and obstetricians. Almost 98% of the more than 5,000 health center physicians are board-certified or eligible[11], and all are required to have hospital admitting privileges.

The hallmarks of effective primary health care are the entry point it provides into the entire system of care, its comprehensiveness, continuity, and responsiveness to the needs of the patients served. Because primary care must be patient-centered to be effective, it is not the same for everyone—one size cannot fit all. Local centers have developed special intervention programs for significant health care needs in their community, including strong obstetrical practices to fill a gap in their community or a special focus on patients with diabetes, or hypertension or AIDS. Many centers have developed special outreach programs to help overcome the cultural and language barriers faced by people who speak little or no English in obtaining primary health care access[12].

Centers also emphasize services designed to enhance the effectiveness of the medical care provided, such as community outreach, health/nutrition education, and case management. Some 98 percent of health centers offer health education services; over 90 percent offer case management services; more than three-quarters offer preventive dental services and in-house laboratory services. All health centers employ outreach and patient relations workers from the communities they serve[13].

Health centers are required by the U.S. Public Health Service (PHS) to update their

quality assurance program and health care plan in response to annual community need assessments, and are required to report to PHS outcome measures, including immunization rates, low birth weight reduction, hospital admission and length of stay[14].

Available literature provides extensive documentation of the quality and effectiveness of care offered by health centers, using factors such as patient health outcomes, satisfaction and health status of the community. These studies provide strong evidence that where there is a health center, the level of health of the community is dramatically improved. For instance:

Infant mortality: Communities served by health centers have been shown to have infant mortality rates from ten to forty percent lower than communities not served by health centers. The provision of health center services also has been linked to improvements in the use of prenatal care and reductions in the incidence of low birthweight[15].

Incidence of disease/hospitalization: Health centers have been shown to reduce rheumatic fever and untreated middle ear infections in children and have significantly increased the proportion of children who are immunized against preventable disease[16].

Use of preventive care: Health centers have increased the use of preventive health services such as Pap smears and physical exams[17].

Effectiveness of care: Health center patients have been shown to have lower hospital admission rates, shorter lengths of stay and make less inappropriate use of emergency room services[18].

Two recent (1994 and 1995) system-wide studies of thousands of Medicaid patient medical records in Maryland found that health centers scored highest among all providers for the proportion of their pediatric patients who had received preventive services, including immunizations; and that health centers consistently scored at or near the highest in 21 separate measures of quality assessment, even though their costs of care were among the lowest of the various provider types reviewed[19].

Health center patients are also overwhelmingly satisfied with their care and treatment. According to a 1993–1994 nationwide study of health center patients conducted by the Picker/Commonwealth Fund: 96% of health center patients were very satisfied or satisfied with the quality of their care; 97% would recommend the health center to friends and family; 95% receive regular health care services, even when they are not sick (preventive and primary care services); 87% have never had a concern or complaint.

HEALTH CENTER COST-EFFECTIVENESS IS SECOND TO NONE

Health centers are subject to ongoing Federal scrutiny of their cost-effectiveness and quality of care. Cost screens applied to health centers by the U.S. Public Health Service and the Health Care Financing Administration, such as administrative costs and costs per patient visit, are virtually unparalleled in the health care industry. The result is that health centers provide quality, comprehensive primary care to some of the hardest-to-reach patients in the health system at a price second to none. Several recent studies have found that Medicaid patients who regularly use health centers cost significantly less than those who use private primary care providers, such as HMO's, hospital outpatient units or private physicians. For instance:

In Washington state in 1992, health center patients were found to be 36% less expensive for all services than patients of other primary care providers and used 31% fewer emergency room services[20];

In California in 1993, health center patients were 33% less expensive overall (controlling for maternity services), and had 27% less total hospital costs[21];

In Maryland in 1993, health center patients had lowest total payments; lowest ambulatory visit cost; lowest incidence of inpatient days and lowest inpatient day cost; health center patients were one-third as likely as hospital outpatient unit patients to be admitted on an inpatient basis and were half as likely to have unstable chronic medical diagnoses as patients of other providers[22];

In New York in 1994, health center patients were 22–30% less expensive overall, and had 41% lower total inpatient costs; diabetics and asthmatics who were regular health center uses had 62% and 44% lower inpatient costs, respectively[23].

These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular addressing the health centers' demonstrated and historic savings to state Medicaid programs. Taken together, these studies have found that:

Use of health centers led to lower utilization of more costly emergency rooms, ranging from 13 percent to 38 percent in the case of pediatric emergency room use.[24]

Health centers have reduced inpatient admission rates for their patients by anywhere from 22 percent to 67 percent, reduced the number of patients admitted per year and the length of stay among those who were admitted.[25]

Health centers have achieved such tremendous success because, like managed care organizations, they are a first point of entry for their patients into the health care delivery system, and they manage their patients' care to keep them healthy and out of costly emergency rooms, hospitals, and specialists' offices. They are also experienced in the management of health care costs, since they must run their programs within a limited annual budget.

Health centers are well tested and highly successful models of community-based health care. They are partnerships of people, governments, and communities working together to meet local health care needs in an culturally competent, effective and efficient way. Health centers develop primary care infrastructure in areas of the nation that need it most with limited Federal assistance. Federal grants to health centers average less than $100 annually per patient. This represents a small investment for what centers accomplish in strengthening community health and fostering prevention and health education.

THE HEALTH OF EACH HEALTH CENTER IS ALWAYS LEADERSHIP AND ACCOUNTABILITY

Health centers are professional health care organizations providing a comprehensive range of high quality services for their community. But their most distinctive feature is that the health centers are developed and run by their communities, and are dedicated to the needs of their people. Health center governing boards are composed of local community leaders and residents who care about the primary health care access needs of their community and are committed to working together to make a difference. Federally funded centers are required to have patients as a majority of their governing board members.

