
The Health Care “Safety Net” in a Post-Reform World

Edited by

Mark A. Hall and Sara Rosenbaum

Rutgers University Press

New Brunswick, New Jersey, and London

Contents

	List of Figures	ix
	List of Tables	xi
Chapter 1	The Health Care Safety Net in the Context of National Health Insurance Reform Mark A. Hall and Sara Rosenbaum	1
Part I Community Health Centers		
Chapter 2	Dr. StrangeRove; or, How Conservatives Learned to Stop Worrying and Love Community Health Centers Robert W. Mickey	21
Chapter 3	Reinventing a Classic: Community Health Centers and the Newly Insured Sara Rosenbaum	67
Chapter 4	Applying Lessons from Social Psychology to Repair the Health Care Safety Net for Undocumented Immigrants Dayna Bowen Matthew	91
Chapter 5	Community Health Center and Academic Medical Partnerships to Expand and Improve Primary Care Thomas R. Oliver, Richard E. Rieselbach, Byron J. Crouse, and John G. Frohna	108
Chapter 6	Examining the Structure and Sustainability of Health Care Safety-Net Services Peter D. Jacobson, Valerie Myers, Judith G. Calhoun, and Jodyn E. Platt	126
Part II Safety-Net Hospitals		
Chapter 7	Safety-Net Hospitals at the Crossroads: Whither Medicaid DSH? Michael K. Gusmano and Frank J. Thompson	153

Chapter 8	The Safety-Net Role of Public Hospitals and Academic Medical Centers: Past, Present, and Future Gloria J. Bazzoli and Sheryl L. Garland	183
Chapter 9	The Declining Public Hospital Sector Jack Needleman and Michelle Ko	200

Part III Safety-Net Systems

Chapter 10	Achieving Universal Access through Safety-Net Coverage Mark A. Hall	217
Chapter 11	Public Coverage Expansions and Private Health Insurance Crowd-Out: Implications for Safety Nets Alison Snow Jones	234
	About the Contributors	261
	Index	265

Dr. StrangeRove; or, How Conservatives Learned to Stop Worrying and Love Community Health Centers

Almost sixty million Americans—about one in five—go without regular primary care (NACHC 2009a; AHRQ 2006). Lack of access is not simply a matter of insurance status; the difficulty of finding a primary care provider is a massive barrier to the use of primary care. Traditionally, charity care for the medically indigent has existed outside of government channels. From the early 1900s, local and county governments experimented with funding, coordinating, and even providing ambulatory care; none of these efforts survived attacks by local physicians. But beginning in the mid-1960s the federal government began funding a new mode of primary care delivery: community health centers.

Community health centers are not-for-profit entities serving residents of areas designated by the Department of Health and Human Services (HHS) as “medically underserved.” Subsisting on third-party reimbursements (mainly Medicaid), competitive federal grants and loan guarantees awarded by the HHS, and some state and local governmental support and philanthropic funding, they provide comprehensive ambulatory care, either free or on a sliding scale. Centers also offer different mixes of “enabling” services, from case management and transportation to and from the facility, to translation services, and to substance abuse programs, immunizations, and screenings. In addition, all centers regularly assess community health problems and conduct health education and outreach programming; some target specific populations, such as migrant workers, public housing residents, homeless individuals, and elementary and secondary school children.

Today, more than 1,100 centers provide what is considered cost-effective and high-quality care to more than twenty million Americans at more than

7,900 delivery sites. Health centers improve access and use for the underserved, and reduce ethnic and racial disparities in health outcomes. About one-third of their patients are Hispanic (most of whom rely on bilingual staff), and another quarter are African American. Seventy percent of patients are poor. Fully 60 percent of users have some form of health insurance.¹

The health centers program constitutes the country's largest primary care system. With annual expenditures of more than \$7 billion (not including additional funding through FY 2015 provided through the Patient Protection and Affordable Care Act of 2010 [Affordable Care Act, or ACA]), community health centers now occupy a central role in America's safety net of health care provision. Combining primary care with some public health functions—a departure from the traditional bifurcation of medical care from public health—health centers also feature a quite radical governance structure begun during the program's origins during the War on Poverty: a majority of each center's governing board must consist of active patients residing nearby (Brandt and Gardner 2000).

Excluding state and local sources, patient payments, and third-party reimbursements, HHS spends more than \$2 billion per year on the program (figure 2.1). Relying more than other health facilities on nurse practitioners, physicians' assistants, and other non-MD health professionals, health centers are also heavily dependent on the National Health Service Corps and other federal medical workforce programs. Just over one-half of health centers are in rural areas while just over one-half of all patients reside in urban areas. Health centers exist in every state, in more than 90 percent of congressional districts, but in only about one-quarter of those areas designated by HHS as medically underserved (Iglehart 2010, 343). The program is managed by HHS's well-regarded Health Resources and Services Administration (HRSA), and for more than three decades a highly effective national lobby and its state affiliates have played a critical role in the program's survival and its recent, strange expansion.

Begun as a demonstration project during the War on Poverty, the program has until recently remained in the shadows of the health care system. Uncontroversial and of low salience to members of Congress, it muddled through for three decades. Targeted by Republican administrations and conservatives for reduction or elimination through budget cuts or conversion into block grants, it survived but never experienced the massive expansion for which its proponents long hoped. The Clinton administration was also strangely uninterested in it, and it grew during the 1990s only due to the initiative of a bipartisan coalition in Congress and improved financing arrangements. In the past decade, a massive expansion has occurred, but under the unlikely stewardship of the George W. Bush administration. While many other programs for the poor

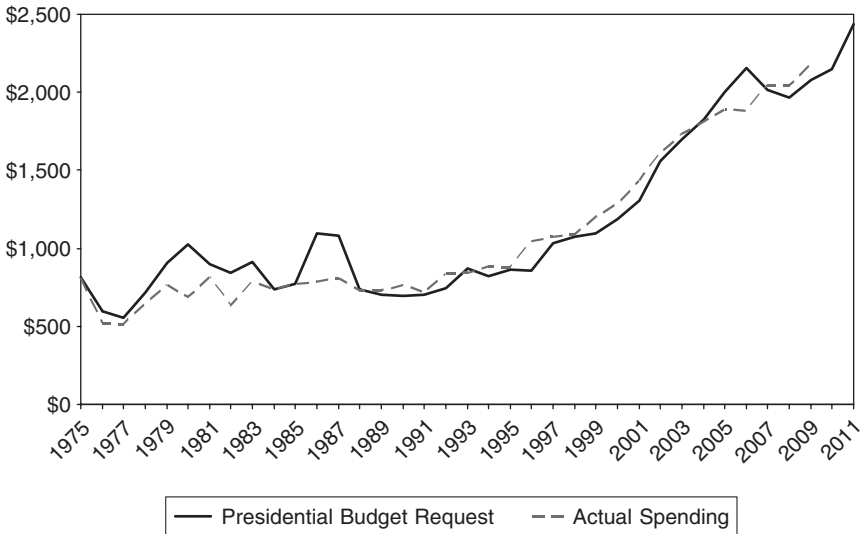


Figure 2.1 Federal Spending on Community Health Centers, 1975 to 2011 (millions, in constant 2010 dollars)

Source: The Budget of the US Government, Appendix, 1975–2009

or medically underserved were slashed or eliminated during the Bush years, the number of delivery sites has tripled since 2000 and the number of patients served has more than doubled. Plans folded into the ACA are even bolder; funding commitments call again for these centers to double their patients served to *forty* million by 2015, or fully two-thirds of America's medically underserved (Ku et al. 2010).

This bizarre trajectory, I argue, cannot be explained simply by shifts in party control of Congress or the White House, ideological trends, or the vagaries of distributive politics. Rather, the ebbs and flows of this program are best understood as the product of political learning. I argue that Democrats and Republicans learned lessons during the long battle over national health insurance (NHI), that they adapted their positions on health policies in light of these lessons, and that these adaptations help explain the trajectory of the health centers program. Beginning in the 1970s Republicans came to see the health centers program, and particularly its national expansion, as part of a strategy to facilitate Democratic proposals for universal coverage. NHI proponents would, Republicans feared, be able to point to the existence of a network of facilities for the poor already in place, thus reducing some of the practical difficulties of creating a workable system. Republican attempts to eliminate the program are best viewed in the context of their efforts to tear down the welfare

state through a frontal assault. Meanwhile, by the 1990s many progressives devoted to the attainment of universal health coverage had developed a strange ambivalence toward programs for the underserved. They came to see them, in Leninist “one step forward” fashion, as weakening pressures for systemic reform of the health care system.

Over time, conservatives came to agree with them. This chapter explains the Bush administration’s embrace of the program as an adaptation to conservatives’ earlier failures to retrench the US welfare state head on, and as part of a renewed effort by conservatives to “limit—or, more often, refocus and redirect—activist government.” The Bush health centers expansion was consistent with other federal interventions into health care, education, and pensions. These interventions, while angering many fiscal conservatives, grow out of their adaptation to lessons learned: a longer-term strategy to build some government programs in order to shrink other larger programs (Pierson and Skocpol 2007, 3; Glenn and Teles 2009). Bush’s health centers initiative reflected this new understanding as well as lessons that Karl Rove and others learned about the electoral consequences of their party’s vilification during budget battles with President Bill Clinton in the mid-1990s. The response to this second set of lessons helped produce “compassionate conservatism.”

Thus, the early conservative attack, many progressives’ puzzling ambivalence toward health centers, and the subsequent conservative embrace are, I argue, explicable in terms of learning and adaptation. I describe the origins and development of the health centers program amidst the War on Poverty, and I chart how the program muddled through from the Nixon years until 2001. Of particular importance here is the ambivalence shown toward the program by the Clinton administration. I offer an explanation of the puzzling Bush health centers initiative. The chapter closes by discussing some challenges facing the program in the aftermath of the landmark ACA.²

The Prehistory of the Federal Community

Health Centers Program

Traditionally, public health and medical care in the United States were squarely the concern of local communities, especially their private actors. States and the federal government evinced little interest in these matters, save for episodic outbreaks of cholera and other infectious diseases (Duffy 1990). During the first three decades of the twentieth century, a health centers movement emerged in America’s cities, growing out of similar circumstances, organizational forms, and objectives as those that would appear in the 1960s—in particular, recent demographic changes in American cities. Reformers focused

on the medically indigent urban poor, the vast majority of whom were thought culturally different from the mainstream.³ They sought to rationalize medical care through community health planning and to disperse medical care in stations or clinics at the neighborhood level. By one count, more than 1,500 centers operated in the United States in 1930. But the term “health center” was applied broadly; it referred to child welfare stations, tuberculosis dispensaries, hospital outpatient departments, settlement houses, local health department substations, and so on. Very few of these offered a full range of primary care. They were not meant to supplant the role of doctors but performed diagnoses and made referrals to private physicians. Still, local medical societies strongly objected to them and blocked efforts by state legislatures to assist them. They faded in the 1930s (Davis 1927; Hiscock 1935, 434; Starr 1982).

For most of its history, the federal government was effectively absent from the provision of health care, apart from its efforts on behalf of a few populations (merchant marines, military personnel, federal prisoners, Native Americans, etc.). This situation began to change somewhat in the early 1920s with the provision of grants to states for establishing centers for prenatal and child care and health education.⁴ During the New Deal, the federal government began experimenting with other public health grants to states (Stern 1946).⁵ In 1946 President Harry S. Truman signed the landmark Hill–Burton Act, and the federal government’s involvement in medical care began in earnest. Over the next two decades, federal matching grants for hospital construction and modernization—alongside “urban renewal” development projects—helped reshape the local political economy of health care access. By 1971 more than \$60 billion (in 2009 dollars) had been spent on almost eleven thousand projects. Hill–Burton helped construct the modern American hospital. But this and other federal interventions did not much change American primary care, the main features of which had taken shape by the 1920s. Most individuals saw fee-for-service doctors in solo practice. Hospital outpatient departments provided some primary care to means-tested charity patients. While there were networks of health reformers, some of whom challenged this orthodoxy, few communities nurtured critical masses of health professionals calling for new ways to deliver care to the medically indigent (Sardell 1988, 37; Derickson 2002; Hoffman 2003).⁶

While most observers of American primary care may have been confident in the basic arrangements, they began to notice problems. Accelerated by technological advances, federal support of biomedical research, and facilities construction, the share of general practitioners (GP) was in sharp decline.⁷ As an older generation of primary care providers began to relocate or retire,

the maldistribution of GPs increased in central cities throughout the 1950s. Poorer city residents increasingly sought care in hospital outpatient departments and emergency rooms (Hoffman 2006). Meanwhile, the demographics of these central cities were changing quickly. At the time of the consolidation of the “second ghetto” in non-Southern cities in the 1930s, the average black city dweller lived in a neighborhood that was about 40 percent black; by 1970 this would rise to 68 percent. Poverty was becoming much more concentrated, and white residents as well as health professionals began to exit central cities in larger and larger numbers in the 1950s. As the quality of care increased for many Americans, it declined in many cities. By 1965 majority-black neighborhoods numbering tens of thousands of residents relied on sometimes no more than five or six doctors, most semiretired (Lashof 1968; Richmond 1969, 94).

On the eve of the development of the community health centers program, observers could reflect back on a recent history in which public health functions remained isolated from the provision of medical care, and local medical establishments had defeated or deterred local and state governments from developing coordinated institutions of subsidized care for the medically indigent. Those interested in developing new arrangements had a good sense of the barriers facing them.

The Origins of the Community Health Centers Amid the War on Poverty

The community health centers program emerged from the confluence of several factors: structural changes in US politics, savvy policy entrepreneurs, pressures from below, and a search by empowered federal officials for policy alternatives that fit their own goals. Here, I sketch the origins of the program and discuss the politics of its early expansion and performance.

