1995

Is Equal Access the Prescription for Equity?

Dorothy E. Roberts
University of Pennsylvania Carey Law School

IS EQUAL ACCESS THE PRESCRIPTION FOR EQUITY?

ROUNDTABLE DISCUSSION*

INTRODUCTION

Health care reform recently has emerged at the forefront of national debates. Brought to the table by the Clinton administration, the issue of health care is critical to economic and social progress in the country. The United States spends over 14 percent of the Gross Domestic Product (GDP) per year on health care;[1] *the average inflation rate for health care spending from 1983 to 1991 was approximately 7 percent.*[2] *These high numbers reflect the dual standards of American health care: while nearly thirty-nine million Americans are currently uninsured,*[3] *those who do have access to American medical treatment receive what may be the highest quality health care in the world.*

Victor W. Sidel, M.D., of Montefiore Medical Center in the Bronx, New York, led the panel of experts and moderated the discussion. Participants included Dr. Katy Anastos, primary care physician, Bronx Lebanan Hospital; Jennifer Dohrn, Director of Midwifery Services, Morris Heights Health Center; Nitza Milagros Escalera, attorney, Community Service Society of

---

* In the interests of conciseness and readability, some of the discussion has been paraphrased or abridged. We have made every effort to ensure accuracy in reporting each participant's contribution to the discussion. Special thanks to Lina Srivastava, Staff Editor on the 1993-1994 *Review of Law and Social Change*. Footnotes have been added to enrich the reader's comprehension and to assist future efforts to research these issues.

1. In 1993, the nation spent 14.3 percent of GDP on health services. COUNCIL OF ECON. ADVISERS, ECON. REP. OF THE PRESIDENT 131 (1994). In terms of real dollars, 14 percent of the GDP translates into one out of every seven dollars spent in the United States. *Id.* In 1991, the United States spent 13.2 percent of GDP on health care. *Id.* This number is higher than all other industrialized nations, none of which spent more than 10 percent of GDP on health care. *Id.*

2. Compare this figure to the national rate of inflation, which was only 3.9 percent on average from 1983 to 1991. *Id.*

3. According to the current population survey, in excess of 15 percent of Americans, the equivalent of nearly 39 million people, were uninsured during 1992. *Id.* at 133.

New York; Peter Holland, Consumer Affairs Director, Lambeth Family Health Authority, London, England; Sylvia Kleinman, National Gray Panthers; Professor Sylvia Law, New York University School of Law; Jack O'Sullivan, journalist, The Independent; Robert Padgug, Director of Health Policy, Empire Blue Cross Blue Shield; Dennis Rivera, President, Local 1199, New York State Health Care Workers Union; Professor Dorothy Roberts, Rutgers Law School; and Professor Beth Weitzman, New York University Wagner School of Public Service. During the first half of the program, experts on the panel elaborated on these problems of cost and access and their effect on the current state of health care delivery. Looking for solutions to existing problems was the focus of the second half of the discussion.

I

PRENATAL CARE FOR THE INSURED

Dr. Sidel: Rebecca and Robert Rich are an affluent couple residing in Manhattan's Upper East Side. Rebecca is thirty-five years old and pregnant for the first time. Her age makes her pregnancy high-risk and exposes her to possible delivery complications. Rebecca has medical care insurance coverage through her employer. Assuming that her insurance policy covers pregnancy and delivery costs, how does Rebecca obtain quality prenatal care in New York City?

Jennifer Dohrn, Director of Midwifery Services, Morris Heights Health Center: One might think, from listening to the story of Rebecca Rich, that she has access to fine medical care. She is employed and has health insurance that will cover the costs of having a baby. Under these circumstances, Rebecca is in a much better position than many pregnant women in New York City.

Because cost is not a factor, Rebecca will contact her gynecologist, who might be an obstetrician or who could refer her to one. She will receive a prenatal care program tailored to a middle-class woman in the United States. Due to her age, however, this program will be extremely interventionist and will utilize high technology. For example, Rebecca very quickly will be introduced to the necessity, rather than the choice, of undergoing amniocentesis.

Given Rebecca's socio-economic background, her doctor might conclude that she will institute a malpractice suit if complications arise. In an

effort to minimize liability exposure, therefore, the doctor would either induce birth if Rebecca did not deliver shortly after her due date[4] or perform a Caesarean section.[5]

It is interesting to note that, despite her financial security, Rebecca will have minimal control over her pregnancy. Additionally, she may experience a diminished sense of self-worth, due to the sexism within the obstetrical community.[6] The medical community also may provide inadequate emotional support to Rebecca in her role as a new mother.