The empowerment and involvement of local citizens in planning and governance has been the essential characteristic that has made in possible for health centers to make a real difference in underserved communities, in terms of both the sense of ownership they help foster and the tangible benefits they yield. In recent years, the role of community governance has achieved increased recognition and respect, especially because it promotes direct involvement by local residents in developing the services they use. Because of their commitment to their local communities, health centers have become an effective solution for primary health care access in thousands of communities across the nation, affirming their vital role in America's future health care system.

THE HEALTH CENTER EXPERIENCE: LIMITED INVESTMENT GENERATES OUTSTANDING SUCCESS

Health center achievements over the past 30 years show how much is known about how to make a difference in the health of the poor and how far even a modest investment will go.

Every Federal dollar invested in health centers leverages another two dollars in other revenues—in addition to the Medicare and Medicaid savings they produce. Health centers understand and respond to their communities' most urgent health care needs. Health centers care for those whom other providers cannot or will not serve. Health centers offer high quality medical care. Health centers have had a major impact on the health of their communities and provide care in a highly cost-effective fashion. There is no better health care bargain anywhere—public or private.

Perhaps the greatest testament to the unique ability of health centers to design services that are accessible to their patients is that, ironically, health centers report that for every 10 patients currently served there are another 3 on local centers' waiting lists who are seeking care there[26]. And those on health center waiting lists do not even begin to take into account the far larger number of persons who need the services of health centers but who do not have a center within reach—particularly in the nearly 1,000 underserved U.S. counties that today have no health center[27].

HEALTH CENTERS CAN DO SO MUCH MORE

As policy makers consider options for improving the reach and effectiveness of America's health care system, they would do well to seriously consider including steps to:

Expand the network of health centers to ultimately reach all medically underserved people and communities. With current funding, health centers are able to reach just 9 million of the 43 million medically underserved Americans who would benefit from their services. This effort could be accomplished incrementally over several years, with each additional $100 million in funding for health centers extending services to an additional 1 million people in some 400 communities.

Assist health centers to fully participate in managed care, by allowing them to form or join Provider Sponsored Networks as fully integrated partners, and by ensuring that any Medicaid or Medicare reforms include supplemental payments to health centers—in addition to other reimbursements from Medicare or Medicaid, or from managed care plans—for the purpose of making sure that health centers receive sufficient funds to adequately care for their Medicaid patients. Without sufficient resources to meet the needs of their patients, centers and clinics would be forced to substantially reduce their services and patient loads (mostly uninsured patients), and many could go out of business.

Involve health centers in the training of the enhanced primary care workforce required for the future, by making teaching health centers eligible for direct payment of their health professions teaching costs. The Council on Graduate Medical Education (COGME), as well as the Institute of Medicine, and the Physician Payment Review

Commission, have recommended revision of current GME policies to support expanded primary care and ambulatory training programs; and health centers represent the ideal site for training in comprehensive preventive and primary ambulatory health care, because they have an established history of functioning as interdisciplinary care environments, providing quality, comprehensive primary and preventive care.

Health centers provide comprehensive, continuous care to their patients regardless of insurance status or ability to pay. It is this ability to offer continuous care that makes the health centers unique and particularly valuable. Health centers form a critical base on which to build managed care systems for low-income and medically underserved populations. Already, health centers are managed care providers for over 1.5 million Medicaid patients, and that number is expected to more than double over the next year or two.

The road to long-term managed care plan viability and effectiveness can be made smoother by the inclusion of health centers in managed care networks. As experienced and effective health care providers to the medically underserved, health centers can provide the primary care infrastructure network which managed care systems need to provide cost efficient quality health care. Health centers have much to offer managed care systems and stand ready to collaborate with them.

NOTES

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[11] Data from Bureau of Primary Health Care, 1994.

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America's Health Centers are comprised of Community, Migrant and Homeless Health Centers and other federally-qualified community-based providers. In a thirty-year history, they have shown the value and strength of a health system rooted in community partnership and built on the delivery of accessible, quality primary care to Americans in need. Today, this growing nationwide network delivers primary and preventive care to more than 10 million medically underserved people—spanning urban and rural communities in all fifty states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands.

HEALTH CENTERS ARE UNIQUE IN STRUCTURE AND MISSION

Health centers are public-private partnerships. They are nonprofit, private corporations, which are locally-owned and operated by the communities they serve.

Health Centers serve in medically underserved communities—America's inner cities, migrant farmworker communities, and isolated rural areas. They are defined areas with few or no physicians—suffering high levels of poverty, infant mortality, elderly, and poor health.

Health centers are governed by consumer boards—composed of 51 percent patients who represent the community served. This is a powerful link to the community. Consumer governance gives patients and local citizens a voice in the workings of their center—and ensures that care is patient-centered and responsive to diverse cultures and needs within the community.

Health center revenues are multi-sourced. Federal grants on average represent 36 percent of a health center budget. Reimbursement from Medicaid and Medicare constitutes 38 percent. The remainder is leveraged from state and local governments, insurance, and patient fees.

Health centers provide care to all who seek their service. Patients are charged on a sliding fee scale to ensure that income or lack of insurance is not a barrier to care. Federal grants received by centers subsidize the cost of care provided to the uninsured—and the cost of services not covered by Medicare or Medicaid or private insurance.

WHY HEALTH CENTERS WORK FOR THE NATION

Health centers fill critical gaps in health care. Health centers serve low-income working families, the uninsured as well as high-risk populations such as the homeless, the frail elderly, migrant farmworkers, and poor women and children. They are people who confront barriers to care and whose unmet health needs represent a huge and growing cost to the nation.

Health Center Patient Profile: Virtually all health center patients have family incomes below 200 percent of the federal poverty level. More than two in five are completely uninsured. More than one-third depend on Medicaid. 70 percent of health center patients are children and poor women of childbearing age. 60 percent of health center patients are members of racial and ethnic minorities at high risk. Nearly half a million of our patient population are migrant farmworkers and their families.

Health Centers are built by community initiative. A limited federal grant program provides seed money. The purpose: to empower communities themselves to find partners and resources to develop centers—to hire doctors and needed health professionals—and to build their own points of entry into the nation's health care delivery system.