The overarching context in which the health centers program developed was an especially propitious environment for new social policymaking. President John Kennedy’s death provided President Lyndon Johnson with an opportunity to pursue his longstanding interest in attacking poverty. However, Johnson’s 1964 landslide victory over Goldwater, coupled with now massive Democratic majorities in Congress, provided the real political opening. In their absence, the Great Society along with its War on Poverty programs would not have been possible.

Besides this structural opportunity, the Johnson administration felt pressured from many quarters to address issues of poverty and inequality, especially as these affected American cities. As early as 1964 the administration perceived the need to craft urban policies that would reduce material

deprivation and thereby reduce the likelihood of riots and other threats to social order. And Johnson was himself personally driven to attack poverty in cities and in rural America. With respect to electoral considerations, even after the landslide victory over Goldwater, Johnson and others in his administration were growing worried about the health of the Democratic Party's New Deal coalition. As "white ethnics" streamed out to the suburbs, the White House felt an urgent need to cement the party loyalty of America's increasingly black and brown cities—and, if necessary, to do so by delivering policy benefits to them over and around potentially recalcitrant city halls.⁸

The War on Poverty also provided a favorable institutional setting. In early 1964 the White House began to develop the legislation that came to be known as the Economic Opportunity Act (EOA), as well as plans for the Office of Economic Opportunity (OEO). Johnson preferred that War on Poverty programs be developed and implemented by the OEO, a new agency housed within the Executive Office of the President. This was done partly to facilitate more rapid, innovative programs that would not be slowed or stalled in the federal bureaucracy (Flanagan 2001). The OEO would be staffed by officials highly sympathetic to Johnson's aims. Many of them had been involved in, or witness to, direct action and other campaigns in the South and North beginning in the 1940s.⁹ Thus, when the poverty warriors would turn to the health care of the poor, they did so in communities already marked by episodic organized protest on health issues.¹⁰

A sustained, federal intervention into the provision of primary care was anything but preordained. Of course, health care was in the forefront of the administration's policy goals. Medicare and Medicaid would become law during the same year that the first health centers were established. Still, the EOA did not suggest that the federal government's antipoverty programs would impinge upon medical care. Nor did OEO staff or White House officials plan on developing health-related programs. However, as other programs such as Head Start and Job Corps conducted physical and dental exams for its participants, OEO staffers were shocked by the magnitude of the health problems they encountered. According to one report, 70 percent of Head Start children had never seen a doctor (Geiger 1984). This led OEO staff and, later, community action agencies to develop health delivery projects as part of other antipoverty programs, such as Volunteers in Service to America (VISTA).

OEO officials could choose to help local community action agencies develop a range of small projects or they could develop a program that, if successful, could be deployed on a larger scale. Still, they believed that the poor had much more complex health needs than the nonpoor, and that these

needs were not being met by current arrangements of uneven charity care and beleaguered city hospitals. Federal bureaucrats and other policymakers located within the executive branch developed key precepts of the War on Poverty—including its emphasis on community participation, enshrined in the EOA—from a variety of sources. The roots of many programs later associated with the War on Poverty began several years earlier in the form of interventions by philanthropic foundations and governments to attack problems of juvenile delinquency and joblessness. Casting about for ideas to develop programs of medical care for the poor, OEO staffers were disappointed with what they found via inquiries to the Department of Health, Education, and Welfare (HEW), and in particular its Public Health Service (Administrative History Papers 1974, 131, 327; Schorr 1988, 130). Thus, even after OEO officials had convinced themselves that an expansion of antipoverty programming into health care was advisable, developing something like a health centers program was still far from likely.

Then, one day in early 1965, Dr. William Kissick, assistant to the Surgeon General of the US Public Health Service, called Lee Bamberger Schorr, an OEO official with a background in health policy. “There’s a wild man in my office, and he’s got some ideas we can’t do much with over here, but I think you people in the War on Poverty would find him pretty interesting. I’m sending him right over.” Jack Geiger met with Schorr, and the health centers program soon began (Schorr 1988, 130–131). Geiger, a physician long active in efforts to fight race-based inequalities in the United States, had worked in the 1950s as part of a legendary effort in rural South Africa to craft what public health advocates now call “community-oriented primary care.”

Along with a collaborator, Dr. Count Gibson Jr., Geiger developed a funding proposal to establish two community health centers that built on the South Africa model. The first would be in Boston’s Columbia Point, a predominantly black housing project. The second, later named the Delta Health Center, would operate in Bolivar County, Mississippi, a rural, predominantly black area. The centers would provide comprehensive ambulatory care to all residents in these severely medically underserved areas (Geiger 2005, 314; Lefkowitz 2007, 35). Like those in South Africa, these centers would conduct aggressive outreach work through the employment of local residents as health workers. They would also provide a range of public health functions. And the centers were to be managed and operated in part by residents themselves.¹¹

OEO staff welcomed the proposal, and Geiger and Gibson won approval for grants for both centers in June 1965.¹² The funding source was the research and demonstration authorization of the OEO’s Community Action

Program. Both centers were quickly successful in increasing access to primary care, and in developing and implementing public health functions (Administrative History Papers 1974, 346; Geiger 2002, 1715; Geiger 2005, 317; Dittmer 2009).

Through these and a handful of other grants over the next year, the health centers program began to take shape. Several important decisions were made early on. First, the program would continue to develop quietly, without the visibility that would come with its own statutory authorization or budget line. As a research and demonstration project, it would be housed in the research and development office of the Community Action Program.¹³ Second, the program would operate by providing grants in a competitive process. Applicants would have to come from a public or private nonprofit organization, and would have to be sponsored by another institution, whether a community action agency, medical school, hospital, or local health department. A sufficient coalition of actors within a community would have to want health centers in order to receive federal funding for them. It is generally agreed that the OEO (and, later, the HEW) kept “politics” out of the grant evaluation process. Third, in keeping with the “maximum feasible participation” directive of the EOA, all centers would have to be either advised or actually governed by nearby residents. Fourth, all residents living in a center’s designated catchment area (between ten thousand and thirty thousand) would be eligible for free care. Fifth, centers would provide not just comprehensive ambulatory care but also what would come to be called supplementary services, from health education to substance abuse to transportation arrangement and outreach efforts. Sixth, health workers would explore new ways of using support staff and developing careers for poor residents.

Growth, Eligibility, Financing, and Community Relations

By 1971 there were between eighty and one hundred ongoing projects, three-quarters of them in urban areas (particularly those where black protest had been strong) (Hollister 1974, 2; Hollister, Kramer, and Bellin 1974, 17). The health centers were often thought of as “ghetto medicine,” a view that did not change much until the rapid expansion of rural centers during the Carter administration. Some preferred that the program develop slowly and remain small enough so that it did not develop bureaucratic requirements that would stymie the ability of centers to adapt to local needs, conditions, and resources (Administrative History Papers 1974, 326). From this perspective, it was an asset that the program was a demonstration project shielded from congressional oversight and much publicity. Those who sought to revolutionize the

provision of primary care, or those who wanted to maximize access to the underserved, wanted a much larger funded program to develop quickly. For instance, an HEW planning document in 1967 called for the establishment of one thousand centers that would serve some twenty-five million poor individuals by 1975. Projected costs were \$3.5 billion (or about \$15 billion in 2009 dollars) (HEW 1967; Lefkowitz 2007, 10).

Besides budget constraints, there were additional limits on the size of the program on both the supply and demand sides. The OEO lacked the administrative capacity to encourage, review, and help implement many federal grants (Administrative History Papers 1974, 327, 337–338).¹⁴ Moreover, the number and quality of applications depended in part on the number of local health care reformers. A weak infrastructure nationwide limited the number of communities with a critical mass of reform-minded medical professionals who could agitate, advocate, and cajole potential health center sponsors to help develop and sign onto grant proposals.

After a few years of receiving and encouraging grant proposals from maverick, reformist public health activists and medical professionals, it became increasingly difficult for potential applicants to find sponsoring institutions that would accept the required governance structure and other features of the program (Lefkowitz 2007, 12). A successful application required that an organization could demonstrate that it had the potential involvement of health professionals and institutions as well as a physical location, a financial plan, and so on. Local and state networks of health center advocates were vital for encouraging organizations within communities to apply; the communities in greatest need often lacked the resources to craft competitive applications. Of course, in the mid-1960s, these networks had not yet developed. Many communities were prevented from submitting competitive applications often for the same reason they needed health centers: the lack of primary care providers. The program began almost ten years before the first group of National Health Service Corps physicians began arriving at (usually rural) centers (Zwick 1972, 392, 404).

Within the OEO, views differed on key issues such as eligibility. OEO initially imagined that all residents of a health center's designated area would be eligible for free care there, and program guidelines reflected this. However, this preference was based in part on their expectation that some 80 percent of families in designated neighborhoods lived below the federal poverty line. This estimate was significantly off; the actual share was between 40 and 60 percent. If centers came to serve as the regular primary care provider for a higher share of the nonpoor, the program would be open to the same criticism that

ultimately killed off the health centers of the 1920s—that the nonpoor abused the public trust as private physicians lost patients to the state. Officials in OEO’s legal and political offices therefore opposed a geographic eligibility standard. They were not disappointed, then, when Congress in 1967 restricted free care to “low-income” residents. In the OEO’s interpretation of this statutory language, the poverty index or the particular state’s Medicaid income eligibility standard was to be used. Thus the program became known as “poor people’s medicine.” Of course, the near-poor would be shut out of this arrangement. In 1969, spurred on by complaints from local doctors, Congress held that although health centers could serve families above poverty on a partial or full-pay basis, no more than one-fifth of all patients could be served in this manner (Zwick 1972, 410). Observers argued later that these restrictions on health centers’ ability to rely on paying patients “guaranteed the almost total dependence of the . . . program on public funds” (Davis and Schoen 1978).

In 1965 OEO officials never envisioned that the centers would become fully federally funded. Indeed, the hope was that local resources, paying patients, and Medicare and Medicaid would develop self-sufficient centers (Schorr and English 1974). Medicare and Medicaid—especially the latter—would be the key to financing the centers. Indeed, Medicaid officials expected that the program would be able to support health centers across all fifty states by 1975. Federal grants, then, would provide resources for establishing centers and perhaps expanding the services they could offer but would not be critical to year-to-year operation.

On this view, the program’s fate depended on the reimbursement arrangements that OEO made with HEW (for Medicare and maternal and child health programs), HEW and the states (for Medicaid), and private insurers. By the late 1960s it was clear that the early hopes of financial self-sufficiency would not be fulfilled. State Medicaid programs restricted rather than expanded both eligibility standards and the scope of reimbursable services. Some did not even recognize health centers as facilities qualifying for reimbursement. Adding insult to injury, both Medicaid and Medicare developed much more generous reimbursement systems with hospital outpatient departments. Still, health centers treated many patients not covered by state Medicaid programs. Even worse for their financing, they remained true to their mission. By the early 1970s only about 60 percent of operating expenses went to medical care. Dental care absorbed another 15 percent, as did health education, community organization, and social work—none of which Medicaid reimbursed. By the early 1970s Medicaid and Medicare constituted less than 20 percent of operating revenues (Zwick 1972; GAO 1973, 79; Sardell 1988; Schorr 1988).

Most centers partnered with hospitals and medical schools. This was part of a conscious strategy by OEO staff to prevent local opposition. Reform-minded medical professionals were more likely to be located in these institutions than, say, local health departments; the latter often resented competing for control of services for the medically indigent with others, or were ideologically opposed to the mixture of medical care and public health functions (Colgrove 2007, 15).¹⁵ Indeed, medical schools submitted the best applications. Another motive drove this pattern—because this was a new program initiated by a quickly beleaguered agency, there was a strong desire among OEO staffers that the first wave of centers succeed. Finally, any OEO grants to “limited purpose organizations” such as community action agencies could be vetoed by governors, and OEO officials feared Southern vetoes of health care funds. However, educational institutions such as medical schools were exempt from this rule.

From the start, program administrators leaned on grantees to involve members of the local medical establishment wherever possible in order to tamp down opposition to the centers. Additionally, health centers were directed by hospital staff, medical school faculty, officials from local health departments, and physicians in private practice.

Local (white) medical societies often opposed health centers in their early days. Still, outright battles with local doctors and grant applicants were not very common; doctors rarely intervened in communities where applications had been submitted. Hospitals were at first hesitant about accepting health centers. After all, health centers could be seen as competing with hospitals’ own outpatient departments. However, many came to appreciate the presence of health centers for reducing problems of overcrowding. Later still, some saw them as competition as their worries shifted to empty beds, especially given expanding new opportunities for recouping third-party payments (Hollister 1974, 17).

Advocates and Critics

There were early concerns that the American Medical Association (AMA) might kill off the program. Young senator Ted Kennedy (D-MA) was chosen to sell the program on the Hill, and his staff crafted amendments to the EOA.¹⁶ In 1966 Congress provided for the funding of “comprehensive health service programs” for the underserved in both rural and urban areas. Kennedy proposed a budget of \$100 million, but about \$51 million dollars was authorized (for thirty-three existing centers and eight new ones). Congress nodded at centers’ less strictly health-related activities, noting that whenever possible they should furnish “arrangements for providing employment, education, social

or other assistance needed by the families and individuals served.” Kennedy argued that the program should be viewed separately from other War on Poverty programs; health centers, unlike community action agencies, were apolitical.¹⁷

At this time Congress began to fund a range of regional health planning projects, formula grants to states for health services, and state comprehensive health planning agencies. Much of this activity came in the form of block grants authorized by the Partnership for Health Act. The legislation also authorized project grants for new types of health services. Vague language provided the surgeon general (then head of the Public Health Service) with discretion to operate many different programs. A small coalition of health center advocates inside the HEW eventually won this budget line as a safe place from which to fund health centers.¹⁸

In Washington the health centers program engendered little discussion and even less controversy.¹⁹ This was in part a function of the program’s small size; in terms of appropriations, it lagged far behind youth programs, Job Corps, Head Start, VISTA, and other programs. Many OEO controversies involved the mobilization of the poor—especially blacks and Hispanics—in central cities. But health centers were effectively framed in congressional hearings as non-political in a way that other OEO programs were not. Still, the appearance of a new generation of “activist MDs” often proved controversial at the local level. In some cities, large conflicts were sparked by health centers and other efforts to introduce community input in the governance of health facilities (including mental health clinics and hospitals) (Mullan 1976).