Dr. Sidel: What will happen if Rebecca wants to deliver her baby at a birthing center or at home? How does she gain access to an unconventional delivery program?

Professor Dorothy Roberts, Rutgers Law School: Although there may be a hospital available to her that has an auxiliary birthing center,[7] the primary barrier she will encounter is the pressure from her doctor to have her baby in the hospital.[8] Like many patients, her attitude toward the role of doctors and patients may result in unquestioning compliance with the doctor's instructions. It is ironic that even though Rebecca can find and afford the precise type of birthing experience she wants, she may succumb to external forces and have a technology-intensive and hospital-based birth.

Dr. Kathy Anastos, primary care physician, Bronx Lebanon Hospital: The process of being hospitalized, whether for birthing or an ailment, is a process that denies personal autonomy. Regardless of existing legal protections, the fact is that hospitalized patients have to fight to maintain control over their bodies.

A woman, whether pregnant or not, must be ready to contend not only with a general loss of autonomy, but also with sexism from the medical

4. *See* Winston A. Campbell, David J. Nochimson & Anthony M. Vintzileos, *Prolonged Pregnancy*, *in* HIGH RISK PREGNANCY: A TEAM APPROACH 422, 428 (Robert A. Knuppel & Joan E. Drukker eds., 2d ed. 1993) (advising that, because of the risks associated with a prolonged pregnancy, labor induction is the best course of health management once the cervix is favorable).

5. *See* ECONOMICS & STAT. ADMIN., U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE U.S.: 1993 77 (113th ed. 1993) (reporting that, as a woman ages, the likelihood that she will need a Caesarean section increases).

6. *See* BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES: A BOOK BY AND FOR WOMEN 667-68 (1992). *But see* Carol S. Weisman, *Women and Their Health Care Providers: A Matter of Communication*, 102 PUB. HEALTH REP. 147, 148 (Supp. 1987) (noting that assertions that physicians "talk down" to female, and not to male, patients are based on anecdotal data). *See also* Howard Waitzkin, *Doctor-Patient Communication: Clinical Implications of Social Scientific Research*, 252 JAMA 2441 (1984) (finding no evidence that doctors withhold information from female patients).

7. Vicki A. Lucas, *Birth: Nursing's Role in Today's Choices*, RN, June 1993, at 38, 42 (indicating that there are approximately 135 birthing centers throughout the United States).

8. *Id.* at 40.

community.[9] In low-income communities, the issue of sexism is confounded with racism.[10]

Patient autonomy in the United States is tethered further by the fact that Western medicine is infused with the sentiment that high-tech is best and that patients should defer to the provider.[11]

Dr. Sidel: On the topic of access, what we have said so far is that if Rebecca wants to have a different kind of birth experience, even though she is insured and has a fair amount of money, the system may try to drive her in another direction. What are the pressures on providers and institutions at large to give Rebecca what she wants?

Professor Sylvia Law, New York University School of Law: Many of the problems can be resolved through informed consent. Doctors could say to a patient, "You can choose to have a Caesarean section or a vaginal birth." To the extent that the patient is fully informed and involved in the decision-making process, the patient will be less likely to sue when one of the risks that might have been avoided by a Caesarean section occurs during a vaginal birth.[12] As a legal matter, to the extent that the patient is well informed and has consented to the less interventionist approach, it will be more difficult for the patient to win a future lawsuit.[13]

Having said that, though, I think the risk of malpractice liability is vastly exaggerated by medical professionals. Many procedures are done from fear of malpractice liability.[14] In situations where there is no perceived risk of malpractice liability, providers act in a less interventionist way.[15]

With respect to childbirth, however, malpractice litigation is of a different order, because parental responsibility for the welfare of children raises different issues. Even a nonlitigious parent will feel compelled to

9. *See* BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 6.

10. David R. Williams & Risa Lavizzo-Mourey, *The Concept of Race and Health Status in America*, 109 PUB. HEALTH REP. 26, 30 (1994).

11. *See* David A. Grimes, *Technological Follies: The Uncritical Acceptance of Medical Innovation*, 269 JAMA 3030, 3031-32 (1993) (describing the "false idol of technology").