Health centers focus on wellness and prevention—the keys to cost savings in health care. Through innovative programs in outreach, education, and prevention centers reach out and energize communities to meet critical health needs and promote greater personal responsibility for good health.

Health centers produce savings. Their skills and experience are unsurpassed as providers of quality, cost-effective health care to high-risk and vulnerable populations.

HEALTH CENTERS MAKE A DIFFERENCE

Cost effectiveness: Health centers provide cost-effective high quality care—second to none. Total health care costs for center patients are on average 40 percent lower than for other providers serving the same populations. Centers also achieve significant savings by reducing the need for hospital admissions and costly emergency care.

Improving Access: Health centers bring needed health services and facilities to areas of greatest need—often not served by traditional providers. They train, recruit, and retain highly-skilled health professional in acute shortage areas.

Quality Managed care: Health centers provide comprehensive primary and preventive care. Ninety-eight percent of health center physicians are board certified/eligible. Centers are linked to hospitals, health departments, nursing homes, and other providers as well as social service agencies to ensure that patients have access not only to primary care but a continuum of coordinated care, including special treatment and support services.

Accountability: Health centers meet high uniform standards of accountability and performance. Health centers demonstrate the effective utilization of public and private investment as reflected in positive health outcomes; a 40 percent reduction in infant mortality; improved immunization and prenatal care rates; and increased use of preventive health services.

OTHER KEY FACTORS

Health Centers empower Communities. They provide jobs and generate new investment into devastated and poor communities. Health centers employ over 50,000 community residents. They are the nation's leading trainer and health career path for minority health professionals. Their total operating budget of $2.8 billion leverages over $14 billion in economic development in needy urban and rural areas—Which translates into jobs, facilities and contracts.

Health Centers are vital safety net providers for millions of poor Americans. They are frontline providers of care helping communities attack costly and compelling health problems such as AIDS, substance abuse, teenage pregnancy, and crime. But, they are more than just providers. They are catalysts—empowering communities with the resources, jobs/education—and leadership—that can improve health and bring new promise to America's disadvantaged.

Community, Migrant and Homeless Health Centers and other community-based providers comprise America's Health Centers. In a thirty year history, they have shown the value and strength of a health system rooted in community partnership—and built on the delivery of accessible, quality primary care to Americans in need. Today, this growing nationwide network delivers primary and preventive care to more than 9 million medically underserved people—spanning urban and rural communities in all fifty states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands.

WHY HEALTH CENTERS WORK FOR THE NATION

Health centers fill critical gaps in health care delivery. Health centers serve low-income working families, the uninsured as well as high-risk populations such as the homeless, the frail elderly, the disabled, migrant farmworkers, and poor women and children and others. They are people who confront barriers to health care—and whose unmet health needs represent a huge and growing cost to the nation.

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Health centers focus on wellness and prevention—the keys to cost savings in health care. Through innovative programs in outreach, education and prevention—centers reach out and energize communities and their people to meet critical health needs and promote greater personal responsibility for good health.

Health centers produce savings—in Medicare and Medicaid—and preventive care. Their skills and experience are unsurpassed as providers of quality, cost-effective health care to vulnerable populations. A track record of accomplishment demonstrates that prevention and primary care works: It keeps people healthy—It saves tax dollars—It builds stronger communities.

Community Partnership is the dynamic that drives the success of America's Health Centers. Health centers are partnerships of people, governments, businesses, communities working together to expand access and to improve health.

HOW HEALTH CENTERS ARE UNIQUE—IN STRUCTURE AND MISSION

Health centers are public/private partnerships. They are nonprofit, private corporations, which are locally owned and operated by the people and communities they serve.

Health centers are governed by consumer boards—composed of 51 percent patients—who represent the community served. This is a powerful link to the community. It not only gives patients and local citizens a voice in the workings of their center—but ensures that care is patient centered and responsive to diverse cultures and needs within the community.

Health centers revenues are multi-sourced. Federal grants on average represent 36 percent of a health centers budget. Reimbursements from Medicaid and Medicare constitute 38 percent. There remainder is leveraged from state and local governments, private contributions, insurance and patient fees.

Health centers serve in medically underserved communities—America's inner cities—migrant farmworker communities—and isolated rural areas. They are defined areas with few or no physicians—suffering high levels of poverty, infant mortality, elderly and poor health.

Health centers provide care to all people who seek their services. Patients are charged on a sliding fee scale to ensure that income or lack of insurance is not a barrier to care. All patients pay something toward the cost of their care. Medicare and Medicaid as well as private insurance are billed for those with coverage. Federal grants received by centers subsidize the cost of care provided to the uninsured—and the cost of services not covered by public or private insurance.

Health center care is patient centered and community directed. Centers provide additional services of outreach—transportation and translation—education, and case management—to maximize effectiveness in producing long-term, positive health outcomes for high-risk populations. Health centers also deal with costly community health problems such as teenage pregnancy, infant mortality, homelessness, substance abuse, AIDS and others.

Today, a cost-conscious nation is looking to the success of the U.S. health center model, which has produced the markers to an effective alternative in accessible, affordable community based care. This model has shown that it takes more than governments to solve the problems in health care; that people and community partners must be involved to protect health—to realize cost savings—and to make health care delivery work for more Americans.

HOW HEALTH CENTERS MAKE A DIFFERENCE

Cost Effectiveness. Health centers provide cost-effective, high-quality health care—second to none. Total health care costs for center patients are on average 30 percent lower than for other providers serving the same populations. Centers also achieve significant savings by reducing the need for hospital admissions and costly emergency care.

Improving Access. Health centers bring needed health care services and facilities to areas of greatest need—often, not served by traditional providers. They train, recruit, and retain highly skilled health professionals in acute shortage areas.

Quality Managed Care. Health centers provide comprehensive primary and preventive health care. Ninety-eight percent of health center physicians are board certified/eligible. Centers are linked to hospitals, health departments, nursing homes and other providers as well as social service agencies to ensure that patients have access not only to primary care, but a continuum of coordinated care, including specialized treatment and support services. Numerous independent studies document that health centers improve the health of their communities—reducing preventable deaths, costly disability, and communicable disease.

