

Back To School: A Health Care Strategy For Youth

The school-based health centers are controversial—but they might just fit the political temper of our times.

by James A. Morone, Elizabeth H. Kilbreth, and Kathryn M. Langwell

ABSTRACT: School-based health centers (SBHCs) are a policy innovation designed to increase health care access among youth. The centers offer primary and acute care, often to underserved populations. We describe SBHCs, trace their history, and analyze the three great political challenges they face: moral opposition triggered by concern about reproductive health services in schools; funding in a managed care era; and partisan state politics. We show how the centers have been meeting these challenges. Finally, we consider the prospect of this innovation going to scale across the nation.

122 **BACK TO
SCHOOL**

ELEVEN MILLION CHILDREN have no health insurance. Ambitious efforts to reach them—such as the State Children’s Health Insurance Program (SCHIP)—have gotten bogged down in the states, which enroll fewer than half of the eligible kids.¹ For teenagers, access to health care is especially tricky. Teens face problems—substance abuse, reproductive health needs, and depression, among others—that are difficult to face and can land them in serious trouble. However, ignoring the problems of adolescents can lead to even bigger troubles: one million unintended pregnancies a year, three million sexually transmitted diseases, more than four thousand suicides, and flashes of school violence. The adolescent and young adult death rate in the United States is high—1.5 deaths per thousand young males. (In contrast, the rate is 0.7 in England, 0.6 in Sweden, and 0.9 in Germany.) In the United States, one of every three youth deaths comes from homicide, suicide, or acquired immunodeficiency syndrome (AIDS).²

One response, now stirring across the nation, springs from a simple intuition: Put the health care where the kids are. Communities are opening health centers in the schools, especially in poor neighborhoods. Local hospitals, community health centers, or public health departments often run school-based health centers (SBHCs).

Jim Morone is a professor in the Department of Political Science at Brown University in Providence, Rhode Island. Beth Kilbreth is an associate professor at the Edmund Muskie Institute of the University of Southern Maine in Portland. Kathy Langwell is a managing director of the Health Economics Practice, Barents Group, in Washington, D.C.

The idea sounds simple, but the centers have raised all kinds of objections. They do not fit the logic of managed care. They look like a throwback to the community health center model last touted in the 1960s. And they enrage some social conservatives; critics worry about encouraging promiscuity, turning schools into social service centers, and undermining parental authority. SBHCs kindle anxieties about difficult matters: How should a community deal with adolescents who drink, use illegal drugs, or have high-risk sex?

Despite the hurdles, SBHCs have spread rapidly—from roughly 150 centers (covering an estimated 137,000 children) in 1990 to more than 1,300 centers (covering 1.1 million) today.³ Ten years ago SBHCs were concentrated in the Northeast; now they operate in forty-five states and the District of Columbia (Exhibit 1).⁴ The centers offer a simple, relatively inexpensive way to whittle away at the problems of children’s health care. While most policy analyses focus on the big-ticket items, such as SCHIP and Medicaid, SBHCs are tackling the same problems, one school at a time.

Will the school centers grow into an important feature of the American health care landscape? Will they effectively address young people’s health needs? It is too soon to tell. But despite all the red flags they send up, SBHCs may prove to be an important innovation that fits the political temper of our time.

A Snapshot Of Children’s Health

During the past two years we have visited SBHCs across the country.⁵ The first thing to strike us was the sheer level of need. Kids, and their schools, face extraordinary pressures. They have to cope with all of the tensions of American society. The data are familiar. Child poverty rates may be falling, but almost one of every five children (18.7 percent) lives below the poverty line. The economy grows stronger, but homelessness continues to rise—perhaps as much as 50 percent in the past decade; some seven million persons, mostly

EXHIBIT 1
Number And Regional Distribution Of School-Based Health Centers, 1996 And 1998

Region	1996	1998
Mid-Atlantic and New England	379	422
Southwest and Rocky Mountain	155	233
Southeast and South-Central	180	212
Midwest	109	173
Pacific Coast	77	114
Total	900	1,154

SOURCE: *School-Based Health Centers—National Survey, 1997/1998 Report* (Washington: Making the Grade National Program Office, January 1999).

families with children, are at high risk of homelessness. We are experiencing the second-largest immigration wave in American history; almost one of every ten persons in the United States was born abroad. Even schools in small cities face students speaking many different languages (in the case of Woonsocket, Rhode Island, thirty-five).⁶ But the statistics failed to prepare us for what we saw and heard, traveling from school to school.