For the program’s first decade, the (white) AMA as a national body vacillated between rejecting almost any federal role in health care delivery and seeking a leadership role in the health centers program for local medical societies.²⁰ Despite OEO’s commitments to AMA representatives that its projects would not compete with local physicians, medical societies sometimes blocked applications, and it is likely that many more individuals and groups were self-deterred by potential opposition. But in 1969, just four years after the program began, the OEO considered the AMA a strong supporter of the program. In the interim, the AMA had become somewhat more image-conscious. Medical schools soon came around, often in part to deflect standard “town/gown” criticisms of their (non)involvement in communities. The black National Medical Association was mostly supportive, but at the local level, groups of black health care professionals and community groups frequently charged that OEO failed to incorporate black doctors into the program (Boyce 1969; Richard 1969).

As oversight of OEO increased and its budget declined, the heat on the program rose. OEO (and later HEW) was pressured to evaluate the program

according to some often-ridiculous standards—such as demonstrating immediate reductions in rates of infant mortality (Tilson 1973; Hollister 1974). Early assessments suggested that centers increased access and use of health care, reduced the use of emergency rooms by the poor, and elicited positive assessments by users (Hillman and Charney 1972; Zwick 1972). Serious criticisms existed on both the left and right. From the right, they were criticized as too costly and inefficient. In particular, there were often administrative problems, especially involving recordkeeping, securing reimbursement from third-party payers, and personnel issues. From the left, there was some concern that the program merely maintained rather than alleviated a “two-tiered” health care system, and that they served as a safety valve to relieve pressure on systemic health care reform (Torrens 1971; Hollister 1974, 3; Marcus 1981). On the eve of Nixon’s inauguration, the future of the program was in doubt.

Health Centers from Nixon through Bush, 1969–1993

What is impressive about the health centers program across this quarter-century is its stability amid so much change. The program was transferred multiple times across and within cabinet departments and agencies, and survived attempts to reduce or eliminate it by three Republican presidents. Begun as a predominantly urban program dispensing what many called “ghetto medicine,” community health centers had to weather an abrupt decline in interest in and attention to America’s cities. Moreover, they had to compete for attention amid various proposals for health maintenance organizations (HMO), NHI, and calls for the retrenchment of Medicare and Medicaid. Meanwhile, the problems driving the program worsened, among them increasing numbers of underserved and uninsured individuals and decaying safety-net facilities. Over this period, the program did develop a means to defend itself in the form of a federated lobby. But it also developed more serious opponents. As the program wended its way through the 1970s and 1980s, conservatives began to see it less as a small, if inefficient program, better administered by the states and more as one step in a carefully planned incrementalist drive toward NHI.

The Nixon and Ford Years

The rapid expansion of medical costs put cost containment at the forefront of President Richard Nixon’s health agenda (Richmond and Fein 2005, 59–60). During his first term, Democrats continued to capture the momentum on developing credible NHI proposals, most importantly the Kennedy–Griffiths proposal. In late 1970 Nixon searched for a way to advance his own health reform as this momentum increased. He asked HEW secretary Elliott Richardson to

prepare a major “presidential health message” describing Nixon’s alternative health insurance proposal, with HMOs as its centerpiece. However, OEO director Donald Rumsfeld proposed an alternative restructuring of the health care system: a network of eight hundred to one thousand health centers providing primary care to tens of millions of Americans. The idea was rejected for several reasons, among which were HEW’s preference for HMOs and the fact that calling for an expansion of a War on Poverty program would not allow Nixon to leave his own mark on health policy (Nixon 1971).²¹

Perhaps more consequential for the health centers program was Nixon’s determination to reverse President Johnson’s “creative federalism.” For Nixon, an appropriate balance of power between the federal government and the states required for devolution to the states of program administration. Given his proposed massive expansions of income transfers to the poor, his concerns seemed less budgetary than administrative. Plans for several large block grants coupled with revenue sharing would, he hoped, allow states to administer federal funds more effectively. Block grants would reduce the administrative complexity and poor performance of hundreds of federal programs in states and municipalities, each with its own (often contradictory) requirements. Additionally, Nixon sought to shrink the federal bureaucracy he so loathed and distrusted (Conlan 1998).²²

Nixon’s efforts were generally unsuccessful. Proposing six large block grants, he was able to secure passage of two of them through a distrustful Democratic-controlled Congress. Block grants have always been feared by constituencies of discretionary programs. When funds are transferred to states, a mad scramble often ensues to preserve funding for each program. But the situation for health centers was much more difficult than usual. First, the program served social groups who had very little power. Second, states had not come to rely on this new program. Thus, surmised its proponents, it would have to compete for funds with other programs for the disadvantaged and would have to face off against much more politically influential programs (such as those providing funding to hospitals). Health centers, they feared, would be early victims in the budgetary politics that followed a conversion of federal health programs into block grants. For reasons that had little to do with the particularities of the program, Congress defeated proposals to block grant health centers. But the specter of health centers’ death-by-block-grants would appear again.

OEO remained supportive of the health centers program, which it saw as generally successful.²³ Nevertheless, Nixon downgraded OEO into an incubator of new programs, as was expected; more stable ones would be moved to relevant agencies. From 1970 operational responsibilities for the health centers program began to be transferred gradually to HEW, a process that ended in

1973 when the OEO was effectively terminated. There was a good deal of concern that the move from OEO to HEW would damage the program. HEW's regional offices oversaw health centers and took over the grant awards process. However, the staff of these regional offices rarely had experience with or taste for health centers (Sardell 1988, 79). More generally, health center advocates feared that the move from OEO to HEW would rob the program of its staunchest allies in the executive branch during its hour of need, and might defang the program of its most provocative features. Most important here were the centers' provision of nonmedical and social services, and their community governance requirements. However, by the time the move occurred, a small but determined group of advocates for the program had developed in HEW's new Bureau of Comprehensive Health Services (which was established in 1972 as part of another reorganization of the Public Health Service).

Besides the danger of block grants, Nixon (and, later, President Gerald Ford) opposed what seemed like runaway growth in federal spending via discretionary grants and sought to attack them directly. (Here, community health centers were not themselves singled out among primary care programs.) The Nixon administration directed the HEW to reduce or eliminate discretionary programs the administration had been unable to block-grant back to the states. HEW had been forced by the White House to cease its communication with congressional supporters of health centers, part of a larger "centralized politicization" of the executive branch during the Nixon years (Nathan 1975). Relatedly, the White House demanded that the program justify its existence in terms of both cost-benefit analysis and financial self-sufficiency. In 1972 and 1973 the HEW published regulations claiming that the health centers' statutory authorization required them to become self-sufficient. Thus, federal grants supporting them would be ending.

Given the financing problems presented by Medicare and Medicaid, self-sufficiency was out of the question unless the health centers were to be converted into the barest of clinics (GAO 1973). The Medicaid situation was dire. In 1973 federal bureaucrats required states to provide outpatient care at hospital "clinics" to Medicaid patients, but payment to health centers were considered "optional." Four years later, only twenty-two states and Washington, DC, recognized health centers as "clinics" and therefore guaranteed their reimbursement. Even when so recognized, only five of these states reimbursed centers for their outreach services. Worse, neither Medicare nor Medicaid reimbursed health centers for the work of nontraditional providers, such as nurse practitioners, physician assistants, and family health workers.²⁴ Finally, reimbursement rates for Medicaid were often very low. The continued

provision of federal grants was thus imperative. Ultimately, HEW decided to guarantee continued financing but demanded that centers rely more heavily on third-party payers (GAO 1973; Sardell 1988, 87, 127–128; Lefkowitz 2007, 20).

The budgetary authority used for health centers remained a vague “projects” line for HEW. The weakness of lacking its own specified budgetary authority was becoming apparent, for Nixon used this same budget line to finance HMO demonstration projects.²⁵ These projects effectively squeezed out health center funding. In 1971 one hundred OEO centers and about fifty HEW centers were in operation. From 1971 to 1973, no grants were awarded to establish new centers. Still, congressional appropriations each year exceeded Nixon’s requests. Members from highly rural and highly urban states were most supportive.

The most serious threat to the program’s survival occurred when Nixon (and later Ford) opposed the reauthorization of grants for health centers. At the time, health centers and twelve other health programs were due to expire at the end of fiscal year (FY) 1973. Nixon proposed that health centers and five related programs not be reauthorized, and the remainder reduced in size. Congress balked, extending funding for the threatened six for one more year. Congress did so by veto-proof margins, and Nixon signed this into law in June 1974. Congress then sought to stabilize the program through new legislation that specifically authorized “community health centers” by name and with its own designated funding. It did so by unanimous voice vote in the Senate and by a vote of 359–12 in the House. The program clearly remained uncontroversial, but Ford pocket-vetoed the legislation in December 1974, arguing that it “would result in an unjustified expenditure of federal taxpayers’ funds” (Ford 1974). Congress repeated the process in 1975, Ford vetoed the bill, and Congress overrode his veto by huge margins.

Health centers had, for the first time, their own legislative authority.²⁶ They now also had legislative protection from future Republican presidents who might seek to use HEW rulemaking powers to weaken the centers. Congressional advocates did this by explicitly defining “primary” (required) services and so-called supplementary (recommended) services. Still, Ford continued to fight health centers and major discretionary health programs through low budget requests, another veto, and continued efforts to block-grant these programs. He envisioned replacing not just these small programs but also Medicaid and all health planning funding with revenue sharing (Sardell 1988, 100–101, 111).

Organized Interests

At the national level, the AMA continued to send mixed signals. While ostensibly advocating for the program’s continuation, AMA president Carl A. Hoffman,

MD, suggested in 1972 that armed guards be stationed outside “ghetto health centers” in order to overcome doctors’ reluctance to work in them (*New York Times*, Nov. 27, 1972). But the AMA did not deploy its still considerable political forces in Washington against the program during congressional deliberations. Rather, it voiced in rather perfunctory fashion its arguments for a more limited federal role in the provision of health care. One observer suggested that serious opposition would develop only “when the program gets bigger.” These mixed signals may have reflected ideological and generational conflict within the national organization. Perhaps more important than the lobbying of the national association was the behavior of county medical societies. At the local level its county medical societies seemed to have made their peace with the program; by 1982 they were considered “overwhelmingly positive” toward the health centers. The passage of time convinced many that health centers would not destroy their private practices. And the relative importance of local doctors’ preferences vis-à-vis the AMA grew over time as a result both of the waning power of the latter and of the increasing share of congressional districts featuring health centers (Sardell 1988, 94–95, 80–81, 183).

Over this period, the most important development regarding organized interests was the birth and growth of a lobby for health centers. Termed a “health centers movement” by those involved, the National Association of Community Health Centers (NACHC) formed in the early 1970s and played a pivotal role in the program’s survival and growth. The federal government also played a critical role in accelerating the development of the NACHC by awarding it training and research grants. OEO staffers were well aware of the need for a “viable political constituency” supporting health centers. By 1973 it had supplanted the regional networks of health centers that had begun in the late 1960s. However, it was not until the late 1970s that the NACHC moved to center stage in health center policymaking. While useful in congressional deliberations and helping advocates within HEW prevent cuts in the list of services required of health centers, the lobby’s real impact would be felt a few years later, as it did battle with the Reagan administration.²⁷

In another significant development, in the 1980s the Robert Wood Johnson Foundation helped fund efforts by the NACHC to develop state-level primary care associations and nine regional associations (mirroring HEW-designated regions) (Sardell 1988, 190). State-level lobbies were potentially important, especially in congressional deliberations about funding and finance mechanisms. Finally, as health centers became established in their communities, their governing boards became important political supporters. Impressively, the community governance element of health center governance did not fade, even

as the mantra of “maximum feasible participation” had been replaced, at least in elite policy circles, with the mocking phrase “maximum feasible misunderstanding.” On the contrary, governance requirements grew *more* demanding, not less. By 1973 OEO required that community participation be effected only through governing, not advisory, boards featuring a majority of active consumers. Many of the nonconsumer members were pillars of their communities, knowledgeable about politics, and familiar with their member of Congress. Over time, the duration of health centers thus came to enhance their durability.

The Carter Administration

Health policy during the Carter years is remembered for the failed attempts to contain hospital costs and for the failure of progressives and political leaders to converge behind a single NHI proposal. Even in failure, though, the administration’s own NHI proposal confirmed many conservatives’ suspicion that the expansion of community health centers was a key part of a long-term plot to secure NHI.

In 1977 the incoming Carter administration gave reason for both health center advocates and proponents of NHI to be optimistic (Iglehart 1978). The 1976 Democratic party platform had urged that the health centers program be “resumed.” Unlike Nixon and Ford, Carter and his advisers were likely to be sympathetic toward the program, and he staffed HEW with several individuals who had been instrumental in nurturing the program from the beginning. Carter—unlike Republican presidents—needed to reward traditional Democratic voters, including those in big cities. He could also look out his window and see a Congress controlled by very large Democratic majorities.