Accountability. Health centers meet high, uniform standards of accountability in terms of cost effectiveness and quality care under the Public Health Service Act. Centers are subject to periodic reviews and federal audits, and are required to submit comprehensive health plans detailing health services in their geographic area, demonstrating need and demand, and showing the impact of their intervention. Health centers demonstrate effective use of resources and public and private funds.

Empowerment. Health centers empower communities to take charge and meet health needs. They engage citizen participation and involvement—facilitate the flow of public and private investment into communities—and generate jobs and new community development.

Opportunity. Health centers contribute to the well being and strength of communities. By providing cost-effective prenatal care—health centers reduce the high costs associated with adverse pregnancy outcomes. By keeping children healthy—centers enable them to stay in school and train for the future as responsible members of the community. By keeping workers healthy—health centers reduce absenteeism and help workers remain productive and contributing citizens.

Investment. Health centers yield a substantial return on public and private investment. They are more than providers. Health centers are community assets that improve health—provide jobs—strengthen schools—stabilize neighborhoods—and enhance community pride.

COMMUNITY, MIGRANT AND HOMELESS HEALTH CENTERS—UNITED STATES

(Presented by: Thomas J. Van Coverden, president and chief executive officer, National Association of Community Health Centers, Inc.)

HISTORICAL BACKGROUND AND DEVELOPMENT

Community and Migrant Health Center programs were established by the federal

government in the decade of the sixties. Conceived as part of a war on poverty, the programs were a major social experiment joining the resources of the federal government and local communities to expand quality and accessible health care to Americans in need.

Health centers were the product of two powerful forces. Social unrest was erupting in riots for lack of jobs, opportunities, and health care in inner cities. Reform-minded physicians and nurses were calling for a better way to deliver health care by reaching out into communities in need and attacking the problems underlying poverty.

This step in U.S. health care was historically significant. For the first time, resources were committed by the federal government to assist local communities in development of a community-based primary care infrastructure to serve medically underserved populations. Experimentation with a new model of health care marked recognition of large gaps in America's health delivery system. It confronted the reality that even with expansion of public health insurance to cover broad segments of the poor and elderly, millions of Americans and their families would still lack access to doctors and basic health services because of poverty, cultural, and geographic barriers. Moreover, it conceded that a national war on poverty to help all Americans to education and job opportunities and a better standard of living would never be won without a frontal assault on the problems of inadequate health care.

Federal grants to public and nonprofit entities for the development and operation of neighborhood health centers (later called community health centers) were made available in 1965 under the Office of Economic Opportunity (OEO). The first two neighborhood health centers opened in rural Mississippi and in a public housing project in Boston, Massachusetts. While services were directed to the poor and near poor, centers also provided care to individuals who could pay all or part of the cost of their health care. During the early years, grants were awarded to established medical entities such as hospitals, health departments, and medical schools. Later this orientation was to change to nonprofit community groups, which reinforced independent, local control over health centers; community management; and a focus on tailoring health services to specific community needs.

A similar program of grants for the development of migrant health centers was authorized by the U.S. Congress with enactment of the Migrant Health Act in 1962. Centers were to provide medical and essential support services such as translation, outreach, and social service linkages to the nation's migrant and seasonal farmworkers and their families.

Steadily and with growing local and congressional support, both the migrant and neighborhood health center programs took root. By the mid-1970's and phaseout of the OEO, about 100 neighborhood health centers were in operation, mainly in poverty-stricken inner cities and isolated rural areas.

PHASES OF HEALTH CENTER DEVELOPMENT

1965–1975: a period of demonstration projects, with authority broadly defined, but calling for targeted focus on the needs of the poor, accessible health care services plus outreach and full integration and coordination with community resources, and community participation.

1975–1980: a period of growth with enactment of permanent legislation laying the foundation for community health centers with establishment of standards of clinical practice and administrative efficiencies related to fee schedules, billings and collections, patient care, administrative cost limitations, productivity, and hospital linkages as well as consumer board involvement.

1981–1990: a period of retrenchment and consolidation for health centers fending off reduced funding and conversion of health center grants to state block grants until 1986.

1990–Present: a period of expansion and public recognition with changes in federal reimbursement policy for health centers requiring full cost-reimbursement for services rendered to Medicaid and Medicare patients, and federal malpractice coverage for centers and their clinical staffs.

Health centers have evolved through the years into a dynamic and expanding network of locally-owned, nonprofit community-based health providers. Their mission is a provide comprehensive primary and preventive care to America's poor and underserved. America's health center network, today, is comprised of federally-assisted community and migrant, and homeless health centers as well as other community-based health centers, which are qualified under the Medicare and Medicaid laws.

Nationwide 2200 health center service sites deliver primary and preventive health care to almost 8.8 million people in urban and rural underserved communities. More than 7.5 million people obtain care from health centers that receive funding from the four principal health center grant programs administered by the U.S. Public Health Service: Community Health Centers; Migrant Health; Health Care for the Homeless; and Health Service for Residents of Public Housing. Another 1.3 million persons receive care from other federally qualified centers that do not receive federal grant funds. Health centers are located in all fifty states including the District of Columbia and the American territories of Guam, Puerto Rico, and the Virgin Islands.

In Fiscal Year 1995, Congress appropriated $757 million for the support of America's health center programs. It is a modest sum in public investment given that health centers have been given the challenging task of providing care for some of America's poorest, sickest, and hard-to-reach populations. The typical budget of an urban health center is $3.7 million; a typical rural health center budget is $1.6 million. The average health center operates with a main facility and three to four satellite delivery sites, which are all located in the center's service area. The collective budget of the nation's health centers, inclusive of grants, Medicare and Medicaid reimbursements, and other revenues approximate $2 billion annually, which is less than one-fourth of one percent of total U.S. health care expenditures.