In an Oregon elementary school, a student's mother stormed into the classroom and began to scream at her child. The mother, it turned out, had just been released from prison. Her three children had been living in a garage with their grandmother, sleeping in sleeping bags. Their only meals were the free breakfast and lunch provided at the school. In Colorado a Mexican American child came into the clinic complaining of a sore throat. When approached by the clinician, the child recoiled in fear. He had never seen a tongue depressor before.

One New England school board sternly forbade any birth-control services in the local SBHC. School officials accepted the decision without protest. They understood that there were deeply held views on all sides of the issue. Still, teachers in the high school we visited faced a stubborn reality: forty pregnant girls. In Louisiana a rural, largely African American parish is home to 9,000 children and three physicians. None of the doctors are pediatricians, two are over age sixty-five, and only one accepts Medicaid. For most children in the parish, the SBHC is their first and only source of regular care.

Across the country we saw clinic providers overwhelmed by the mental health needs of their students. The staffs see depression, anxiety, phobias, eating disorders, self-mutilation, substance abuse, uncontrolled anger, and the sheer stress from broken homes and life below the poverty line. Clinic staff routinely deal with multiple suicide attempts during each academic year. In that same Louisiana parish, for example, five high school students attempted suicide on the same day. The teens did not seem to know one another, and no one ever figured out the cause.

We heard these kinds of stories everywhere we went. They reminded us that behind the data and the policy debates lies a sharp reality: American youth face enormous health care needs. We found ourselves sobered by the scope of the problem. Anyone interested in questions about our children and their health care ought to plant those hard images front and center.

A New Model For Age-Old Problems

Today's SBHCs are a far cry from yesterday's school nurse. The health centers are designed to deliver comprehensive primary, pre-

ventive, and acute care. Most are staffed by nurse practitioners, nurses, mental health care providers, and aides. Many include part-time physicians on a regular schedule; some are training sites for medical students. SBHCs often have lab facilities for routine blood tests, and some even offer dental care.

Students either make appointments or walk in. The centers conduct comprehensive physical exams, treat chronic conditions (such as asthma), diagnose injuries, treat sexually transmitted diseases, monitor mental health problems, and—we heard this all the time—offer a trained adult ear when children (or their parents) need to talk. The clinicians educate parents, consult with teachers, and teach students about anger management, nutrition, and sex.

Most important, providers in the SBHCs are experts in adolescent and child health care. When the clinics work well, staff members win a reputation among students for compassionate, confidential, and nonjudgmental treatment. Students actually use the services. They have a safe place to take their aches and anxieties.

■ **History of SBHCs.** The SBHC idea goes back to the late 1960s and early 1970s. It flowed from two very different public health impulses. First, pediatricians organized school clinics in cities such as Dallas, Minneapolis–St. Paul, and Cambridge, Massachusetts. These early efforts shaped the model. A small circle of policy entrepreneurs began championing the school clinics.⁷ The Robert Wood Johnson Foundation (RWJF) jump-started broader interest through funding initiatives starting in 1978.⁸ In the 1980s a handful of state and local policymakers picked up the idea. Gov. Lowell Weicker Jr. (I) of Connecticut, for example, imagined an SBHC in every school (although he left office, in 1995, fewer than fifty schools into the campaign). More recently, the federal government dipped a funding toe into the field with a grant program titled Healthy Schools, Healthy Communities, launched in 1994.⁹

The second impulse proved more controversial. In the mid-1980s organizations such as the Children's Defense Fund began to publicize the teen pregnancy crisis. Between 1970 and 1989 the teen pregnancy rate among young white teens (ages fifteen to seventeen) rose 250 percent. Sexually transmitted disease rates also rose sharply. (Despite all of the “underclass” hype, the pregnancy rate for young black women, while much higher, declined 13 percent during the same period.)¹⁰ Public health advocates and politicians scrambled for solutions. Joy Dryfoos, who is often considered the “mother” of the SBHC movement, wrote a series of influential articles promoting family planning through SBHCs.¹¹

In the early 1990s family planning in SBHCs got a more flamboyant advocate. In her autobiography, former U.S. surgeon general