Carter called for and won funding increases for both community health centers and migrant health centers. The year 1978 was important for the program. Having finally secured its own legislative authority in 1975, it was now up for reauthorization.²⁸ Still, the program attracted little attention, positive or negative.²⁹ The program received a three-year reauthorization and substantially higher funding levels; its FY 1981 authorization was more than double that of FY 1978 (not controlling for inflation). It passed by large margins in both chambers but faced substantial Republican opposition in the House.

Besides securing separate legislative authority in 1975, the most important change in the 1970s was Carter’s expansion of the program. Through the Rural Health Initiative, Carter’s HEW built on a small program begun by HEW’s Bureau of Comprehensive Health Services to target more funding to rural areas—especially those unable to develop competitive grant proposals. This was funded out of the same appropriation as all other centers.³⁰ Politically, this

was advantageous to the health centers program because it greatly widened the number of congressional districts with centers; no longer would it be a “black program” (Sardell 1988, 117). Substantively, the Rural Health Initiative’s effects were less clear. On the one hand, it redressed a serious imbalance. One-half of medically underserved individuals lived in rural areas, and yet some 85 percent of grant funding went to cities (*ibid.*, 112). This imbalance had many causes, one of which may have been that urban proposals were more competitive because they were more likely to make credible claims about recruiting health professionals than their rural counterparts. By the end of Carter’s term, every state and a majority of congressional districts had at least one of the 862 health centers funded in 1978; of these, 571 were in rural areas (Reynolds 1999, 8).

On the other hand, the Rural Health Initiative also began a tendency to develop a “lean and mean” program. The emphasis was on developing hundreds of additional centers, but smaller ones.³¹ Later the “lean and mean” ethos extended to urban centers. Prodded by members of Congress representing large cities, Carter launched an urban health initiative that funded many projects at smaller levels (Sardell 1988, 118). To many HEW officials, the program’s expansion meant developing sites of care provision that more closely resembled existing safety-net facilities, such as hospital outpatient clinics, and turning away from the grander visions of the 1960s. While many centers managed to find nonfederal sources to fund environmental and other nonmedical services, or coordinated with other local organizations and agencies, smaller awards for new and existing centers—coupled with inflation—forced many centers to abandon their supplementary services; in fact, HEW enacted rule changes that made it easier for grantees to avoid offering these services (Lefkowitz 2007, 299).³² Although the program was expanding, by 1978 it still reached fewer than 10 percent of the medically underserved. And while it now had its own legislative authorization, it still remained poorly integrated with Medicaid and therefore remained financially vulnerable. Its next problem, though, was political.

Ronald Reagan and the Threat of Death-by-Block Grant

President Reagan posed the most serious threat to the health centers program thus far in its history (Reynolds 1999). While continuing efforts of his Republican predecessors to kill off discretionary health programs through block grants, he had some important resources that they had lacked. He operated with a perceived mandate to cut taxes and spending and to devolve the role of the federal government. Moreover, he assumed office with this mandate

while Republicans held a majority of Senate seats; the Democratic majority in the House had been whittled down to only twenty-six seats. Congressional Republicans had grown much more conservative since the Nixon years, and many Democrats, especially in Reagan's first term, were "running scared" and in a mood to compromise.

It is in the early Reagan administration that we can begin to see more clearly the influence of the conservative movement on Republican domestic policy. This is in part because the Reagan years both were fueled by and further accelerated the development of an infrastructure for conservative policy analysts and political strategists. This is visible most clearly in *Mandate for Leadership*, the Heritage Foundation's famous 1980 effort to assist a victorious conservative candidate. Subtitled *Policy Management in a Conservative Administration*, the 1,093-page book was made available to Reagan's transition team. The chapter on the Department of Health and Human Services (HHS) is instructive, for it articulated the then-predominant view of conservative analysts and officeholders about community health centers and other health care delivery programs. Here the program's national expansion was viewed as a conscious strategy to hasten the passage of Democratic proposals for universal coverage. The prior development of health centers might serve as a "bootstrap" to NHI because proponents would be able to point to the existence of a delivery network of facilities for the poor already in place, thus reducing some of the practical difficulties toward a workable system.³³

Reagan's first budget (FY 1982) slashed \$6.6 billion in grants-in-aid funding, including cuts in funding for health centers of about 25 percent.³⁴ These cuts forced the Health Services Administration, the agency then administering the health centers program in the new HHS, to alter the metrics used to designate areas as either "medically underserved" or as "health professional shortage areas" in an effort to justify cuts to health center funding. The Bureau of Comprehensive Health Services took back control of the grant-making process so it could manage the cuts, which led to a reduction in patients served and a decline in the nonprimary services that the centers offered. In all, about 187 centers were eliminated.³⁵

As with many parts of the federal bureaucracy, the early 1980s were not happy times for health center advocates in the HEW/HHS. Reagan cleaned house, sweeping away many of the more pragmatic appointees, convincing many civil servants to resign, and taking budget-making power away from the agency and installing it in the Office of Management and Budget (OMB). The AMA and the Association of Medical Colleges chose the appointees for the critical positions of assistant secretary for health affairs and his deputy;

these appointees were not enamored with the health centers program. Civil servants who remained in the agency were “severely limited in their ability to make autonomous decisions” (Sardell 1988, 180). Reagan named Richard Schweicker, a former Republican senator from Pennsylvania (home, he reminded, to the nation’s largest rural population), to serve as HHS secretary. Schweicker insisted that between 40 to 60 percent of all grants be awarded to rural areas. By 1987, by one estimate, rural grantees operated 825 of 1,264 health centers, and served 2.6 million people, one-half of the national total.

More threatening than the 25 percent cut in federal grant funding was Reagan’s attempt to block-grant health programs. His overall proposal was to consolidate eighty-five discretionary grant programs into five large block grants to the states. Congress eventually consolidated fifty-seven of these programs into nine block grants. The community health centers program was among twenty-six health services and research programs that would be combined into two large block grants. States would then decide how to allocate resources across the programs, and decide services provided, eligibility standards, and so on. The only federal restriction was that the monies spent for each block grant had to be one-quarter less than the FY 1981 appropriations level. In this proposal, health centers would be part of the health services block grant. However, due to some impressive politicking, the proposal became a completely unique animal: a “block grant in name only” (Sardell 1988, 166).

The Health subcommittee of the House Committee on Energy and Commerce was ideologically polarized. Members were able to agree that migrant health centers should be spared from a block grant. Migrant workers traveled across states, and thus it made more sense for the program to remain a federal one; moreover, because they did not vote, committee members expected states to neglect their health needs rather than cut another troubled program (*New York Times*, Apr. 3, 1981). Rep. Henry Waxman (D-CA) argued that because states had never been involved in the program or shown much interest in community health centers, the program should remain a discretionary federal program. States would naturally fund those programs that organized interests and state officials had become accustomed to (Reynolds 1999, 18). But Republicans disagreed, and the full committee failed to approve a budget proposal. The Senate considered the health services block grant proposal in the full Labor and Human Resources committee, chaired by Sen. Orrin Hatch (R-UT). This committee finally decided to place community health centers and migrant health centers in a protected block grant. Here existing centers would be funded through FY 1983, and funding had to be maintained by each state at a certain percentage of the FY 1981 appropriation through FY 1985.

In conference committee, the largest conflicts occurred over the National Health Service Corps, family planning projects, and community health centers. Hatch was adamant about the need to block-grant the health centers. He viewed them, along with the National Health Service Corps, as part of Carter's plan to build the "core of a national health insurance scheme," and "a significant portion of the population would receive health services at federally run clinics staffed by federally salaried physicians." For evidence, he pointed to planning papers written by Carter HEW official Karen Davis concerning a rapid expansion in centers over a five-year period. He also argued that many centers served areas that did not need them, and that much of the program's spending was inefficient (Sardell 1988, 175–176; Reynolds 1999). Here Hatch followed the Heritage Foundation's analysis closely. Twenty years later, conservatives would offer precisely the opposite analysis: rather than part of an incrementalist strategy by liberals to build national health insurance, health centers were a benign—even helpful—means of avoiding an incrementalist path to NHI.

In the end, while the Republicans saved face by placing primary care programs in what they called a block grant, they had lost. Health centers would remain a federal program for FY 1982; for FY 1983, states would have to apply to take over their administration. If a state did not do so, the program would remain federal. If it did choose to do so, it would have to fund each existing center at the same FY 1982 grant level, match a share of federal funds, and meet other requirements, including the community governance requirement. It was understood that these and other strings attached served to deter states from accepting the primary care block grant. This was "devolution" in name only, and a key moment for health centers. Fending off the block-granting of the program was much more significant than absorbing budget decreases. There was good reason to think that budgets could recover, but a block grant seemed like a death sentence (Davis 1981, 322). While funding did decline by about one-quarter (from \$325 million to about \$248 million), the NACHC declared victory.

Reagan was not done. Each year from 1982 to 1986, the administration proposed that health centers be included in a health services block grant. Finally, in 1986, over Reagan's pocket veto and thanks in large part to moderate Republican senators Robert Stafford (VT) and John Chafee (RI), Congress secured legislation authorizing health centers as an independent, discretionary grant program. After five years, the program's bizarre, quasi-block-grant status had ended.³⁶

Bush 41 and the Birth of Federally Qualified Health Centers

The atmosphere in Washington for community health centers improved a good deal under the administration of President George H. W. Bush. While many

social programs were cut, there were some important expansions of the activist state as well, including the Americans with Disability Act. Bush's attitude toward health centers differed from Reagan's as well. He requested spending increases, and in 1988 and in 1990, the program was reauthorized at a higher level and with his support (Reynolds 1999, 32). Health centers also benefited from drug company discounts and federal liability protection (which greatly reduced malpractice insurance costs). However, the most important change for health centers during this period involved changes in their financing.

In 1990, due in large measure to the persistence of the NACHC and a strong health center advocate, Sen. John Chafee (R-RI), Congress established an official reimbursement category in Medicare and Medicaid for what were termed federally qualified health centers (FQHCs). These provided much higher reimbursement rates based on actual costs. As part of this legislation, FQHCs were legally defined, reimbursable services were enumerated, and reimbursement arrangements specified. Moreover, health centers not receiving federal grants but otherwise fulfilling all legal requirements were termed "look-alikes," and these were also eligible for the same reimbursements from Medicare and Medicaid.

Although these arrangements have undergone several changes—most importantly the move to a prospective-payment system in Medicaid managed care—the FQHC arrangement effectively saved the program. Medicaid eligibility expansions began in the 1980s, but the FQHC arrangement provided the financial footing it needed; health centers would no longer have to rely so heavily on federal grants to cover the underpayments for Medicaid patients. By 1996 Medicaid reimbursements constituted a greater share of operating revenues than federal grants; today Medicaid's share is more than two-and-one-half times higher than it was in 1985.³⁷ Moreover, Medicaid managed care is credited with forcing health centers to improve their business acumen; this, in turn, has helped them survive and thrive. OEO's health centers program began in 1965, as Medicare and Medicaid were enacted. Twenty-five years later, they were finally integrated.

During the 1970s health centers were seen as complementary with national health insurance, not as a substitute or as a hindrance for winning support for national health insurance. As revealed in its deliberations over health centers and HMOs, the Nixon White House did not perceive them as in tension with NHI. Nor did Senator Kennedy, who saw the two as linked. In the early 1970s his staff even drafted legislation for comprehensive health centers that would merge mental health centers with community health centers and be a key service provider in his NHI proposal (Sardell 1988, 91–92). Carter and congressional supporters expanded the program even as they attempted to

hammer out a workable NHI proposal. Besides the program's survival through three hostile Republican administrations, the most important development was the highly belated integration of Medicare and Medicaid financing with health center operations. As the problems of the underserved grew more severe, this integration meant that the centers were poised to assume a more central role in the US health safety net.

The Dog That Didn't Bark: Clinton and the Health Centers

The opposition by Republican administrations to the federal health centers program may seem unsurprising given traditional Republican principled commitments to federalism and limited government and a suspicion that a large health centers program could help pave the way for a national health insurance program. Here I try to understand why the Clinton administration did not push for the expansion of a small program that targeted a Democratic constituency with a typically Democratic redistributive policy. Clinton placed health care access at the center of his 1992 presidential campaign. After the failure of his proposed Health Security Act, why did he not assert himself in attacking problems of primary care access for the underserved? Why were congressional appropriations for health centers larger than the president's budgetary requests for seven of Clinton's eight budgets (see figure 2.1)? It is worth noting that this lack of assertion was not deadly for the program. Given the new surge of Medicaid funding coursing through the network of community health centers, increasing the number and size of federal grants was no longer a matter of survival. Still, the Clinton administration's ambivalence to health centers—referred to by a former HHS official as a “mystery and a scandal” (*Washington Post*, Aug. 26, 1999)—is important and needs to be explained.

The failure of the administration to back health centers was not due to a misunderstanding of the issue. During the efforts in 1993 to develop comprehensive reform proposals, internal deliberations recognized that the need for health centers would not disappear with the arrival of universal coverage (White House 1994, 2–3, 5). As planning proceeded, health center advocates in NACHC and elsewhere worried about some features of the proposed system. In particular, they were concerned about what looked like a block-granting of health centers in the midst of the proposed health alliances. They pushed for and won the designation “essential community provider” for health centers, at least for a transitional period. Concern with the effects on underserved access and safety-net facilities in the wake of national health insurance was not new to the Clinton years, but the health center lobby worried about the administration's downgrading of access issues that were unrelated to insurance status.³⁸

After Clinton's failure at comprehensive reform and the Republican landslide in the 1994 midterm elections, budget constraints seemed to dominate administration thinking on discretionary health programs. Health centers rarely were protected by being placed in "the most highly protected budget category"; this honor was reserved for, among other programs, AIDS and family planning. HHS secretary Donna Shalala even had the heretical preference for "marrying the health centers to teaching hospitals," thus scrapping their governance feature (teaching hospitals could not become controlled by patients). This also jeopardized health centers' supplementary services. In fact, "HHS officials . . . questioned whether health centers were 'community friendly,' because they were rarely funded through local health departments." The administration's attitude toward the program drifted further still from that of the Johnson years (Lefkowitz 2007, 22).