In structure, health centers are public/private partnerships. They nonprofit corporations, locally owned and operated by the people and communities they serve. Their revenue base is multisourced. Federal grants, on average, represent 36 percent of a health center's budget. Reimbursements from Medicaid, the public insurance program which pays for the care of many low-income and poor, on average, accounts for 33 percent of a health center's budget. Medicare, which insures the nation's elderly, is approximately 5 percent of a health center's budget. State and local government contributions as well as foundation and private donations average about 11 percent of a health center budget. Eight percent of a health center budget is derived from private insurance and about 7 percent is from patient fees.

SERVICE CHARACTERISTICS

The health center mission is to promote high quality, comprehensive health care that is accessible, culturally and linguistically competent, and community directed for all medically underserved populations.

Health centers are required to provide a broad range of primary and preventive health services including physician, physician assistant and nurse clinician services; diagnostic laboratory and radiology services; perinatal services, immunizations, preventive dental care, disease screening and control, case management, emergency medical services, and family planning services, and hospital referrals.

The focus of health centers is prevention and health care access. Centers emphasize services that are designed to enhance access and the effectiveness of medical care through outreach, transportation services, heath/nutrition education and case management. Some 98 percent of health centers offer health education services; over 90 percent offer case management service; more than three-quarters offer preventive dental services and in-home laboratory services. All health centers employ outreach and patient relations workers from the communities they serve. Health centers recognize that the risk factors and pervasive needs of patients from low-income underserved communities require health services not typically offered by traditional providers.

Health centers promote community directed responsive, patient-centered care. Special intervention programs are frequently developed by local health centers to address significant community health needs such as teenage pregnancy/infant mortality, AIDS, substance abuse, hypertension, diabetes. Centers also organize the provision of services to ensure that medical care is available at convenient times, and in locations that take into account the special needs of the populations they serve. Many centers offer evening and weekend hours for working families; provide care at multiple sites; use mobile clinics to reach rural and homeless patients, and employ multi-lingual staffs or translators to overcome barriers faced by people who speak little or no English. Bilingual physicians are available at 63% of health centers. All health centers have a 24 hour system for after-hours calls and emergencies.

Health Centers are appropriately linked to hospitals, health departments, nursing homes, and other providers and social service agencies for emergency and specialty referrals as well as counseling and other assistance as may be needed by patients. The goal is to ensure that patients have access not only to primary care, but a continuum of coordinated care, including specialized treatment and support services.

Health centers serve in areas of greatest need. By law health centers are mandated to serve urban and rural communities that have been designated as ''medically underserved''—areas suffering acute physician shortages, with high levels of poverty, elderly, infant mortality, and/or poor health status. Health centers are equally distributed between urban and rural areas. Half are located in isolated rural areas, the other half in economically-depressed inner cities. In these locations, they are often the only available and accessible primary care providers for the patients they serve.

America's health centers are able to reach 20 percent of America's 43 million medically underserved. They are America's poor and vulnerable—persons who even if insured, nonetheless remain isolated from traditional forms of medical care because of where they live, who they are, and frequently, their far greater levels of complex health care needs.

Virtually all patients have family incomes below 200 percent of the federal poverty levels ($28,700 annually for a family of four in 1994).

Nearly one in two is completely uninsured, either publicly or privately, and more than one-third depend on Medicaid.

44 percent of all patients are children under 18, and 30 percent are women of childbearing age (nearly one in ten is pregnant).

Over 60 percent of health center patients are members of racial or ethnic minorities, compared to 26.3 percent for the nation's population as a whole.

Health Centers improve access to care. Within available resources, health centers must serve all who seek their services. Patients are charged on a sliding fee scale to ensure that income or lack of insurance is not a barrier to care. All patients pay something toward the cost of their care. Medicare and Medicaid as well as private insurance are billed for those with coverage. Federal grants received by health centers subsidize the cost of care furnished to the uninsured, and additional services not covered by public or private insurance.

ORGANIZATION AND ADMINISTRATION

Health centers recruit, train, and retain health professionals. They bring physicians and health professionals and needed services and health facilities to people not served by traditional providers. Health center practices are staffed by a team of board certified or board eligible physicians, nurses, physician's assistants, nurses practitioners, nurse mid-wives, dentists, social workers and other health professionals. In rural areas, physicians are typically family practitioners, while larger urban centers are usually staffed with multi-disciplinary teams of internists, pediatricians and obstetricians.

Health centers employ 5000 physicians. Almost 98 percent are board certified or eligible and all are required to have hospital admitting privileges. The number of other health professions serving the nation's health centers is approximately 6200.

Health center physicians and staff are salaried employees. Salaries are negotiated and paid out of budget by the individual health center entity. In some cases, staff services may be contracted. The National Health Service Corps (NHSC) also provides a source of doctors and other health care professionals who serve in health centers in partial obligation to repay government student loans and/or educational scholarships. Approximately 1900 NHSC primary care providers serve in underserved/shortage areas. Health center employment for Community and Migrant Health Centers alone is more than 35,700 with a total health center payroll of $1.4 billion.

Health centers are governed by volunteer consumer boards, composed of leaders and residents of the communities they serve. A unique and distinguishing feature of health center boards is that a majority of board members (51 percent) must be patients of the center and who, as a group, represent the community of patients served. The remaining members of the board must be individuals who are actively engaged in the community with local government, finance and banking, legal affairs, business and/or cultural and social endeavors. At present, there are a total of 12,500 health center community board members.

Health center boards foster community ownership and local participation. Health center boards meet on a regular basis and are responsible for the approval of the health center budget; financial management practices; the establishment of center policies and priorities; personnel policies, including the hiring and firing of the executive director; evaluation of center activities, including program services and patient satisfaction; and health center compliance with applicable federal, state, and local laws and regulations. Health centers are managed by a team led by an executive director or chief executive officer, including a clinical/medical director responsible or clinical programs and a chief financial officer with responsibility for fiscal affairs.