12. Gerald B. Hickson, Ellen Wright Clayton, Penny B. Githens & Frank A. Sloan, *Factors That Prompted Families to File Medical Malpractice Claims Following Perinatal Injuries*, 267 JAMA 1359, 1362 (1992).

13. *See* Marvin F. Kraushar & James A. Steinberg, *Informed Consent: Surrender or Salvation?*, 104 ARCH. OPHTHALMOLOGY 352 (1986).

14. Walter S. Keifer, *Preparing for Obstetrics in the Twenty-First Century: Quo Vadis?*, 168 AM. J. OBSTET. GYNECOL. 1787, 1789 (1993) (noting that increased malpractice risks have prompted doctors to practice defensive medicine).

15. *See* A. Russell Localio, Ann G. Lawthers, Joan M. Bengtson, Liesi E. Hebert, Susan L. Weaver, Troyen A. Brennan & J. Richard Landis, *Relationship Between Malpractice Claims and Caesarean Delivery*, 269 JAMA 366 (1993).

pursue legal remedies when confronted with a child whose costly birth defect might have been prevented had more aggressive medicine been utilized.[16] Interestingly, parents may feel less responsibility to pursue legal remedies on behalf of their child if the country instituted a national health service similar to Great Britain's.

Dr. Sidel: In the event that Rebecca's medical care insurance policy does not cover pregnancy and delivery, what problems could she encounter?

Robert Padgug, Director of Health Policy, Empire Blue Cross Blue Shield: First, we should distinguish between insurance, insured plans, and self-insured plans. Almost everywhere in the country, if a woman is enrolled in an insured plan, she will be covered for pre-, peri-, and postnatal care.[17] If a woman is a member of a self-insured plan—that is, when the employer does not share risk with an insurance company, but pays for the care of employees directly from its own checking fund—she may not be covered.

Because of the multitude of differences among insurance plans, every woman needs to be familiar with her policy before deciding on where and how to deliver a baby. Companies pay different rates, depending on whether the birth was performed in a hospital or birthing center and whether a doctor or midwife assisted. Some policies specifically exclude coverage for a delivery in a birthing center.

Professor Law: Insurance companies, seeking to maximize their profits, often attempt to exclude benefits for services that are expensive or used by politically vulnerable people.[18] For example, until the late 1960s, many insurance policies excluded coverage for vaginal delivery on the ground that birth is a normal process, not an illness.[19] Coverage was only available for Caesarean births.[20] Additionally, many policies excluded coverage for neonatal services on the theory that the company must have an opportunity

16. Hickson, Clayton, Githens & Sloan, *supra* note 12, at 1361. *Cf.* Keifer, *supra* note 14, at 1789 (finding that malpractice rates swell as the legal profession responds to the fallacy that if the product is not perfect, the fault must lie with the provider).

17. Telephone interview with Al F. Minor, Consumer Research Coordinator, Health Ins. Ass'n of Am. (Nov. 8, 1994) (claiming that approximately 95 percent of commercial insurance carriers who provide group coverage cover pregnancy services).

18. *See, e.g.*, Benjamin Schatz, *The Aids Insurance Crisis: Underwriting or Overreaching?*, 100 HARV. L. REV. 1782, 1786 (1987). *See* plaintiffs' arguments in McGann v. H. & H. Music Co., 946 F.2d 401 (5th Cir. 1991) (affirming that an employer who reduced AIDS-related benefits under an ERISA-qualified plan from $1,000,000 to $5,000 did not unlawfully discriminate against an employee who had contracted AIDS, because the reduction applied to all employees), *cert. denied sub nom.* Greenberg v. H. & H. Music Co., 113 S. Ct. 482 (1992); Tingey v. Pixley-Richards West, 953 F.2d 1124, 1133 (9th Cir. 1992) (holding that plaintiff's state law claims, arising when an employer allegedly wrongfully terminated the plaintiff upon discovering that the plaintiff's son had spina bifida, were preempted by remedies enforceable under ERISA).

19. GEORGE J. ANNAS, SYLVIA A. LAW, RAND E. ROSENBLATT & KENNETH R. WING, AMERICAN HEALTH LAW 146 (1990).

20. *Id.*

to evaluate whether or not to extend coverage to the baby.[21] Similarly, mental health services and drug and alcohol treatments often were excluded.[22] In the early 1970s, states responded to this problem by adopting laws requiring all insurance policies to include particular essential services.[23] In 1974, Congress passed the Employee Retirement Security Act (ERISA).[24] In *Metropolitan Life Insurance v. Massachusetts*,[25] the Supreme Court held that ERISA preempts state laws that mandate certain forms of insurance coverage if the insurance is provided through an employment-based benefit program. States, however, are free to regulate insurance that is not obtained through an employment-based plan.[26] Employers, quite sensibly, have responded by structuring their insurance to assure that state mandates—for normal delivery, AIDS services, pediatric care, and mental health services, among others—do not apply to them.