In late 1995 Clinton had a classic confrontation with the Republican leadership. Clinton seized the initiative by linking Medicare cuts to Republican tax cuts, charging them with a regressive redistribution of income, and dramatizing proposed cuts in popular programs such as school lunches. Gingrich's room for maneuver in these negotiations was hampered greatly by his new House firebrands. After a settlement was reached, conservatives were left caricatured by Clinton and the Democrats (Zelizer 2007, 127).

The administration as well as health reform advocates in Congress continued to pursue incremental advances in insurance expansion, such as the Kennedy-Kassenbaum Health Insurance Portability and Accountability Act of 1996 and the State Children's Health Insurance Program (SCHIP), an amendment to the Social Security Act that assisted states in expanding coverage to poor and near-poor children.³⁹ For the rest of his term, though, Clinton prioritized reforms that would improve quality and lower the costs of health care, giving little attention to access for the underserved (Richmond and Fein 2005, 149).

Gearing up for the general election in the summer of 1996, top Clinton advisers suggested in a memo to the president how he might claim credit for substantial health policy achievements, and they provided a menu of proposals to be developed and advanced in a second term. Health centers were not mentioned in the "achievements" section; indeed, improvements in access to care were not mentioned. Looking to a second term, all possible policies were examined through the prism of insurance coverage of children. Health center expansion, perhaps through school-based clinics, was rejected because it would not "significantly increase coverage." Moreover, funding for health centers under a balanced budget imperative was considered impossible without dropping "some other priority," since "investments in community health

centers and school-based centers” would cost “something like \$15–\$20 billion over 7 years.” A final concern was that working on health centers might convince Democrats in Congress that the administration had given up on expanding coverage (Rasco and Tyson 1996).

Of course, HHS did not lack for health center advocates. By the mid-1990s, HRSA served as an important lobby for the program within the department. Still, neither HHS leadership nor Clinton’s top domestic policy aides placed much attention on the growing problems of the medically underserved. HHS secretary Donna Shalala interpreted the administration’s health priorities in terms of the expansion of coverage for children. In addition, Assistant Secretary for Health Phil Lee focused single-mindedly on insurance coverage rather than access and, like Shalala, was drawn more toward the world of academic medical centers instead of community clinics (Shalala 1999, 4, 6). And this is not because the problem was easing. The numbers of uninsured American residents continued to climb throughout the 1990s. Almost one-half of health centers were in “severe fiscal trouble” (*Washington Post*, Aug. 26, 1999). Bonnie Lefkowitz, a long-time HHS policy analyst with expertise in health centers, served on the White House Health Care Interdepartmental Working Group. She notes diplomatically that the administration did not “provide the support health center advocates had hoped for” (Lefkowitz 2007, 21). Why not?

A few answers are possible. First, perhaps the administration viewed the US public as arrayed against any other reforms of the health care system. This was certainly not what his own pollsters must have told Clinton, however. By the end of his first term, the public still favored some sort of comprehensive reform, and a majority of respondents concluded that Clinton’s Health Security Act would have left them “better off.” Nor was there much support for slashing Medicare and Medicaid, even among Republican groups (Peterson 2000). Additionally, it is unlikely that the administration feared advancing a large expansion in health centers out of fear that the Republican-controlled Congress would attack it.

A second possibility is related: the administration may have sought to avoid, as both a political and a policy matter, discussions of the poor when advocating health care reforms. Its relentless focus on the middle-class and “hardworking” Americans, both during the 1992 campaign and during the push for health savings accounts, is well known and was aimed in part at clarifying to the public the intended beneficiaries of structural reform. However, it is not at all obvious why programs for the poor could not have been folded into the array of smaller initiatives developed after the failure of the Clintons’ comprehensive reform proposal. A third possible answer is that

the administration—prioritizing budget reductions and cognizant of bipartisan support on the Hill for health centers—decided to keep the president’s budget request lower as a political move. It could do so, in this view, without harming the underserved.⁴⁰ There is some evidence that this indeed occurred. Still, it leaves unexplained why the White House did not imagine an expansion of the program beyond the moderate increases appropriated by Congress.

Did the administration—or its advocates in Congress who also supported NHI—fear the deleterious political consequences for NHI of a health centers “fig leaf”? In 1994 congressional debates over health insurance, there was an interesting exchange over a Republican bill to increase funding for community health centers. Democrats, led by House Appropriations Committee chair David Obey (D-WI), “denounced the proposal as an effort to undermine any health care reform package that Congress might produce in 1994.” “What we have here is a political fig leaf . . . They want to be on the record, somewhere, somehow, on the cheap, in voting for health care. I don’t think that’s the way to do business.” House Minority Leader Robert H. Michel (R-IL) replied that, “regardless of what health care reform we eventually undertake, we still need expansion of the community health center network.” (CQ Almanac 1995).⁴¹ Especially after Clinton’s defeat of Gingrich over the government shutdown in 1995, Republicans were motivated to adopt a caring posture.

As discussed earlier, during the Reagan years, many conservatives feared an expansion of health centers as laying the groundwork—really, the delivery system—for a nationalized system featuring universal coverage. Democratic proponents of NHI such as Kennedy and Carter, on the other hand, were comfortable seeing health centers and NHI as complementary—maybe even both necessary—for successful systemic reforms. Thus, many progressives’ ambivalence about a strong health safety net was not logically entailed in the long struggle for something close to universal coverage.

But the exchange described earlier suggests that both opponents and supporters of NHI might have flipped their strategic assessments of the effects of federal safety-net programs on NHI politics. The Democrat favoring NHI worried that an expansion of health centers would relieve pressure on the system. Meanwhile, perhaps Michel believed the same thing and therefore pushed for this expansion.⁴² In this 1990s perspective, an NHI politics of incrementalism had faded, and in its place had arisen on both sides a Leninist “one step forward” conception of NHI politics. Anything that papered over the severity of the problems at hand or reduced the crisis footing set back the cause. Senator Kennedy, the leading defender of health centers since their inception more than forty years ago, over time seemed to articulate just this fear. He said in a

1996 interview that the “more conservative members of Congress view health centers as an alternative way of serving the poor, rather than through universal health care.” He continued, “There will never be enough money or enough health centers to truly care for the needs of the underserved. Without universal health care, there will always be people who fall through the cracks.” “I’m not prepared at this time to think that [expansion of the program to cover underserved areas] is the way [to] go. . . . This doesn’t replace the need for universal health care coverage” (Reynolds 1999, 95, 127, 121).⁴³

Additionally, health center advocates report in confidential interviews that they are often confronted with this criticism of their efforts to expand primary care to the underserved. NHI advocates accuse them of “aiding and abetting” conservatives opposed to NHI. Clearly, not everybody “learns” the same lessons. Leading voices in the philanthropic, research, and advocacy communities, such as the Commonwealth Fund, the Robert Wood Johnson Foundation, the Milbank Fund, the Urban Institute, and many others, championed both universal coverage and the expansion of health centers. But over the past two decades, health center advocates have felt the need to reassure others that health centers are a complement to, not a substitute for, universal coverage (Wilensky and Roby 2005). While this is not evidence that the refusal of the Clinton administration to push for safety-net initiatives was motivated by fear of a “one step forward” dynamic, the fact pattern sketched here is not inconsistent with this motivation. I now turn to a different but related puzzle: the Bush health centers initiative.

George W. Bush’s Health Centers Initiative

The health centers initiative, which Bush signed into law early in his first term, was rolled out in his 2000 presidential campaign. One stated goal of the initiative was to create twelve hundred new or expanded centers in five years, but the primary goal was to expand health center care to an additional 6.1 million patients. In order to accomplish this goal—which was completed ahead of schedule—funding for the centers more than doubled (see figure 2.1) (Politzer 2005). Moreover, the administration stayed vigilant in meeting its necessary spending goals even as wars, homeland security appropriations, Hurricane Katrina, and other forces impinged on the budget. For instance, in the FY 2006 budget, health center spending continued to increase even as Bush and the Republican Congress eliminated many discretionary programs and cut discretionary spending by 1 percent. This included a reduction in health safety-net programs such as Medicaid disproportionate share hospital payments (*Washington Post*, Feb. 57, 2005). And in FY 2007—the most fiscally conservative

of Bush-era budgets—health centers secured an increase of more than \$100 million, the largest increase for any HHS discretionary program (Lefkowitz 2007, 24).

Throughout his time in office, Bush highlighted the health centers initiative as a prominent goal, and then a major achievement, of his presidency (*New York Times*, Feb. 28, 2001; White House 2004, 2006). While Clinton mentioned health centers fewer than ten times, Bush mentioned the program—one of only hundreds of HHS programs receiving OMB’s top ranking—in countless speeches and settings, even defending it on the *Bill O’Reilly Show*.⁴⁴ Additionally, members of Congress regularly publicized—often with high-level HHS political appointees, if they were Republicans representing marginal districts—the opening or expansion of federally funded health centers. The health centers initiative was obviously out of step with three Republican administrations and with Republican and conservative commitments in favor of traditional federalism, against redistribution, against larger discretionary spending programs, and against a strong federal role in health care finance (much less health care delivery). The initiative also seemed to offer a conservative Republican president little; the beneficiaries of the health centers are highly unlikely to become loyal, active, Republican voters.⁴⁵ What is going on here?

The 2000 Campaign

Bush rolled out his health centers initiative during the 2000 campaign as part of a plan titled, “Strengthening the Health Care Safety Net.” “Under my plan, we would provide \$3.6 billion in federal money over a five-year period to create 1,200 new centers from coast to coast,” Bush said. This was intended “for those in the most desperate circumstances—a safety net that includes income support, housing assistance, and health services” (Bush 2000a).⁴⁶ In calling for a large expansion of health centers, he joined Democratic presidential candidate Sen. Bill Bradley (D-NJ), who called for doubling the capacity of health centers in one to two years. (The Democratic presidential nominee, Vice President Al Gore, did not mention health centers.)

The health centers initiative seemed constructed to help Bush win the election; it did not emerge clearly out of his tenure as governor of Texas from 1995 to 2001. As governor, he did not prioritize health policy, his aides acknowledged (Clymer 2000). He rarely spoke in public about health policy, despite his state’s crisis of the uninsured, weak health safety net, and deplorable public health record in its forty-three border counties (including a return of tuberculosis). On the stump in 2000, he took credit for the state’s patient’s bill of rights, and claimed to have “embraced” Texas’s participation in the Children’s Health Insurance Program; neither assertion was accurate

(Dubose 1999; Dubose 2000; *New York Times*, Oct. 16 and 18, 2000; *Texas Observer*, Nov. 3, 2000). And he presided over one of the country's most onerous and intimidating Medicaid systems. Finally, the uninsured were not a big priority for him; his own commissioner of health downplayed the importance of insurance as a determinant of health outcomes. There is evidence that Bush visited health centers in Texas and thought the program a valuable one; clearly, however, his support of health centers, and the development of his initiative, did not have deep ideological roots.

Bush adviser Karl Rove emphasized six issues during this campaign: tax cuts, federal education standards, military upgrades and a defense shield, federal support for faith-based initiatives, the partial privatization of Social Security, and Medicare reform and prescription drug coverage (Sinclair 2008, 166). The safety-net proposal fit here as "part of a sustained drive by [Bush] to eat into the traditional Democratic advantage on issues like education and health care, which have moved into the forefront of public concern in a time of peace and security" (*New York Times*, Apr. 13, 2000). At the 2000 Republican national convention, Bush spelled out his governing philosophy of "compassionate conservatism": "Big government is not the answer, but the alternative to bureaucracy is not indifference. It is to put conservative values and conservative ideas into the thick of the fight for justice and opportunity" (Bush 2000b).⁴⁷ To describe the health centers initiative as a small, cheap effort that amounted to little more than posturing is to raise the question, why did it take Republican party leaders and presidents thirty-five years to seize on this long-available opportunity? This policy and compassionate conservatism reflect both Republican learning about electoral politics and the conservative movement's learning about how to wield the activist state to achieve privatization in several policy areas.

Short-Term and Long-Term Electoral Goals

To a greater degree than any presidential adviser in decades, Bush strategist Karl Rove remained focused on carving a durable partisan majority out of the electorate. Attempting to use domestic policy to induce a realignment, rather than waiting for voters to do it, Rove left normally implacable scholars marveling at his audacity (Conlan and Dinan 2007, 18; Green 2007, 56).⁴⁸ He and his staff devised policies that would entice additional voters into the party, in particular Catholics, white women, African Americans, and Hispanics.

Like other Republicans, Rove watched and learned from Gov. Pete Wilson's (R-CA) ill-fated embrace of Proposition 187's restrictions on illegal immigrants, as well as the perceived electoral consequences of the "Republican Revolution"

of 1994 and Clinton's besting of Newt Gingrich during the government shutdown of 1995–1996. Compassionate conservatism—as it was employed as a frame for domestic policies—can be seen as a direct result of Republican learning from these episodes. Bush's faith-based initiative was intended partly to offer patronage to black religious leaders (especially in the South) (Conason 2003; Wills 2006), while a number of appeals to Hispanics were thought important in Bush's winning 39–40 percent of the Hispanic vote in 2004 (Leal et al. 2005).⁴⁹ In 2000 and 2004 Rove and other Republicans were determined not to repeat the mistakes of the past. As one GOP staffer said, "We're not going to be throwing something out there for liberal to portray as wild-eyed conservatives running amok through the Capitol" (*Washington Post*, Nov. 7, 2002).