Health centers meet high national standards of accountability. They are subject to ongoing federal scrutiny of their cost effectiveness and quality of care. Health centers are required to periodically report to the government on services, utilization, quality measures (for perinatal, pediatric, adolescent, adult and geriatric services, low birthweight, and infant mortality, and hospital admissions and length of stay), financial management and status, billings and collections, and patient satisfaction. In addition, they are required to submit comprehensive health plans for their geographic area detailing services, demonstrating need and demand, and showing the impact of their intervention.

Health centers hold an unparalleled 30 year track record of providing quality and cost-effective care. Studies demonstrate that health care costs for health center patients are on average 30 percent lower than for other providers serving the same populations. Health centers also achieve significant cost savings by reducing the need for hospital admissions and costly emergency care. The federal grant cost for each patient cared for by health centers is less than $100 annually; and the total cost of health center services amounts to less than $300 when compared to other providers serving similar populations.

Independent studies further document the success of health centers in achieving positive health outcomes. Communities served by health centers have cut infant mortality rates 10–40 percent as compared to those that are not served by health centers. In addition, centers have increased the proportion of children who are immunized and have increased the use of preventive health services such as Pap smears and physical exams. Patients also have expressed overwhelming satisfaction with the care they receive in health centers.

COMMUNITY PARTNERSHIP

Health Centers Empower the Community. The empowerment and involvement of local citizens in planning and governance has been the basic characteristic that has made it possible for health centers to make a difference in medically underserved communities in terms of the community ownership they foster and the tangible benefits they yield. The community is directly involved in every aspect of center operations—from setting policy to staffing vital services, from providing information on community needs to determining whether the center is properly responding to those needs.

Health center governing boards, composed of community leaders and patients/residents, engage citizen participation and responsiveness to local health needs. In turn, health centers are an integral part of their communities—providing meaningful jobs for local residents, a means to attract investment and other business and forms of community/economic development, a base for community advocacy and action, and a source for developing community leaders and giving them recognition and stature in the community.

Health center board members and staff are vital to building community ties and partnerships. They are actively involved with schools, hospitals, state and local health departments, community groups, businesses, churches and others in developing health/education programs, identifying community health needs, and creating integrated health networks to enhance service capacity. They reach out to the greater community leveraging support, additional resources, and investment in health center programs. Successful collaborative efforts, for example, are currently helping 337 health centers access free prescription drugs for low-income patients. Center ties with universities and medical schools are fostering the training of leaders in community-based health care and promoting health centers as recognized environments for the training of needed primary care physicians.

Health centers are advocates for the patients and the communities they serve. As a nationwide network, they are using their experience, expertise and ideas to help communities and governments leaders find solutions to health care needs. Through education, communication, and interaction, they are telling their remarkable story of success in serving medically underserved populations—making this nation aware that programs in primary care, outreach and prevention work are essential to expanding access and building stronger and healthier communities.

SUMMARY

America's health centers are tested models of community based care. They are partnerships of people, governments, and communities working together to meet health needs. In three decades of growth and development, health centers have become an integral part of America's health delivery system serving as a safety net for the nation's poor and medically underserved.

America's health centers have yielded a substantial return on public and private investment. They have proven that the special needs of high-risk and vulnerable populations can be met with quality, dignity, and cost-effective health care. In their committed work, they have produced compelling evidence showing the dollar value of their programs, the cost savings to communities, and the positive case-by-case outcomes of primary care intervention.

Yet, health centers confront serious challenge as the health care industry rapidly consolidates to contain costs and the federal government moves to reduce public spending and shift greater responsibility for health care and other social programs to the states and private sector. The reality is that health centers are being thrust into a price-driven, competitive health care market. In a new managed care environment, centers are being forced to compete not only for scarce resources, but for paying/insured patients and market base, which are vital to their financial viability and their continued ability to serve the poor and uninsured.

While America's health centers are determined to survive, the problem is that they face large and well-financed providers such as HMOs and other conglomerates, who are now tapping the Medicaid market and competing for lucrative and exclusive managed care contracts with States. In some cases, centers are being forced to contract with purchasers and providers for health care whose bottom line is cost and who have little or no interest in paying for a broad range of social and other support services that have traditionally characterized the health center mission, and which have been the hallmark of their success in achieving quality and containing health care costs.

The looming question is whether, in the process of integrating into a managed care market, health centers will be able to retain their unique identity as health care providers. Will health centers be able to access the capital and sources of investment needed for growth and development; improved organizational frameworks to leverage strength and capacity as providers; management and financial skills and advanced technologies to sustain a competitive position? Will health centers have access to adequate resources to

compete for doctors and other health professional staff? Will the federal government continue to support the health center mission to the extent that appropriate funding and safeguards are provided to ensure a level playing field of competition?

Today, health centers are aggressively moving to be part of the evolving health care system. In states and communities across the country, health centers are taking steps to form networks and full managed care plans with other local providers, to negotiate subcontracts with other managed care plans, and to develop the financial, legal, and business acumen necessary to effectively function in the new environment.

Health centers hold many strengths. They are low-cost providers in high-risk markets. Their skills and experience are unsurpassed as providers of patient-centered care to vulnerable populations. They are locally owned businesses and community driven in their approach to meeting health care needs. Health center programs in primary care offer accountability, quality, efficiency and cost savings. In addition, they hold tremendous assets in a nationwide solid infrastructure ready for fast-track development to meet growing health needs.

America's health centers stand prepared to build on their heritage and compete and endure in the future.

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BUREAU OF PRIMARY HEALTH CARE: 43 MILLION PEOPLE LACK ACCESS TO PRIMARY HEALTH CARE

UNMET NEED

Forty-three million persons without access to a primary care provider; 41 million persons are uninsured; minority health status disparities.

PRESSURES FACING THE SAFETY NET

Reduced Medicaid revenue from managed care: reimbursement rates down; reduction in Medicaid eligibles.

Increase in the number of uninsured served; e.g. health center uninsured up 46% from 1990–96 (national up 16%)

Mergers/Privatization decrease capacity: reduced outpatient provider capacity.