Joycelyn Elders gleefully describes her first press conference as director of the Arkansas Department of Health. Reporters were sleepily going through the motions until she promised to reduce teen pregnancy. “How?” they asked, stirring to life. Elders responded:

“We’re going to have...school-based clinics,” [I said]. Now they were all wide awake. Somebody said, “School-based health clinics? Does that mean you’re going to distribute condoms in schools?” I said, “Yes it does. We aren’t going to put them on their lunch trays. But yes, we intend to distribute condoms.”¹²

Gov. Bill Clinton, concluded Elders, looked like he was “trying hard to swallow something.” The image of condoms on the cafeteria trays would haunt school clinics and their advocates. But that politically combustible image was just the hottest in a series of challenges to come.

Barriers To The Spread Of School-Based Centers

SBHCs have a lot going for them. They offer access to services for kids who are not getting health care. They reach teens who might be afraid or embarrassed to confide in their parents. They can be invaluable for working parents who cannot take time from their jobs to deal with sick calls from school—an especially urgent issue now that welfare reform has pushed many poor people into low-wage, often precarious jobs. They are bargains compared with the large insurance programs that states normally wrestle over—“decimal dust” in the budget process, one program manager told us.¹³ All of these advantages did not get the SBHCs very far until they solved three basic challenges: negotiating the culture wars, getting funded, and managing partisan politics.

■ **The culture wars.** Opening an SBHC often means confronting the image of condoms on the cafeteria trays. Teen health care raises all of the thorny issues surrounding sexuality and reproductive health. As a result, the centers face instant enemies almost everywhere. In the Northeast, Roman Catholic bishops are chary of birth control. In the South and West, conservative Christians see a danger to family values. On the airwaves, Laura Schlessinger (“Dr. Laura”) skewers the health centers for snatching moral guidance from parents and placing it in the hands of secular school officials.

These are not easy issues. Some parents are comfortable with school programs that promote safer sex. Many would want their children treated for sexually transmitted diseases as swiftly and efficiently as possible. Other parents are horrified at the implicit message—such services condone promiscuity, they say. The issue is further complicated by the question of parental notification. Many providers are reluctant to violate students’ requests for confidentiality. But shouldn’t parents know? Of course, clinic staff can urge

children to inform their parents. But should they be required to do so?

For all the political passion, most SBHC supporters have learned to defuse the critics. Some former skeptics—many Catholic bishops, for example—have become forceful allies. How? The most important strategy is the most obvious: compromise. Everywhere, clinic staff repeat the same mantra: You do what the community will accept. Naturally, the local norms vary enormously. New York legislation requires SBHCs to provide reproductive health services, either on site or by “active referral.” Louisiana’s authorizing legislation, on the other hand, explicitly prohibits dispensing contraceptives or counseling for abortions on school grounds; some Louisiana communities do not permit testing for sexually transmitted diseases and explicitly forbid pelvic exams for adolescent girls.¹⁴

Since school politics normally plays out on the local level, the pattern can vary within a single state. Take Maryland, for example, where local taxes fund education and local school boards make the rules. In Baltimore, SBHCs offer a full range of reproductive services. In Maryland’s affluent District of Columbia suburbs, program sponsors scrupulously sidestep the issue. School board meetings are televised. As one official told us, “Those people have to get elected—they aren’t going to talk dirty on television.” Instead, reforming energy gets concentrated onto the safer ground of elementary schools. Some communities in rural Maryland have worked out an unofficial compromise. SBHCs do not treat any reproductive health problem except sexually transmitted diseases. But parents and school board members live comfortably with the unstated but broadly recognized policy (reported to us by a board member) that center staff refer students to community-based services—and even accompany them if they need transportation or emotional support.

The sticking point often comes with parental consent and notification. The issues sometime trip up even savvy political advocates. In California, SBHC legislation that left parental notification up to the local centers stirred a rally of 10,000 parents and a governor’s veto.¹⁵ Even the simpler matter of permission has to be negotiated. Most places simply ask parents to fill out blanket consent forms, a necessary ticket for access to the health centers. The forms allow parents with strong objections to take their kids out of the system. Different school systems have sampled all kinds of approaches: Some ask for a single form when the child enters school; others require an annual form; and—in one short-lived maneuver—a skeptical state committee proposed requiring parental consent for every possible clinical service on a form that went on for pages.