Dr. Padgug referred to the fact that state mandates do not apply to insurance obtained through a self-insured plan. Most insurance today is self-insured because the insurance companies do not want to comply with state mandates which require coverage for mental health benefits and vaginal delivery. Although states want to require such benefits, in effect, the federal government prevents them.

Dr. Sidel: If universal health care coverage is achieved and the benefit package includes care for pregnancy and delivery, does that solve the access problems for Rebecca?

Jack O'Sullivan, journalist, The Independent: I will discuss Great Britain—my native country—as an example. In Great Britain, Rebecca will be enrolled with a family practitioner, whom she will have seen intermittently in the past.[27] As a pregnant woman, she will be enrolled in a prenatal care program and deliver in a general hospital. Subsequent to her date of delivery and discharge from the hospital, a community nurse or midwife will visit her at home for ten days.[28]

In order to position yourself within this system, you must be an articulate and knowledgeable person. If, for example, you are a foreign native who has relocated to Great Britain, your family doctor may not speak your

21. *Cf.* Metropolitan Life Ins. Co. v. Mass., 471 U.S. 724, 729 (1985) (citing that, since 1970, all 50 states have required that coverage of infants begin at birth, rather than shortly after birth).

22. *See* Brian D. Shannon, *The Brain Gets Sick, Too—The Case for Equal Insurance Coverage for Serious Mental Illness*, 24 ST. MARY'S L.J. 365, 387 (1993).

23. David J. Brummond, *Federal Preemption of State Insurance Regulation Under ERISA*, 62 IOWA L. REV. 57, 83-84 (1976).

24. 88 Stat. 832, *as amended by* 29 U.S.C. § 1001 (1982 & Supp. III 1992).

25. 471 U.S. 724 (1985).

26. 29 U.S.C. § 1002(2)(A) (1988).

27. *See* RICHARD A. KURTZ & H. PAUL CHALFANT, THE SOCIOLOGY OF MEDICINE AND ILLNESS 190 (2d ed. 1991).

28. Nurses, Midwives and Health Visitor's Rules, S.I. 1983/873, R. 27 (substituted by rules approved by S.I. 1986/786).

language. Furthermore, translators may not be readily available.[29] Before receiving medical care, the non-English speaking patient will have to exert time and energy to find a facilitator who is familiar with the internal mechanism of the system.

The National Health Service in Britain is highly medicalized. Therefore, there will be great pressure on a pregnant woman to undergo a high-tech delivery in the hospital. A woman would need to be well informed and capable of articulating her preferences to alter where and how she gives birth.[30]

II

Prenatal Care for the Uninsured and the Homeless

Dr. Sidel: Maria Morales lives in the South Bronx, a financially depressed area of New York City. She lives in an apartment and works, but she has no medical insurance. She qualifies as part of the working poor. If Maria becomes pregnant, what are the main problems of access she will encounter?

Nitza Milagros Escalera, attorney, Community Service Society of New York: First of all, she probably does not have a primary health care provider or a gynecologist whom she sees on a regular basis.[31] She probably will obtain the name of a doctor through a friend, and she will visit that doctor in a late stage of pregnancy. If she does not speak English, she will have the additional burden of seeking a health care provider with whom she can communicate.[32] As a working person, she will be ineligible for Medicaid.[33] If she is unemployed and pregnant, her prenatal care would be financed through Medicaid.

---

29. Dr. Sidel informed the audience that, in order to assist patients, Montefiore Medical Center has identified staff members who can act as translators for 50 languages.

30. Ms. Dohrn, Professor Roberts, and Dr. Anastos referred to the experience of diminished autonomy women face within the health care system. Given the paternalistic attitudes of many caregivers and the existence of the "technological imperative," *see supra* note 11 and accompanying text, women often must fight harder to retain control over the course of their treatment.