HEALTH CENTERS

Private, not-for-profit organizations: true safety net providers, obligated to serve all patients without regard to ability to pay; community-based governing boards, and community supported; located in underserved areas; provide comprehensive care services and enabling services; improve health outcomes and decrease Medicaid costs; 685 center grantees; services provided at 3,032 sites (incl. NHSC); over 10 million uninsured and vulnerable patients served; 33 million encounters in 1996; and 5,500 primary care providers.

HEALTH CENTER PATIENT CHARACTERISTICS

42% children; 32% women of child-bearing age; 65% minority; 41% uninsured; and 85% poor and near poor.

CHCS AS ''ECONOMIC ENGINES''—THE ECONOMIC BENEFIT OF CHCS

CHCs as ''employers'': CHCs are often one of the largest employers within their immediate service area.

CHCs as ''purchasers'': CHCs are often one of the largest purchasers of goods and services within their service area.

CHCs represent a significant and vital source of economic inertia for local communities which is consistent with the objectives of emerging economic development initiatives.

RESPONSE OF HEALTH CENTERS TO MANAGED CARE

Individual contracts with managed care organizations; Formation of health center-owned health plans and MCOs; and Development of integrated service networks to contract with managed care organizations.

MARKET SHARE—HEALTH CENTER-OWNED MANAGED CARE PLANS IN 12 STATES

Number of States: first in market share: Connecticut; New York; California; Massachusetts; Colorado; and Washington

Second in market share: Rhode Island.

Third in market share: Maryland and Oregon.

Fourth in market share: Ohio; Hawaii; and Missouri.

SOLUTIONS NOT BUSINESS AS USUAL

Increased partnerships; integrated networks/delivery systems; innovative models of care; and document impact.

HEALTH CENTERS

Agents of care.

Agents of change: Integrated delivery system; making system responsive to local needs; and giving communities control.

HEALTH CENTERS AS SOLUTIONS

Serve everyone regardless of ability to pay; guaranteed access through enabling services; empower communities; improve health outcomes and lower Medicaid costs; and economic engines and create jobs.

THE ''COMMUNITY'' IN HEALTH CARE CENTERS

The most frequently mentioned aspect of consumer involvement in the health center programs is the fact that a majority of each center's policy, or governing board must consist of persons who are patients of the center and who, as a group, represent the community of patients served there. We use many terms to describe this characteristic of the health centers: consumer-controlled, consumer-directed, community-responsive, and so on. Their majority status on the health center policy boards gives patients control in determining how the centers operate: what services are provided, the locations and hours of operation, the sliding scale fee discount system, the annual budget and program plans. But the real value of this patient-majority governance system lies in the fact that, as a result of it, the community is given a true sense of ''ownership'' over the health centers; and this feeling of ownership makes the centers a course of community empowerment, in which the centers serve as the basis and focal point for a whole host of activities that serve the community and its people. When the community is empowered in this fashion, they will actively involve themselves in being a part of its work (a part of the solution, not the problem). They will care for and nurture ''their'' system of care, and they will fight like hell to keep it going. This experience plays itself out in any number of ways, such as:

Creating a forum for bringing real and immediate problems to the table for action. This clearly happens as a natural part of the regular policy board meetings; but most health centers also reach out to the whole community as part of their needs assessment process. For Asian Health Services, in Oakland, CA, this has meant community meetings conducted in 6 different languages to involve each of the population subgroups they serve: Korean, Japanese, Chinese, Laotian, Cambodian, and Pacific Islander. Their efforts have been rewarded with high community turnout and solid input from the residents.

Getting feedback on the acceptability and appropriateness of services and the centers' program plans. Here again the policy boards provide a vehicle for evaluating the center's responsiveness to the community's needs. Consumer board members bring the community's needs and concerns and complaints about the health center to the board for consideration. This is perhaps the most important role they can play.

Providing a training ground for community leaders and spokespersons—including board members and center employees—and giving them credibility, recognition, and stature in advancing or advocating community needs or concerns.

Providing a means and forum for involving community residents, and the community itself, in the political process and system—at the local, state, and national levels. The critical value of this point is that several individuals in the health center movement have—for perhaps the first time in their lives—involved themselves actively in our American political system. This has helped the movement itself, which has survived and benefitted from their advocacy. Through NACHC and the State Primary Care Associations, community residents have found an invaluable mechanism for taking on critical health policy issues, and winning for their communities. As a direct result of their experience, many health center representatives have become quite involved in local, state, and national politics—for example, former board member Danny Davis is now a Member of Congress; community representative Lenny Walker is now a Rhode Island state representative; and former center Director Harvey Sloane has served as Mayor of Louisville and almost became Kentucky's junior U.S. Senator.

Serving as a conduit of important information to and from the community. Whether this involves information on how to avoid common childhood injuries or potentially serious agricultural accidents, warnings about unsafe water supply sources or the emerging incidence of an infectious disease, or whether the community provides information that the center needs to better serve its needs, the centers can serve as a vital communications link for the entire community. For example, a Brownsville, TX health center brought considerable national attention to a growing local controversy, reported in the New York Times and on ABC's Prime Time

Live, involving the center's report of an abnormally high number of births to babies with severe anencephaly and a possible connection to certain airborne toxins being emitted from nearby chemical plants. Here, obviously, the center is serving both as an information source and as an advocate for its community.

Generating action in response to community needs, even in case where those needs might not appear to be health-related. Whether it is the affordable, low income housing developed by health centers in Boston and Wood River, RI, or the community water supply and sewer systems spawned by centers in Beaufort County, SC, and the lower Rio Grande Valley of Texas, health centers all over the country have played key roles in organizing their communities to address pressing local needs.

Providing jobs and meaningful employment for community residents. In particular, when respected community people are employed and trained by the health center as outreach or community health workers, or as patient advocates, or in any of the dozens of clinical and administrative positions, it can be the start of a long and rewarding health career. Many health center directors today are community residents who have worked their way up the ladder at the health center over the past 15 or 20 years. Employees with the longest tenure at health centers—often dating back to the center's founding—are local community residents. One such person recently stated, ''It's been a wonderful experience, working at a great place like a health center, serving the community and helping my neighbors and friends—and being paid a decent salary to boot!''