■ **Quiet victories.** And yet the school clinics thrive, even in culturally conservative states where arguments against social serv-

“Health centers have defused fears of creeping socialism with a bit of political wisdom: Build a constituency.”

ices might have found a sympathetic audience. In South Carolina, for example, the number of centers jumped from three to twenty-two in the past four years. In Louisiana an all-out campaign by the Christian Coalition failed to dislodge the health centers; by the time the battle was over, the legislature had used its tobacco settlement funds to lock in a long-term SBHC funding stream.

The health centers have defused fears of creeping socialism with another classic bit of political wisdom: Build a constituency for your service. Some communities introduce the clinics in the lower schools, where sex, violence, and substance abuse are not major issues. As the children move up the grades, parents push to keep their health services, which means extending them to older youth. Once parents turn into stakeholders defending “their” social entitlements, the ideologues face an uphill battle. Ultimately, children and parents telling personal health care stories are the most effective way to quell the culture wars.

128 **BACK TO
SCHOOL**

Supporters often dig up dramatic cases. For example, an African American high school student electrified a legislative task force on youth violence in Louisiana. He calmly described how his plan to shoot his abusive stepfather was diverted by mental health counselors in a school-based anger management class. “This spring,” he summed up softly, “I’m graduating high school instead of doing time.” Any adult in the packed hearing room who had ever had an abusive relationship or an angry divorce could understand the young man’s anguish.

■ **But where’s the money?** A decade ago, advocates imagined school health centers playing an important role in that long-awaited Shangri-La, national health insurance. Ironically, the Clinton administration proposal, with its emphasis on managed competition, spurred an industry surge toward market competition and managed care. SBHCs were not ready for that.

Most public clinics (community health centers, hospital clinics, and SBHCs) had been operating worlds apart from managed care. They generally served low-income persons who were irrelevant to the commercial managed care industry. Most SBHCs had never billed for services. Staff did not know the children’s insurance status. Neither did the children. The centers were not wired for sophisticated record keeping and did not have the staff (much less the funding) to track down coverage data or bill the payers. On the

contrary, many staff members worked up a warm contempt for the insurance industry and its “insurance-ese.”

The great shift in Medicaid policy changed all that. By the mid-1990s every state had turned to managed care for its Medicaid populations. The school centers and their medical sponsors spent the end of the decade scrambling to catch up. They never succeeded.

Many managed care organizations rely on a “gatekeeper” to control costs. Enrollees get a primary care provider who authorizes most services. SBHCs normally cannot operate as the gatekeeper since they do not provide coverage twenty-four hours a day, seven days a week.¹⁶ As a result, school clinics have to negotiate a marriage with an outside primary care organization. The predictable difficulties always spring up: Who is responsible for what? What may the SBHC do without prior authorization? And, most important, what about payment?

The basic problem is both simple and intractable: Limited funds have to be stretched across two facilities. Medicaid capitation rates for school-age children generally range from \$6 to \$10 a month. Medicaid providers and health plans are reluctant to split such meager payment with the schools. And children are likely to use the school health services far more often than the models predicted when rates were set—precisely the point of the SBHC exercise.

Some SBHCs, backed up by a community health center or a local hospital, do serve as the primary care provider. But the clinics are in the schools to improve access to health care services, not to guard the gates. Children walk in without appointments. Clinics respond to kids in crisis by calling in mental health professionals without waiting for authorization. Payers rightly distrust the SBHCs—their mission makes them terrible gatekeepers.

These organizational tensions defeat even good-faith efforts by managed care organizations and SBHCs to forge working relationships. When they negotiate an agreement—no easy job—the school clinics still find their billings routinely denied. SBHCs have sunk enormous energy into gearing up for managed care. Many now have far better record-keeping systems than they did a decade ago, and they routinely report utilization information to their state health departments. The effort may have made the centers more credible among state health policymakers. But SBHCs do not bring in much cash. The most recent survey of twenty-six states indicates that no SBHC receives more than 10 percent of its revenue from third-party billings to managed care contractors.¹⁷