Developing and deploying domestic policies for political uses required unusually pliable policymaking institutions. These included a highly centralized domestic policy apparatus in the White House, which Rove quickly harnessed and eventually housed within his Office of Political Affairs, an unprecedented centralization and merging of electoral politics and governing (Dilulio and Suskind 2002; Green 2007; Rudalevige 2008). Moreover, the White House ran roughshod over both career civil servants and its own political appointees in the federal agencies, and it perfected what came to be called "asset deployment." For example, Rove's office bested all of its predecessors in using announcements of federal grants for electoral purposes. HHS was no exception, focusing its very public rollout of health center awards on swing congressional districts (Solomon, MacGillis, and Cohen 2007).

One of the ways in which the health centers initiative might be considered strange as an electorally useful policy is that, unlike most policies, the administration's vote-seeking targets were not usually the policy's beneficiaries. Rather, the health centers initiative fit into a range of policies that were used to perform "bankshot politics." In the same way that African Americans filling the dais at the Republican national convention were not present to help usher blacks into the Republican party, programs such as health centers can be interpreted as directed more toward suburban white women worried that "Republicanism with a Human Face" is an oxymoron. Programs such as SCHIP are simply too expensive to be deployed as a tool of electoral politics, but programs of the size of health centers work nicely.⁵⁰ On the view sketched here, the health centers program was viewed by Bush and by many in his party as electorally useful for more than seven years. Of course, the health centers initiative was a fairly small, so it was useful only at the margins. However, in an era when the partisan balance in Congress, state legislatures, and presidential elections sat on a knife's edge, all of the era's politics were on the margins.

Long-Term Policy Goals

The Bush administration's policy goals meshed fairly well—but not perfectly—with an emerging consensus among conservatives to retrench many tasks of the state. Building on insights developed by conservative politicians and the ideational infrastructure developed on the right over the past few decades, the Bush administration, some argue, embraced longer time-horizons, and a controversial statism to pursue retrenchment across various policy arenas. Not only did the administration and leading conservatives back away from the goals of the 1980s and 1990s to shrink government directly, but their own policy ideas also became increasingly statist. In current dollars, total federal outlays from 2001 to 2007 increased 49 percent, and 18 percent in constant dollars (Conlan and Dinan 2007, 13).⁵¹ Federal grants—not including so-called entitlements—increased from \$55 billion to \$93 billion, mainly for education, Homeland Security, and other programs. Even in 2006, as the administration made some attempts to rein in its spending, federal grants amounted to 16 percent of total federal spending, a higher share than in any year from 1980 to 2000 (Bartlett 2007, 14).

From *No Child Left Behind* to his yearlong attempt to privatize Social Security, Bush proposed several large new public policies in what many saw as an effort to shrink the state. As many policy analysts have argued, *No Child Left Behind*, which would typically be an offense to conservative mores, might actually be useful in developing a metric of school quality, shining a spotlight on poor school performance, and hastening public support for vouchers (Butler and Germanis 1983; Derthick and Teles 2003; Henig 2009; Teles and Derthick 2009). Additionally, Medicare reform emerged as a clear long-term policy goal of conservatives. Here, though, the goal was not a short-term frontal assault on the program but a policy of gradually drawing down Medicare spending in order to fund tax credits for the purchase of private insurance. Of course, the Medicare Modernization Act of 2003 entailed huge federal expenditures. Usually reliable small-government conservatives such as Newt Gingrich, though, urged Republican congressional support (Gingrich 2003). Democrats and progressives lamented that “their” issue had been co-opted by Republicans even as the latter’s long-term policy goals diverged greatly from progressives’ understanding of public opinion regarding Medicare.

All of these policies seemed to have both short- and long-term electoral benefits because they struck at the heart of the major policies that have provided the glue between Democratic candidates and voters over the past several decades. Bush’s health centers initiative is consistent with this overall project. Republicans and conservatives have realized over the past few decades that a frontal

assault on the welfare state has not worked, whether defunding, block-granting, or attacking the federal agencies that implemented social policies. And they realized, consistent with compassionate conservatism (or what Bush White House courtiers such as Fred Barnes termed “big-government conservatism” [Barnes 2003]), that there are electoral benefits to doing redistribution on the cheap.

Of course, the Bush administration’s embrace of statism and massive tax cuts managed to anger many conservatives, and some skillful messaging was needed to limit this anger (Tanner 2007). To this end, Bush, Rove, Republicans on Capitol Hill, and conservative commentators spread the gospel of “starve the beast.” This notion holds that if tax cuts are piled one atop another, deficit imperatives will emerge before long and will force spending cuts. Bush sometimes justified his 2001 tax cuts in these terms. Regardless of its validity, the idea was politically very useful for the Bush White House in that it provided conservatives with a rationalization for the Bush era’s combination of tax cuts and spending increases (Bartlett 2006, 50, 157–174).

Witness the convergence from the 1970s to the 1990s of Senators Kennedy and Hatch on the “lesson” that expanded health centers may not hasten the coming of national health insurance. As recently as the Heritage Foundation’s 1980 *Mandate for Leadership*, a sophisticated conservative health analyst had learned the very different “lesson” that an expanded network of health centers amounted to a stage-setting for NHI. It is unclear why health centers constitute an “incremental” move accelerating or slowing momentum toward universal coverage (depending on the lessons one thinks one has learned since the 1960s). Health centers may or may not stall momentum toward universal coverage, but they are properly understood *not* as incremental progress toward universal coverage. After all, they have little or no impact on the share of the population that is insured.⁵² Rather, they are meant to alleviate some of the negative consequences—for individuals as well as the health care system—of uninsurance and the maldistribution of primary care providers. Conservative fears about health centers were therefore not really fears about a politics of incrementalism. Rather, the fear was that the prior existence of an infrastructure to implement universal coverage might weaken arguments about the doability of universal coverage. There is, of course, a wide range of views about incrementalism, and advocates of NHI have offered a number of possible ways by which incremental gains in health care access might stall progress toward their goal (Oliver 1999; Jacobs 2007).

Whether there *are* lessons to learn about incrementalism is beside the point; rather, we must understand what lessons about the political effects of public policies that politicians *think* they have learned in order to explain their

choices. The (admittedly highly suggestive) argument made here is not that Bush did not himself sincerely like health centers. There is evidence that he does, as did (and do) many Republicans. But presidents like many policies that they do not enact. Rather, the argument here is that the health centers initiative was consistent with both shorter-term and longer-term electoral and policy goals of the Bush White House, *and* that it was consistent with an altered Republican and conservative understanding of a large network of health centers in Leninist terms, rather than “Trojan-horse” terms. Even if this argument is correct, however, it is unclear, given the new post-ACA landscape, what the partisan and policy understandings will be that shape future conflict over the health centers program.

Health Centers amid Obama’s Health Care Reform

It might be better to be lucky than good, but the health centers movement has been both, especially of late. While the current and last few Congresses are the most ideologically polarized in almost a century, the health centers movement and trade association have displayed an impressive ability to bring members of Congress together to increase health centers funding. In 2008 Bush signed into law the highly popular Health Care Safety Net Act (Pub. L. 110–355), which both provided substantial new funding and reauthorized the program for an additional four years. Also in 2008, for the first time ever, both major party presidential nominees sang the praises of community health centers. The program already had a great deal of momentum going into 2009 and 2010, as major new opportunities emerged with the combination of unified Democratic control of government and a massive economic recession.

The Obama administration has continued to push the program onward and upward, most importantly through the ACA.⁵³ The ACA authorized \$11 billion in new funding over five years (FY 2011 to FY 2015) on top of the annual discretionary funding for the program, which is estimated to be about \$2.6 billion per year. Thus, for this five-year period, the federal government is providing health centers with more than \$22 billion (Senate Budget Committee 2010; CBO 2010). Perhaps even more important, the ACA included a number of important features that improved the program’s financial standing (see Rosenbaum, this volume). Over the past decade, the program doubled its patient coverage, from about ten million to twenty million. The current plan is to double its coverage again, to forty million, by 2015.⁵⁴ The health centers program has reached a critical new stage: it is larger, financially more sure-footed, and more popular than ever before. It is also now shouldering increasingly weighty expectations and public and political scrutiny.

America's health safety net was fraying substantially *before* the current economic recession.⁵⁵ In the first year of the recession, total visits to health centers increased by 14 percent; among the uninsured, visits increased by 21 percent. There has also been an explosion in Medicaid enrollments; in 2009 the program experienced its single largest one-year increase since the program began in the 1960s, with almost four million new enrollees (NACHC 2009b; Iglehart 2011, 8). Meanwhile, over the past decade, charity care provided by all physicians declined by 10 percent (Cunningham and May 2006).

If the ACA goes according to plan, by the end of the decade an estimated thirty-two million Americans will join the ranks of the insured. Given the limited number of primary care providers, experts predict that, as in Massachusetts after its move to near-universal coverage, health centers could be overwhelmed by new patients (Ku 2009). Conversely, twenty-three million Americans are likely to remain uninsured or underinsured, eight million of whom will likely be undocumented immigrants. They will continue to seek treatment in ERs and health centers (Thomas 2010). And health centers can expect less support from the states. As of FY 2011, state funding has dropped 42 percent since FY 2008 (NACHC 2010a, 2). The expansion in the number of centers, their size, and their service provision has (and will) put enormous pressure on their chief limitation: their workforce. Many centers are being pushed to their limits, and this is true even before we reckon with the move from twenty million to forty million patients, which would require fifteen thousand new health professionals (see Rosenbaum, this volume).⁵⁶

But another problem facing the program may well be political. The program has survived and thrived due to luck, hardworking advocates, an impressive federated lobby, and some very motivated supporters in Congress. However, many involved with the program think it has survived and thrived in part *because* it has remained a low-salience, uncontroversial, small program doing redistributive politics in the guise of distributive politics. Health centers can no longer remain an open secret. The ACA, increased funding, and the anemic condition of other safety-net providers have made the already central health centers absolutely critical to US primary care. Can the program emerge from the shadows and still remain shielded from increasingly embittered congressional politics? Moreover, can it do so once roughly ten million of its patients are Hispanic, many of them undocumented immigrants? Will states continue to fund relatively generous Medicaid reimbursement schemes for centers that have gone from "ghetto medicine" to "barrio medicine"? Will the "gentleman's agreement" that allows health centers to treat undocumented immigrants hold?

Now that national health reform has begun, Republicans have begun to revive arguments against health centers that have not been voiced for more than two decades. For instance, Sen. Tom Coburn (R-OK) attacked the program for providing unfair competition for private practices and decried the program as a “government-centered” rather than a “patient-centered” solution (Favole 2010). More recently, presidential aspirant Gov. Haley Barbour (R-MS) has moved further, along a parallel track, in castigating an updated version of the archetypal Cadillac-driving welfare queen (in his version, BMW-driving individuals receive Medicaid treatments and claim they cannot afford a co-payment) (Goldstein and Balz 2011). In 2011 House Republicans departed from several years of kid-glove treatment for health centers by proposing \$1.3 billion in budget cuts for health centers (along with \$174 million in cuts for the National Health Service Corps). In one estimate, almost three million Americans would lose their regular primary care provider in 2011 if these proposed cuts were enacted (Senate Appropriations Committee 2011, 8). While this effort failed, the fact that it was even attempted suggests that there may be some fraying in the health centers’ bipartisan political safety net. As their visibility, costs, and links to the increasingly criticized Medicaid program become more visible, there are good reasons for their advocates to wonder.

I have sought in this chapter to contextualize some lessons that interested parties think they may have learned about health politics as they have engaged over the last four decades with this remarkable, “strange” program. I have made what is only a highly suggestive argument: the fate of federally funded health centers has been caught up in larger battles over national health reform and party competition. The political forces shaping the world’s largest primary care network will no doubt change in a post-ACA world. However, for good or ill, the development of the health centers program will surely provide both constraints and opportunities for political contestants as they continue to battle over the place of the state in the provision of primary care.

Notes

1. Data on centers and facilities include the US states and territories. The figure of twenty million includes one million patients served by “look-alikes.” These are centers that fulfill all the requirements of federally funded centers but do not rely on federal grants; however, they qualify for the reimbursement relationships that benefit federally qualified health centers (FQHCs).
2. Additional citations and discussions of archival, interview, and other data used in this chapter can be found on the author’s Web site (<http://www-personal.umich.edu/~rmickey/>). This research is based in part on interviews the author conducted in 2007 and 2008 with Lee Schorr, Joyce Lashof, Dan Hawkins, and participants at a policy and issues forum of the National Association of Community Health Centers (NACHC).