Serving as a source of information and inspiration—complete with role models—for the community's youth, encouraging them to pursue a health professions career, and showing them how (and where) they could put that professional training to good use by coming back to serve their old neighborhood or town. Dr. Jack Geiger, one of the founding fathers of the health center movement, recently spoke of what he saw as the real successes of one of the country's first centers, in Mound Bayou, MS. In doing so, he noted that the center had either trained or assisted in helping to train the county's first black sanitarian, several of the physicians now working at the health center, and literally dozens of other professionals working there and at other centers across the country.

Serving as an ''anchor'' in their communities, helping by their presence to attract or retain other local businesses—including other physicians, diagnostic services, pharmacies or other health providers—or to bring in other forms of community or economic development. In a very real sense, many health centers have played pivotal roles in sustaining a sense of ''community'' in neighborhoods or towns that otherwise might well have completely disintegrated, giving its residents a feeling of pride and a ''can-do'' attitude, which in turn has led to significant neighborhood or community revitalization.

Thus, the critical, distinguishing factor that separates the health center model of community empowerment from other, less successful models, is that the community has been directly involved in virtually every aspect of the center's operations—from setting policy to staffing vital services, from providing information on community needs to determining whether the center is properly responding to those needs, and, in turn, the health centers have become an integral part of their communities—providing meaningful jobs for local residents, a means to attract other businesses and other forms of community/economic development, information and opportunities for pursuing health professions careers, a base for community advocacy and action, and a source for developing community leaders and giving them recognition and stature in the community. The greater the degree of community involvement in the health center, the greater the center's role and strength as a vital part of the community itself.

Today, we are in the midst of sweeping changes in the way health care is both financed and delivered, all across the country. As the numbers of uninsured have reached levels not seen since before the creation of Medicare and Medicaid, and as health care costs continue to skyrocket, health care has reached the ''hot button'' level as a public policy issue. The growth in HMOs, PPOs, institutional networks, financing bureaucracies, consolidated services, hospital closings and transitions, self-funded insurance plans—all these thing point to major, fundamental shifts in our health care system. By the end of the decade, there will be no more Marcus Welbys, even in group practice form. Every provider—physician, dentist, midlevel—will work for ''the man''. For us, the big question is who will ''the man'' be? Will it be the government, an HMO, an institutional network—or the community.

The health center model is our last, best hope for community-directed, community-responsive health care. Health centers may well be the closest things to Marcus Welby in the 21st century—the last real opportunity for the community to have a voice in how its health care system functions and meets their needs. We in the health center movement—yes, we still see it as a movement—have our plan, our Access 2000 plan, to bring top quality health care to all 43 million medically underserved Americans by the turn of the century. It's a hefty order, to be sure, but we are committed to that vision, that struggle; and yet, we cannot succeed without an equally committed band of health professionals—and we need to find and train them in record numbers, if we are to have any chance at success. As our health center movement expands and grows, we will continue to need the best and brightest clinicians, to provide care and leadership.

Mr. TOWNS. Mr. Speaker, I rise to day to urge my colleagues to support Community, Migrant and Homeless Health Centers and other community-based providers that comprise successful models for health care delivery across this Nation.

Community health centers benefit the residents and the areas where they are located in many ways. First, with the partnerships between business, government and the people, community residents have a greater sense of control over the quality of health care and the means of gaining health care. This is particularly shown in the health centers that are governed by consumer boards. These boards, where more than half of the board members are patients, represent the community served and give local residents a voice regarding the programs and center's services. With community representation on these boards, responsiveness is no longer a concern—who best knows what services communities need than the people who reside in the community?

Second, health centers service communities which are traditionally and chronically underserved. Often, the inner cities, migrant farmworker communities, and isolated rural areas benefit greatly from these health care services. These often forgotten populations also now have access to quality managed care; health centers provide comprehensive primary and preventive health care. All patients, especially women with their particular health care concerns, can look forward to up-to-date yearly medical exams. We know that the key to health care is taking preventative measures. With community health centers, we can do this by low-income seeing patients early and regularly.

Finally, health centers save money. In total, they provide cost-effective, high-quality health care. The total costs for patients are on average 30 percent lower than for other providers serving the same populations.

Mr. Speaker, I urge my colleagues to support community health centers. In my district these centers have played a vital role, as I am sure they have done in other districts, and we should support them as they continue to support our communities.

IN SUPPORT OF OXI DAY

The SPEAKER pro tempore (Mr. BLUNT). Under the Speaker's announced policy of January 7, 1997, the gentleman from New Jersey [Mr. PAPPAS] is recognized for 60 minutes as the designee of the majority leader.

GENERAL LEAVE

Mr. PAPPAS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and to include extraneous material on the subject of my special order.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New Jersey?

There was no objection.

Mr. PAPPAS. Mr. Speaker, today we celebrate Oxi Day which symbolizes the absolute refusal of the Greek people to succumb to Mussolini's Fascist Italy during World War II.

In August 1940, Mussolini accused Greece of supporting Britain and demanded that she renounce the agreement of neutrality with the Allies. In that same month, the Greek Naval Cruiser *Elli* visited the island of Tinos during its highest religious holiday, paying a visit to the famous holy shrine there. In a sneak attack, the Italians torpedoed and sank the ship in the harbor. Mussolini also massed more than 150,000 troops on the Albanian border, and the Greek government was only able to place about half that number of its own ready to oppose them. In that tense condition on October 28, 1940, at the undignified hour of 3 a.m., the Italian Ambassador delivered an ultimatum from Mussolini to the Greek government set to expire at 6 a.m. that very same day. The Greek Prime Minister's response was oxi, which means ''no'' in Greek. The Italian army was well supplied, fully equipped and supported by state-of-the-art air and naval power. They, the Italians, were expected to overrun the Greeks within a short time. Yet before its expiration and without waiting for an official reply, Italian troops invaded Greece across the Albanian border.

Mussolini had expected an easy victory. His troops had penetrated less than 20 miles into Greek territory against light resistance when the