To make matters worse, the SBHC clientele reflects the usual crazy-quilt of insurance coverage. Students are covered by many different carriers. The SBHCs’ poor and working-class populations

are likely to be uninsured. Even eligible children have often failed to enroll in public programs such as Medicaid or SCHIP. These coverage problems are compounded by the welfare reform law of 1996. The reform split income assistance from Medicaid; persons who are not receiving cash benefits are now far less likely to sign up for Medicaid. In some places, lawsuits charge state officials with actively driving away persons who qualify for Medicaid.¹⁸

So where will SBHCs get their funding? Across all states' programs, about 61 percent of SBHC funding comes from state appropriations, and another 19 percent from state allocation of maternal and child health block grant funds (Exhibit 2). Medicaid fee-for-service payments account for 17.2 percent of total revenues (most of this in New York). Payments from billings to managed care companies—for both Medicaid and commercial insurance enrollees—amount to less than 2 percent of SBHC monies. Of course, winning a dedicated budget line raises still another challenge: To survive and flourish, the school clinics have to negotiate state politics.

■ **Partisan politics.** The 1990s did not appear to be an auspicious period for social welfare innovations on the state level. The 1994 election—marked by Newt Gingrich's celebrated "Contract with America"—was one of the greatest electoral routs in U.S. history. The Republican Party won both houses of Congress. Republicans also captured control of both houses of the legislature in eleven new states (in 1994) and took fifteen new governors' offices (between 1993 and 1996). Political scientists are still puzzling out the implications for governance. The last political sea change of this size occurred in the trough of the Great Depression, between 1930 and 1932.

A shift of such magnitude rattles the policy establishment. Changes in administration normally signal a change in priorities. In some states liberal administrations had embraced SBHCs. Weicker (a liberal independent in Connecticut) and Mario Cuomo (a liberal

130 **BACK TO
SCHOOL**

EXHIBIT 2

Aggregate National Funding Sources For School-Based Health Centers, 1999

Source	Dollars	Percent of total revenues
State general funds	\$29,000,000	60.8%
Maternal and child health block grant	9,270,000	19.4
Medicaid fee-for-service reimbursement	8,200,000	17.2
Medicaid managed care reimbursement	700,000	1.5
Private insurance reimbursement	500,000	1.0
Total	47,670,000	

SOURCE: *School-Based Health Centers—National Survey, 1997/1998 Report* (Washington: Making the Grade National Program Office, January 1999).

NOTE: Total does not reflect miscellaneous additional sources of revenue, such as foundation grants, dollar and in-kind contributions from sponsoring organizations such as hospitals, or local school or health department funds.

“In every case we studied, the innovating spark flew not up from the grassroots but down from state government.”

Democrat in New York) had been perhaps the most active proponents of the school clinics. Their administrations were replaced by conservative Republican John Rowland in Connecticut and moderate Republican George Pataki in New York. Neither would be expected to make the same kind of commitment to what were, after all, the signature programs of their political rivals. The same diffidence could be expected of the rising conservative politicians around the nation.

Sure enough, there seemed to be a major backlash brewing. In North Carolina the new Republican House majority explicitly forbade any of the state’s SCHIP money from going to SBHCs. In Louisiana, where a Republican governor loosely affiliated with the Christian Coalition had bolted from out of nowhere to win, conservatives set out to abolish the school centers. However, once the smoke from that first partisan volley had cleared, it became obvious that school centers would be perfectly compatible with the new Republican era. In the second half of the 1990s the number of SBHCs around the nation more than tripled. North Carolina repealed the bar on funds; as we saw above, Louisiana turned positively generous toward its school centers.

In large measure, success was due to classic interest-group politics. Respectable locals—parents, teachers, and health care providers—went to their legislators and told heartwarming stories about their kids and their SBHCs. This is the kind of language that all legislators understand, regardless of party label. Legislators are always primed to deliver concrete benefits to “responsible” community members. SBHCs make the perfect constituent service. They combine education and health care. They will not bust the budget. They are simple to understand. They are local. They offer fine photo opportunities. They can be doled out slowly, one school at a time.

In brief, expanding the number of SBHCs fits neatly into the dynamics of American state politics: responsive, low cost, and local. And the clinics offer political relief from all the complex, health policy brain-busters that torment state legislators. Connecticut may have elected a conservative Republican governor, but when we visited the state, the legislature had seven different bills before it, each authorizing another new school health clinic.

State Governments In Action

SBHCs involve two unusual political twists: activists in the bureaucracy (which sounds like an oxymoron), and links across three normally unconnected policy areas.