3. In the early part of the century, this meant southern and eastern European immigrants; in the 1960s, it meant blacks and (in the urban West and Southwest) Hispanics (Davis 1921; Rosen 1971).
4. This grew out of the Sheppard–Towner Act of 1921 and ended by 1929, in part due to the AMA’s opposition.
5. From the late 1930s until 1947, the Farm Security Administration established and operated more than one thousand health cooperatives across rural America. These federally subsidized prepaid health plans emphasized preventive care and served some one-half million people (Grey 1999).
6. Local public health departments were usually underfunded, captured by local medical establishments, or patronage operations for political machines; they rarely attacked barriers to access and were not sites of policy innovation. Schools of public health—potential sources of new models of primary care delivery—were minor players on the policy landscape. In 1958, seven years before the first health centers began operation, the United States had only eleven accredited schools of public health and fewer than 1,200 students enrolled (Richmond and Fein 2005, 17–18, 95).
7. In one estimate, this share (among all physicians) declined from 80 to 28 percent from 1931 to 1963 (Richmond 1969, 86; Sardell 1988, 44; Stevens 1999).
8. Johnson’s analysis that the passage of the Civil Rights Act had “lost the South” for the Democratic Party only amplified this need.
9. Since the 1950s the National Medical Association, the membership association of black doctors, had stepped up their calls to end several racially exclusionary practices of medical facilities in the South and North, and had demanded inclusion into county and state medical societies and the AMA (membership in which was often required to secure hospital staff privileges) (Langer 1965, 282–283, 328; Smith 1999).
10. The National Medical Association had encouraged black doctors to join with liberal white physicians—Jack Geiger among them—to protect civil rights workers in the Deep South. The organization developed out of this experience, the Medical Committee for Human Rights, quickly established thirty branches across America’s cities; these protested longstanding patterns of racial discrimination in health care, and agitated for better health care delivery for ethnic and racial minorities (McBride 1991, 154–155; 1993, 322–323; Dittmer 2009).
11. Geiger, Gibson, and OEO staff especially sought to attack racial disparities in health access, care, and outcomes for blacks and Hispanics (Geiger 1993, 946–947).
12. OEO’s director, former Peace Corps director Sargent Shriver, was initially quite skeptical about the health centers project; the support of Dr. Julius Richmond, founder of Head Start, was critical in convincing Shriver to approve the centers as a demonstration project (Schorr 1988, 130–131; Lefkowitz interview with OEO staffer Sandy Kravitz, in Lefkowitz 2007, 9).
13. Section 207 of the EOA of 1964 (Administrative History Papers 1974, 333).
14. Author’s interview with Lee Schorr. By that time, other major OEO programs, including VISTA, Head Start, and Job Corps, had begun medical projects. The Community Action Program established its own Office of Comprehensive Health Services in late 1966.
15. Black GPs near health centers sometimes voiced their opposition. Dr. Paul B. Cornely, the most prominent black figure in American public health, complained that black inner-city doctors were ignored in the planning of the health centers. Still, black inner-city physicians remained more supportive of health centers and other

- safety-net institutions than local (white) medical societies (*New York Times*, Nov. 14, 1968; Richard 1969).
16. Kennedy served on the Senate health subcommittee of the Committee on Labor and Public Welfare, which had jurisdiction over health centers.
 17. EOA, as amended, Section 211–2 (Administrative History Papers 1974, 335; Sardell 1988, 66).
 18. The Comprehensive Health Planning and Public Health Services Act of 1966 (Pub. L. No. 89–749) was amended by the Partnership for Health Amendments of 1967 (Pub. L. No. 90–174). These became known as 314(e) projects.
 19. President Johnson rarely mentioned the program in public and never discussed it in detail in public (fewer than a dozen times, compared to about eighty mentions [and much longer discussions] of Head Start).
 20. The AMA did not require its state affiliates to begin desegregating themselves until 1968.
 21. Generalists at the HEW, as well as OMB staff, rejected Rumsfeld’s “power play” on behalf of the OEO. Also, OMB officials doubted the capacity of health centers to become financially self-sufficient (Starr 1982, 396; Brown 1983, 214–216, 490–491; Reynolds 1999, 10).
 22. Many public health reformers and policy analysts had called for block grants since the Truman administration, and Wilbur Cohen and other important voices during the Johnson administration also backed block grants, such as the 1966 Partnership for Health program.
 23. In a July 8, 1970, press conference, OEO director Donald Rumsfeld stated, “the single most exciting thing going on in the country, from a research standpoint or development standpoint on the supply side [of medical care], is the neighborhood health center concept.”
 24. Medicare began to do so in 1977, but only for rural health centers (Sardell 1988, 131).
 25. The Health Maintenance Act of 1973 (Pub. L. 93–222); Brown 1983.
 26. Ford claimed that the problems of access for the underserved could be met simply by “health care financing programs—such as Medicare and Medicaid” (Ford 1975).
 27. In 1979 NACHC had a budget of \$54,000, compared to \$11 million for the American Hospital Association.
 28. The 1977 Health Services Extension Act (Pub. L. 95–83) had extended the 1975 authorization for another year.
 29. According to one participant on the Hill, it was “difficult to get people in the room for the hearing and the markup” (Sardell 1988, 141).
 30. Through “positive programming,” the HEW staffers used formulas and other indices to determine those areas in greatest need; it then helped them develop proposals (Sardell 1988, 114).
 31. Sen. Ted Kennedy (D-MA) claimed that only 158 of 574 centers provided comprehensive services (Senate Report 95–860 [1978], 27; Sardell 1988, 126).
 32. Similarly, the NACHC complained that smaller grant awards for new and existing centers, coupled with inflation, had forced centers to cut some of their medical services and now rarely could fund supplementary services (Senate Committee on Human Resources, Hearings, 110–114; Sardell 1988, 147).
 33. David Winston, author of the chapter, was an influential Republican health policy analyst and minority staff director of the Senate Committee on Labor and Human Resources (Winston 1981, 248–249, 269, 274–275, 286, 291).

34. The reduction was from about \$325 million in FY 1981 to \$248 million in FY 1982 (Sardell 1988, 177).
35. *Washington Post*, Nov. 4, 1981. Of the eighty medically underserved areas losing their designations, seventy won back their designations on appeal (Sardell 1988, 187). In 1982 two Public Health Service agencies, the Health Services Administration and the Health Resources Administration, were combined into what remains the Health Resources and Services Administration (HRSA). The new Bureau of Health Care Delivery and Assistance within HRSA would administer community health centers, migrant health centers, and the National Health Service Corps. Metrics for designating medically underserved areas and health professional shortage areas continue to be hotly debated.
36. This legislation (Pub. L. 99–280 [1986]) was drafted jointly by Kennedy and Hatch (who was now on board with the program) (Reynolds 1999, 29–30).
37. Pub. L. 101–508, The Omnibus Budget Reconciliation Act of 1990 (Reynolds 1999; Lefkowitz 2007, 21; Rosenbaum, Jones, and Shin 2010, 4); Pub. L. 101–239 (1989, for Medicare), and Pub. L. 101–508 (1990, for Medicaid).
38. The black National Medical Association, concerned about the failure of Carter’s health insurance proposal to tackle access problems, opposed it—a major step for an organization that had backed every NHI proposal since 1945 (McBride 1993, 325–326).
39. Clinton secured SCHIP in exchange for substantial cuts in domestic discretionary spending as part of the Balanced Budget Act of 1997.
40. OMB associate director for health and personnel Dan Mendelson argued along these lines (*Washington Post*, Aug. 26, 1999).
41. House Republicans had also included an expansion of health centers in their counterproposal to the Clinton plan in 1993 (Rich 1993).
42. In 1998 Hatch helped lead the Senate’s effort to increase funding for FY 1999 by \$100 million. By the late 1990s he saw health centers as necessary to “fill in the cracks” as other safety-net programs were cut. However, Hatch had not embraced a cynical “fig leaf” strategy. He opposed a large expansion of the program, and doubted whether “three billion dollars would be sufficient to cover expensive services outside the CHC’s scope and to cover the infrastructure costs in areas which did not currently have CHCs” (Pub. L. 105–277 [1998]; Reynolds 1999, 107, 93, 127).
43. For an articulation of the fear of the health centers as “fig leaf,” see Taylor 1999.
44. The date was Sept. 29, 2004.
45. Republican party platforms have lauded health centers since 1992. See *The American Presidency Project*, <http://www.presidency.ucsb.edu/platforms.php>.
46. The health centers initiative also found expression in the 2000 Republican Party platform. There was no mention of health centers in Democratic Party platforms from 1980 through 2004.
47. Orrin Hatch first used the phrase while defending his support for another War on Poverty program, Job Corps: “I’m a compassionate conservative. I’m not some kind of ultra-right-wing maniac” (*New York Times*, Mar. 13, 1981).
48. Rove’s was a “campaigning and governing philosophy that puts a set of core policies in the service of politics to an unusually direct degree. Some elements of this approach are tonal and symbolic, while others . . . are more concrete” (emphasis added; *New York Times*, Nov. 5, 2004).
49. Of course, the increasingly heated debates over immigration policy since 2006 have made this effort even more difficult.

50. Another target of health-centers-as-bankshot politics may be Hispanics, who now comprise more than one-third of all health center patients nationally. In a small number of states, they comprise a large majority of the patient pool. While many of these users are undocumented, it could be argued that Rove and other Republican strategists viewed their treatment in health centers, along with national immigration reform, as attractive to Hispanic voters.
51. Another departure from traditional Republican prerogatives regarding federalism was the infamous Act for the Relief of the Parents of Theresa Marie Schiavo (Pub. L. 109–3).
52. It is possible that a vast increase in health centers would lower uncompensated care rates, relieve pressure on local safety nets, and thereby marginally decrease local insurance premiums.
53. Additionally, the Economic American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (the “stimulus package”) provided a one-time \$2 billion increase to the HHS to finance health centers.
54. NACHC estimates that the number of patients served would increase by more than 25 percent in a single year (from 2014 to 2015, from 31.6 to 40.0 million). This seems highly optimistic (NACHC 2010b).
55. On the role of adults with Medicaid in driving the rapid increase in the rate of emergency department visits, see Tang et al. 2010.
56. Author’s telephone interview with Dan Hawkins, NACHC, Mar. 2008. The American College of Physicians estimates that the current shortfall in primary care providers is forty thousand (Howell 2010; Neergaard 2010).

References

- Administrative History Papers. 1974. “Administrative History of the OEO during the Johnson Administration, 1963–1969.” Austin, TX: Lyndon B. Johnson Library.
- Agency for Healthcare Research and Quality (AHRQ). 2006. “US Medical Expenditure Panel Survey.” Rockville, MD: AHRQ. meps.ahrq.gov/mepsweb.
- Barnes, F. 2003. “A ‘Big Government Conservatism.’” *Wall Street Journal*, Aug. 15.
- Bartlett, B. 2006. *Impostor: How George W. Bush Bankrupted America and Betrayed the Reagan Legacy*. New York: Doubleday.
- . 2007. “‘Starve the Beast’: Origins and Development of a Budgetary Metaphor.” *The Independent Review* 12:15–26.
- Boyce, J. 1969. “Negro Doctors Label US Health Care a ‘Conspiracy.’” *Chicago Tribune*, Feb. 18.
- Brandt, A. M., and M. Gardner. 2000. “Antagonism and Accommodation: Interpreting the Relationship between Public Health and Medicine in the United States during the 20th Century.” *American Journal of Public Health* 90:707–715.
- Brown, L. D. 1983. *Politics and Health Care Organization: HMOs as Federal Policy*. Washington, DC: Brookings Institution Press.
- Bush, G. W. 2000a. “Lowering Costs is Key.” *USA Today*, Apr. 13: 16A.
- . 2000b. “2000 Republican Presidential Nomination Acceptance Speech.” Philadelphia. Aug. 3.
- Butler, S., and P. Germanis. 1983. “Achieving Social Security Reform: A ‘Leninist’ Strategy.” *Cato Journal* 3:547–556.
- Clymer, A. 2000. “Bush and Texas Have Not Set High Priority on Health Care.” *New York Times*, Apr. 11.
- Colgrove, J. 2007. “Reform and Its Discontents: Public Health in New York City during the Great Society.” *Journal of Policy History* 19:3–28.

- Conason, J. 2003. "Where's the Compassion?" *The Nation*, Sept. 15.
- Congressional Budget Office (CBO). 2010. "Revised Estimate for H.R. 3590 (The Patient Protection and Affordable Care Act (PL 111-48))." Washington, DC: US Congress. May 11.
- Conlan, T. J. 1998. *From New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform*. Washington, DC: Brookings Institution Press.
- Conlan, T., and J. Dinan. 2007. "Federalism, the Bush Administration, and the Transformation of American Conservatism." *Publius* 37:279-303.
- CQ Almanac*. 1995. "Bill for Labor, Health and Human Services Requires Trade-Offs." Washington, DC: Congressional Quarterly.
- Cunningham, P. J., and J. H. May. 2006. "A Growing Hole in the Safety Net: Physician Charity Care Declines Again." Tracking Report No. 13. Mar. Washington, DC: Center for Studying Health Systems Change.
- Davis, K. 1981. "Reagan Administration Health Policy." *Journal of Public Health Policy* 2:312-332.
- Davis, K., and C. Schoen. 1978. *Health and the War on Poverty: A Ten-Year Appraisal*. Washington, DC: Brookings Institution.
- Davis, M. M. 1921. *Immigrant Health and the Community*. New York: Harper and Brothers.
- . 1927. "Goal-Posts and Yardsticks in Health Center Work." *American Journal of Public Health* 17:433-440.
- Derickson, A. 2002. "'Health for Three-Thirds of the Nation': Public Health Advocacy of Universal Access to Medical Care in the United States." *American Journal of Public Health* 92:180-191.
- Derthick, M., and S. M. Teles. 2003. "Riding the Third Rail: Social Security Reform," in *The Reagan Presidency*. ed. W. E. Brownlee and H. D. Graham, 182-208. Lawrence: University Press of Kansas.
- Dilulio, J., and R. Suskind. 2002. "John Dilulio's Letter." *Esquire*, Oct. 2.
- Dittmer, J. 2009. *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care*. London: Bloomsbury Press.
- Dubose, L. 1999. "Running on Empty: The Truth about George W. Bush's 'Compassionate Conservatism.'" *The Nation*, Apr. 26.
- . 2000. "Read My Chips." *Austin Chronicle*, Sept. 1.
- Duffy, J. 1990. *The Sanitarians: A History of American Public Health*. Urbana: University of Illinois Press.
- Favole, J. A. 2010. "Funds Double for Health Clinics." *Wall Street Journal*, Mar. 25.
- Flanagan, R. M. 2001. "Lyndon Johnson, Community Action, and the Management of the Administrative State." *Presidential Studies Quarterly* 31:585-608.
- Ford, G. R. 1974. "Presidential Message." Public Papers of the President, 1974. Dec. 23.
- . 1975. "Veto of a Public Health Services Bill." Public Papers of the President, 1975. July 26.
- Geiger, H. J. 1984. "Community Health Centers: Health Care as an Instrument of Social Change." In *Reforming Medicine: Lessons of the Last Quarter Century*. ed. V. Sidel and R. Sidel. New York: Pantheon.
- . 1993. "Community-Oriented Primary Care: The Legacy of Sidney Kark." *American Journal of Public Health* 83:946-947.
- . 2002. "Community-Oriented Primary Care: A Path to Community Development." *American Journal of Public Health* 92:1713-1716.
- . 2005. "The First Community Health Centers: A Model of Enduring Value." *Journal of Ambulatory Care Management* 28:313-320.