■ **Bureaucratic activists.** From a distance, SBHCs glint with a kind of Jeffersonian haze: Local activists build clinics, round up local providers, mollify opponents and uneasy parents, and then march to the state capital for funding. The reality is different.

In every case we studied, the innovating spark flew not up from the grassroots but down from state government. Sometimes governors championed the reform; when governors were hostile or indifferent, the push often came from health administrators. State officials organized the centers, dug up seed money, compiled data on health care needs, and formed steering committees to draw in the major stakeholders (medical societies, child advocacy groups, and government agencies). State officials even organized local supporters, who eventually ended up lobbying the legislature for more support. And they guided school officials into the health care thickets.

For example, one local school built its clinic with no thought to privacy or antiseptic conditions. These health care novices constructed examining rooms with half-walls (so that anyone could hear everything) and wall-to-wall carpet. A state health official quickly provided “technical assistance,” gently explaining that the carpet would be difficult to keep sterile and had to go.

The political pattern seems to turn conventional wisdom upside down. Aren't state agencies just repositories of fossilized bureaucrats? One provider even proposed a motto for her state department of health: “Don't just do something—stand there!” Activists, in the usual view, rise up from the grassroots and struggle against these unfeeling, red-tape recalcitrants. In contrast to our romantic memories of the 1960s, we found social activists operating in offices throughout the state health bureaucracies. Many are seriously committed to more and better health care. They helped to organize the local activists who then rose up to champion children's health care.

The role played by bureaucratic innovators introduces a classic political theme: the interplay between government action and grassroots mobilization. Some social movements rise up against unfriendly or unresponsive governments—for example, the first wave of AIDS activists (in the early 1980s) or the antiwar movement (in the 1960s). In other cases, government decisions open the door for activists; the U.S. Supreme Court's ruling in *Brown v. Board of Education* helped to transform civil rights agitation into a mass movement in the 1950s, and ambiguous New Deal legislation unleashed the

great labor movement in the 1930s.¹⁹

The bureaucratic activists we observed did not quite fit either of these models. They operated without the sanction of federal policy and, in some instances, independent of state political leadership. Rather than acting within the organizational framework of their state agencies, they reached into the communities to create support for programs, often support that had not existed or had lain dormant. Here is a new twist on health politics: mavericks within the state bureaucracies organizing the grassroots.

■ **Health, education, and crime.** The school clinics stand at the intersection of three very different policy domains: health, education, and criminal justice. Each system operates on different principles. Each has its own assumptions, rules, actors, forms of funding, policy debates, and patterns of power. They even seem to speak different languages—to someone in education, for example, “primary care” goes to the kids in grade school. A successful SBHC program requires “multilingual” leaders.

Obviously, the school clinics bridge the gap between health and education. That means negotiating two radically different authority structures. Health care programs run on federal and state funds guided by federal and state rules. The chain of command invariably runs through the state capital. Education inverts all that. Local taxes (sometimes mixed with state money) fund the schools; local boards make the important decisions. In health care, the state Medicaid agency is a major player; in education, there is rarely a state agency with comparable muscle (or money).

SBHCs are also in the criminal justice business. Mental health issues shade into violence prevention. Substance abuse straddles the blurry line between health problems and criminal matters. Moreover, the school centers find themselves thrust into a major debate on juvenile justice policy. Crime policy specialists face off between tough-minded advocates of “zero tolerance” on the one hand and those who emphasize education, treatment, and rehabilitation on the other. In recent years the proponents of “getting tough” have enjoyed the stronger hand; states have legislated mandatory sentences, pushed young people into adult courts, and introduced a host of zero-tolerance policies in the schools. But critics have now begun to challenge these harsh moves.²⁰

Skeptics of zero tolerance find allies in the school-based health centers. The clinics offer a different way to address youth violence and substance abuse. The partnership between reformers in juvenile justice and health care—still in its infancy—hints at a new, health-based approach to reaching troubled kids. The clinics offer a vehicle through which the juvenile justice “doves” can shift the balance from

harsh sanctions to the education and treatment regimes more familiar to public health advocates.

Toward A Youth-Friendly Health Care System

SBHCs are no substitute for Medicaid or private health insurance. As the only option for school-age children, the small clinics would quickly be overwhelmed by demand. What they do offer is a potentially important—perhaps crucial—addition to a youth-friendly health care system.