- General Accounting Office (GAO). 1973. "Implementation of a Policy of Self-Support by Neighborhood Health Centers." *Report to the Subcommittee on Health*. Committee on Labor and Public Welfare: US Senate. May 2.
- Gingrich, N. 2003. "Conservatives Should Vote 'Yes' on Medicare." *Wall Street Journal*, Nov. 20.
- Glenn, B., and S. M. Teles. 2009. *Conservatism and American Political Development*. New York: Oxford University Press.
- Goldstein, A., and D. Balz. 2011. "Governors Differ on Extent of Flexibility for Medicaid." *Washington Post*, Feb. 28.
- Green, J. 2007. "The Rove Presidency." *Atlantic Monthly* September, 52–72.
- Grey, M. R. 1999. *New Deal Medicine: The Rural Health Programs of the Farm Security Administration*. Baltimore: Johns Hopkins University Press.
- Health, Education, and Welfare (HEW), Department of. 1967. "Delivery of Health Services for the Poor." Washington, DC: Government Printing Office.
- Henig, J. 2009. "Education Policy from 1980 to Present: The Politics of Privatization." In *Conservatism and American Political Development*, ed. B. J. Glenn and S. M. Teles, 291–323. New York: Oxford University Press.
- Hillman, B., and E. Charney. 1972. "A Neighborhood Health Center: What the Patients Know and Think of Its Operation." *Medical Care* 10:336–344.
- Hiscock, I. V. 1935. "The Development of Neighborhood Health Services in the United States." *Milbank Memorial Fund Quarterly* 13:30–51.
- Hoffman, B. 2003. "Health Care and Social Movements in the United States." *American Journal of Public Health* 93:75–85.
- . 2006. "Emergency Rooms: The Reluctant Safety Net." In *History and Health Policy in the United States: Putting the Past Back In*, ed. R. A. Stevens, C. E. Rosenberg, and L. R. Burns. New Brunswick, NJ: Rutgers University Press.
- Hollister, R. M. 1974. "Neighborhood Health Centers as Demonstrations." In *Neighborhood Health Centers*, ed. R. M. Hollister, B. M. Kramer, and S. S. Bellin. Lexington, MA: Lexington Books.
- Hollister, R. M., B. M. Kramer, and S. S. Bellin. 1974. "Neighborhood Health Centers as a Social Movement." In *Neighborhood Health Centers*, ed. R. M. Hollister, B. M. Kramer, and S. S. Bellin. Lexington, MA: Lexington Books.
- Howell, J. D. 2010. "Reflections on the Past and Future of Primary Care." *Health Affairs* 29:760–765.
- Iglehart, J. K. 1978. "The Carter Administration's Health Budget: Charting New Priorities with Limited Dollars." *Milbank Memorial Fund Quarterly* 56:51–77.
- . 2010. "Health Centers Fill Critical Gap, Enjoy Support." *Health Affairs* 29:343–345.
- . 2011. "After Midterm Elections, Changes Are in Store." *Health Affairs* 30:1–8.
- Jacobs, L. R. 2007. "The Medicare Approach: Political Choices and American Institutions." *Journal of Health Politics, Policy, and Law* 32:159–186.
- Ku, L., E. Jones, B. Finnegan, and S. Rosenbaum. 2009. "How Is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform." Issue Brief No. 7878. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Ku, L., P. Richard, A. Dor, E. Tan, P. Shin, S. Rosenbaum. 2010. "Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform." Policy Research Brief No. 19. June 30. Washington, DC: Geiger Gibson/RCHN Community Health Foundation Research Collaborative, George Washington University School of Public Health and Health Services.

- Langer, E. 1965. "AMA (II): Doctors' Organization Faces Growing Outside Criticism, Wide Range of Problems." *Science* 149:282–328.
- Lashof, J. C. 1968. "Medical Care in the Urban Center." *Annals of Internal Medicine* 68:242–245.
- Leal, D. L., M. A. Barreto, J. Lee, and R. O. de la Garza. 2005. "The Latino Vote in the 2004 Election." *Political Science* Jan., 41–49.
- Lefkowitz, B. 2007. *Community Health Centers: A Movement and the People Who Made It Happen*. New Brunswick, NJ: Rutgers University Press.
- Marcus, I. 1981. *Dollars for Reform: The OEO Neighborhood Health Centers*. Lexington, MA: Lexington Books.
- McBride, D. 1991. *From TB to AIDS: Epidemics among Urban Blacks Since 1900*. Albany: SUNY Press.
- . 1993. "From Community Health Care to Crisis Medicine." *Journal of Health Politics, Policy, and Law* 18:322–323.
- Mullan, F. 1976. *White Coat, Clenched Fist: The Political Education of an American Physician*. New York: Macmillan.
- Nathan, R. P. 1975. *The Plot That Failed: Nixon and the Administrative Presidency*. New York: Wiley.
- National Association of Community Health Centers (NACHC) and the Robert Graham Center. 2009a. "Primary Care Access: An Essential Building Block of Health Care Reform." Washington, DC: NACHC.
- . 2009b. "Recession Brings More Patients to Community Health Centers." Fact Sheet No. 0209. September. Washington, DC: NACHC.
- National Association of Community Health Centers (NACHC). 2010a. "Entering the Era of Reform: The Future of State Funding for Health Centers." State Policy Report No. 33, Oct. Washington, DC: NACHC.
- . 2010b. "Expanding Health Centers Under Health Care Reform: Doubling Patient Capacity and Bringing Down Costs." June. Washington, DC: NACHC.
- Neergaard, L. 2010. "Health Overhaul Likely to Strain Doctor Shortage." *Associated Press*, Mar. 29.
- Nixon, R. 1971. "Special Message to the Congress Proposing a National Health Strategy." Speech Addressing Congress. February 18. Public Papers of the President, 1971. The American Presidency Project. <http://www.presidency.ucsb.edu/ws/index.php?pid=3311&st=&st1=#axzz1Zqe0Qi00>.
- Oliver, T. R. 1999. "The Dilemmas of Incrementalism: Logical and Political Constraints in the Design of Health Insurance Reforms." *Journal of Policy Analysis and Management* 18:652–683.
- Peterson, M. A. 2000. "The Fate of 'Big Government' in the United States: Not over, But Undermined?" *Governance* 13:256–257.
- Pierson, P., and T. Skocpol. 2007. "American Politics in the Long Run." In *The Transformation of American Politics: Activist Government and the Rise of Conservatism*, ed. P. Pierson and T. Skocpol. Princeton, NJ: Princeton University Press.
- Politzer, R. M. 2005. "The United States Health Centers Initiative." *Journal of Public Health Policy* 26:418–429.
- Rasco, C., and L. Tyson. 1996. "Memorandum to the President." *Chris Jennings Papers*. Domestic Policy Council Papers. Little Rock, AR: William Jefferson Clinton Presidential Library. Aug. 16, Folder 1 (Box 11), 8–9.
- Reynolds, D.A.V. 1999. "An Analysis of the Political and Economic Viability of Community Health Centers: Implications for Their Future." Ph.D. dissertation, University of Michigan.

- Rich, S. 1993. "House Republicans Propose Alternative Health Care Plan." *Washington Post*, Sept. 16.
- Richard, M. P. 1969. "The Negro Physician: Babbitt or Revolutionary?" *Journal of Health and Social Behavior* 10:265–274.
- Richmond, J. B. 1969. *Currents in American Medicine: A Developmental View of Medical Care and Education*. Cambridge, MA: Harvard University Press.
- Richmond, J. B., and R. Fein. 2005. *The Health Care Mess: How We Got Into It and What It Will Take to Get Out*. Cambridge, MA: Harvard University Press.
- Rosen, G. 1971. "The First Neighborhood Center Movement—Its Rise and Fall." *American Journal of Public Health* 61:1620–1637.
- Rosenbaum, S., E. Jones, and P. Shin. 2010. "Community Health Centers: Opportunities and Challenges of Health Reform." Issue Paper No. 8098. Aug. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Rudalevige, A. 2008. "'The Decider': Issue Management and the Bush White House." In *The George W. Bush Legacy*, ed. C. Campbell, B. A. Rockman, and A. Rudalevige. Washington, DC: Congressional Quarterly Press.
- Sardell, A. B. 1988. *The US Experiment in Social Medicine: The Community Health Center Program, 1965–1986*. Pittsburgh: University of Pittsburgh Press.
- Schorr, L. B. 1988. *Within Our Reach: Breaking the Cycle of Poverty*. With D. Schorr. New York: Doubleday.
- Schorr, L. B., and J. English. 1974. "Background, Context and Significant Issues in Neighborhood Health Centers." In *Neighborhood Health Centers*, ed. R. M. Hollister, B. M. Kramer, and S. S. Bellin, 289–296. Lexington, MA: Lexington Books.
- Senate Appropriations Committee. 2011. "Chairman Inouye Releases Analysis of House CR Proposal." Washington, DC: Press Release. Feb. 15.
- Senate Budget Committee. 2010. Chairman's Mark: FY 2011 Senate Budget Resolution. Washington, DC. Apr. 21.
- Senate Human Resources Committee. 1978. "Health Services Extension Act of 1978: Hearings before the Subcommittee on Health and Scientific Research." 95th Congress, 2nd sess., pp. 110–114.
- Shalala, D. 1999. "Memo to the President, Dec. 26, 1999. History of the Department of HHS." Memos for the President. Little Rock, AR: William Jefferson Clinton Presidential Library. Box 31 (Folder 6).
- Sinclair, B. 2008. "Living (and Dying?) by the Sword: George W. Bush as Legislative Leader." In *The George W. Bush Legacy*, ed. C. Campbell, B. A. Rockman, and A. Rudalevige, Washington, DC: Congressional Quarterly Press.
- Smith, D. B. 1999. *Health Care Divided: Race and Healing a Nation*. Ann Arbor: University of Michigan Press.
- Solomon, J., A. MacGillis, and S. Cohen. 2007. "How Rove Directed Federal Assets for GOP Gains." *Washington Post*, Aug. 19.
- Starr, P. 1982. *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry*. New York: Basic Books.
- Stern, B. J. 1946. *Medical Services by Government: Local, State, and Federal*. New York: Commonwealth Fund.
- Stevens, R. 1999. *In Sickness and in Wealth: American Hospitals in the Twentieth Century*. Baltimore: Johns Hopkins University Press.
- Tang, N., J. Stein, R. Y. Hsia, J. H. Maselli, and R. Gonzales. 2010. "Trends and Characteristics of US Emergency Department Visits, 1997–2007." *Journal of the American Medical Association* 304:664–670.

- Tanner, M. D. 2007. *Leviathan on the Right: How Big-Government Conservatism Brought Down the Republican Revolution*. Washington, DC: Cato Institute.
- Taylor, D. H. 1999. "Do Targeted Efforts for the Rural Underserved Help Kill Comprehensive Reform?" *Journal of Rural Health* 15:55–60.
- Teles, S. M., and M. Derthick. 2009. "Social Security from 1980 to Present: From Third Rail to Presidential Commitment—and Back?" In *Conservatism and American Political Development*, ed. B. J. Glenn and S. M. Teles, 261–290. New York: Oxford University Press.
- Thomas, M. 2010. "After Reform, 23 Million to Remain Uninsured." *Chicago Sun-Times*, Apr. 20.
- Tilson, H. H. 1973. "Stability of Physician Employment in Neighborhood Health Centers." *Medical Care* 11:384–400.
- Torrens, P. R. 1971. "Administrative Problems of Neighborhood Health Centers." *Medical Care* 9:487–497.
- White House. 1994. "Presidential Briefing Book. Access for Underserved and Vulnerable Populations." Papers of the White House Health Care Interdepartmental Working Group. Little Rock, AR: William Jefferson Clinton Presidential Library. Folder 3 (Box 644).
- . 2004. "Making Health Care More Affordable." Office of the Press Secretary, Sept. 2. Washington, DC.
- . 2006. "Reforming Health Care for the 21st Century," National Economic Council, Feb. Washington, DC. http://georgewbush-whitehouse.archives.gov/stateoftheunion/2006/healthcare/healthcare_booklet.pdf.
- Wilensky, S., and D. H. Roby. 2005. "Health Centers and Health Insurance: Complements, Not Alternatives." *Journal of Ambulatory Care Management* 28:348–356.
- Wills, G. 2006. "A Country Ruled by Faith." *New York Review of Books* 53:8–12.
- Winston, D. A. 1981. "The Department of Health and Human Services." In *Mandate for Leadership: Policy Management in a Conservative Administration*, ed. C. L. Heatherly. Washington, DC: The Heritage Foundation.
- Zelizer, J. 2007. "Seizing Power: Conservatives and Congress since the 1970s." In *The Transformation of American Politics*, ed. P. Pierson and T. Skocpol. Princeton, NJ: Princeton University Press.
- Zwick, D. I. 1972. "Some Accomplishments and Findings of Neighborhood Health Centers." *Milbank Memorial Fund Quarterly* 50:392, 404.