In a sense, the clinics complement the managed care ideal. In theory, managed care offers a professionally monitored gateway into integrated and comprehensive health services, organized in a way that breaks both providers and consumers of their presumed addiction to overtreatment. In practice, managed care organizations ration care with relatively blunt instruments that do not always identify essential care, especially for treating mental illness and substance abuse. It takes persistence and skill to get around the barriers.

SBHCs offer almost the reverse. They do not offer a comprehensive, much less an integrated, care model. And they are organized on the reverse assumption: that adolescents underuse health care services. SBHC culture encourages repeat visits, active outreach, and leisurely paced visits, where children are encouraged to open up about anxieties or high-risk behavior that may underlie their health complaints. The centers fill the gaps in health education, counseling, and mental health care. They are well placed to reach the many kids who fall through the cracks of the health care system.

Terrible events, such as the shootings at Colorado's Columbine High School, might have provoked a national conversation about our children and their needs. Instead, they provoked thin debates between congressional conservatives touting the Ten Commandments and liberals answering with gun control. Meanwhile, in the trenches, schools face pressing needs with limited resources. SBHCs offer a small response with the potential to do a lot of good. They are a simple, inexpensive way to get care to underserved children and reluctant teenagers. They help working parents—especially low-wage workers—who cannot take time off for sick children. They pose an alternative to the harsh zero-tolerance policies that throw young people—minorities first—out of the education system at the first sign of trouble. They offer state legislators a health care solution that works across party lines.

It is too early to know how far school clinics can take children's health care. But this reform is moving steadily across the states, spreading far beyond the familiar health policy innovators. For all the barriers they face, the school clinics might just fit the political

temper of the times. They are certainly worth keeping an eye on. They are also, we believe, a reform well worth encouraging.

.....
This paper was supported by the Robert Wood Johnson Foundation. We thank Kate Kraft, our program officer, as well as Paul Jellinek, Jim Knickman, Beth Stevens, and Marjorie Guttman. Special thanks to Julia Lear and to our colleagues Lisa Rogers, Sharone Jacobs, and Ellen Jo Hier. We also thank Deborah Stone, Don Metz, and two anonymous reviewers.

NOTES

1. Data on the uninsured are from a survey conducted by Wirthlin Worldwide, July 2000, reported in D. Ho, "Eligible Children Not Being Signed Up for Health Insurance," *Boston Globe*, 10 August 2000, A3. For a discussion of the low "take-up" rate plaguing SCHIP and Medicaid generally, see F. Thompson, "Federalism and Health Care Policy," in *State Health Policy*, ed. R. Hackey and D. Rochefort (Lawrence: University Press of Kansas, 2001).
2. *World Health Statistics Annual: 1996* (Geneva: World Health Organization, 1998). See also *1999 Annual Report on School Safety*, joint report prepared by the U.S. Departments of Education and Justice (Washington: U.S. Government Printing Office, 2000).
3. Growth rate data on SBHCs are reported on two Web sites: the Robert Wood Johnson Foundation's Making the Grade site, <www.gwu.edu/~mtg/index.htm>, and the National Assembly on School-Based Health Care site, <www.nasbhc.org>. The estimate of 1,300 comes from Julia Lear, national director, Making the Grade, personal communication, 14 October 2000, based on a national survey now being completed. Data for 1990 are from Advocates for Youth (Center for Population Options), Washington, D.C.
4. *School-Based Health Centers—National Survey, 1997/1998 Report*, January 1999, <www.gwu.edu/~mtg/sbhcs/papers/98natlreport.htm> (6 November 2000).
5. In 1998–1999 we visited schools in multiple sites (ranging from Brooklyn, New York, to rural Oregon) across nine states as part of an evaluation of the Robert Wood Johnson Foundation's (RWJF's) Making the Grade initiative. The program is designed to encourage state development of SBHCs. The nine states were Colorado, Connecticut, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, and Vermont. We especially focused on the policy questions raised by the school centers. What are the advantages and the pitfalls of SBHCs? Are they financially sustainable? With what sources of funding? And what about the politics? Do communities need clinics if most children can be enrolled in an insurance program? We talked with a broad range of people including legislators, state officials, school principals, students, parents, advocates, skeptics, and health care providers.
6. D. Terry, "U.S. Child Poverty Rate Fell as Economy Grew, but Is Above 1979 Level," *New York Times*, 11 August 2000, A10. On immigration, see D. Tichenor, *Controlling the Community* (Princeton, N.J.: Princeton University Press, 2001), chap. 10.
7. P. Brodeur, "School-Based Health Clinics," in *To Improve Health and Health Care 2000: The Robert Wood Johnson Foundation Anthology*, ed. S.L. Isaacs and J.R. Knickman (San Francisco: Jossey-Bass, 1999). The most energetic policy entrepreneur we encountered was Julia Lear, of the RWJF's Making the Grade program.
8. *Ibid.* The RWJF first underwrote school health services in four states in 1978. Between 1981 and 1989 the foundation promoted community health centers in

eight cities. Five of these cities established primary care centers in schools, as a part of this program. Then, in 1986, the RWJF launched the School-Based Adolescent Health Care Program and awarded nineteen six-year grants to public and private institutions to set up health centers in twenty-four high schools in fourteen cities. Finally, the Making the Grade initiative, launched in 1993, awarded grants to states to create state sponsorship, sustainable funding strategies, and regulatory oversight of SBHCs. Through these various initiatives the RWJF has, at one time or another, supported the development of school-based health care in twenty-one states. Twenty-four other states, plus the District of Columbia, have adopted the strategy.

9. The program funds thirty-three organizations to establish new school-based health centers in twenty-three states. "Healthy Schools, Healthy Communities Program," 20 April 2000, <bphc.hrsa.gov/hshc/hshcfact.htm> (28 July 2000).
10. Data computed from House Committee on Ways and Means, 102d Cong., 2d sess., 1992 *Green Book Overview of Entitlement Programs* (Washington: U.S. GPO, 15 May 1992), 1099.
11. See, for example, J.G. Dryfoos, "The Incidence and Outcome of Adolescent Pregnancy in the United States," *Journal of Biosocial Science* (Supplement 1978): 85-99; J.G. Dryfoos and T. Heisler, "Contraceptive Services for Adolescents: An Overview," *Family Planning Perspective* 10, no. 4 (1978): 223-225, 229-233; J.G. Dryfoos, "What President Bush Can Do about Family Planning" (editorial), *American Journal of Public Health* 79, no. 6 (1989): 689-690; and J.G. Dryfoos, "School-Based Health Clinics: Three Years of Experience," *Family Planning Perspective* 20, no. 4 (1988): 193-200.
12. J.J. Elders, *Joycelyn Elders, M.D.: From Sharecropper's Daughter to Surgeon General of the United States of America* (New York: Avon Books, 1996), 242.
13. SBHCs offer efficiencies through their use of mid-level practitioners. However, the lower salary costs of the staff may be offset by the longer visit time taken with each student. Obviously, the major reason that SBHCs are low cost is because they are, so far, small programs. Costs will increase as the programs expand to reach more children. However, one thing making SBHCs politically attractive is that they can be carefully targeted and incrementally funded.
14. Act 1055, House Bill no. 169L, signed by Louisiana Governor Charles E. "Buddy" Roemer II (R), 1991.
15. The controversy occurred in October 1999. See "Angry Parents Storm State Capitol to Protest School Health Bill," Associated Press, 1 October 1999.
16. Managed care organizations require that their primary care gatekeepers provide access twenty-four hours a day, seven days a week for their patients, so that persons with acute or emergency conditions can get medical advice or authorization for emergency care at any time. This means that even physicians in solo practices have to have arrangements with colleagues to cover for each other twenty-four hours a day. Most SBHCs operate only during school hours and are closed for the summer and are thus not positioned to share on-call requirements with full-time medical practices.
17. Lear, personal communication. See also J. Koppelman and J.G. Lear, *From the Margins to the Mainstream: Institutionalizing School-Based Health Centers* (Washington: Making the Grade, George Washington University, June 2000).
18. See Thompson, "Federalism and Health Care Policy."
19. J.A. Morone, *The Democratic Wish: Popular Participation and the Limits of American Government*, 2d ed. (New Haven: Yale University Press, 1998).
20. See, for example, "Rethinking Zero Tolerance," editorial in the *Boston Globe*, 17 August 2000, A19.