Health care providers have an obligation to contribute to patients' autonomy by informing them about choices available in treatment. *See* Marie R. Haug & Bebe Lavin, *Practitioner or Patient—Who's in Charge?*, 22 J. Health & Soc. Behav. 212, 217-18 (1981). If patients are not informed of the available options—at least those that laypeople can comprehend—health care providers prevent them from fully participating in the health care system as a consumer. *See supra* notes 12-16 and accompanying text.

31. One out of seven pregnant women in New York City receives late or no prenatal care. The waiting period for essential prenatal care has grown to as long as three months. Richard M. Schwarz, *Providing Access to Obstetric Care in New York State*, N.Y. St. J. Med. 235, 235 (1992). In 1990, the number of physician contacts per 1000 patients decreased as the income level of the patient decreased. Economics and Statistics Administration, U.S. Bureau of the Census, *supra* note 5, at 77 (1993).

32. *See supra* note 29 and accompanying text.

33. Medicaid provides medical assistance to low-income persons, including welfare recipients and those who cannot afford medical care. Alan L. Sorkin, Health Economics:

Ms. Dohrn: I want to build on what Ms. Escalera has begun to sketch. Given that Maria is uninsured and working full-time at a low paying job, she may not be able to afford to enter the system for prenatal care. Women like Maria often neglect medical attention until a problem arises, at which point a neighbor or family member calls an ambulance, and the woman is taken to the local hospital emergency room. Consequently, Maria's first contact with prenatal care would be in an emergency room setting where, unfortunately, unless a pregnant woman is dying on the floor, she can expect to wait six to eight hours.[34] This scenario exemplifies the way in which many poor pregnant women in New York City enter the system for prenatal care.

If Maria is marginally employed, she might qualify for PCAP,[35] the New York state program that covers prenatal care and delivery. To receive care, however, she has to be able to take time off from her job, go to the hospital, and endure a long application process. She has to have some ability to speak the language and know the system. If, for example, she is a Vietnamese woman who recently has settled in the United States, it is a given that she will never make it through the system.

Let us envision the best scenario, in which Maria has made it through the bureaucracy, whether by favorable circumstances or with the help of a friend. While still working full-time, Maria will enroll in PCAP and qualify for prenatal care. In order to take advantage of medical care, she will have to be able to take time off from work. If Maria is not working but has children, the lack of childcare facilities will compromise her ability to take advantage of the prenatal care program.

Once again, we will proceed on the assumption that Maria is able to schedule an appointment and take time off work to attend. In all probability, she will be given a 9:00 a.m. appointment at a backed-up hospital, where she will sit and wait with thirty other women who have been scheduled for the same appointment time. If she is lucky, she will see a professional by 1:00 or 2:00 p.m. At each subsequent visit, she will see a different doctor or resident who is working under extreme stress from handling too many patients. No one might ever speak to her about what is happening to her body and how the fetus is developing.

AN INTRODUCTION 197 (3d ed., Lexington Books 1992) (1975). *See also* 42 U.S.C. § 1396a (1988); N.Y. SOC. SERV. LAW § 366 (McKinney 1992).

34. *See* Kevin Grumbach, Dennis Keane & Andrew Bindman, *Primary Care and Public Emergency Department Overcrowding*, 83 AM. J. PUB. HEALTH 372, 372 (1993) (noting that patients with noncritical conditions in San Francisco General Hospital face waiting times of up to 17 hours). Waiting four to five hours was not unusual in New York hospitals during the 1980s. Eli Ginzberg, *Improving Health Care for the Poor: Lessons from the 1980s*, 271 JAMA 464, 465 (1994).

35. PCAP is the New York Medicaid Prenatal Care Assistance Program, which expands Medicaid eligibility for pregnant women and children under the age of one. N.Y. PUB. HEALTH LAW § 2529 (McKinney 1990).

The system is not properly designed to provide a woman such as Maria with adequate reproductive care. Her failure to receive quality prenatal care exposes her to the risk of having a premature or low birth-weight baby.[36] It is an incredible injustice to a woman and to an innocent child. Society is also a victim in terms of morbidity costs and treatment expenses.[37] For example, the costs of having a newborn spend a week or a month in an intensive care unit are terribly in excess of the cost of providing her mother with prenatal care.[38] The solution is to provide all pregnant women with affordable and accessible prenatal care.

Dr. Sidel: If Maria is a recent immigrant to the United States and lives with her two children in a shelter for the homeless, what problems of access to care will she have?

Professor Beth Weitzman, New York University Wagner School of Public Service: Because most homeless families in New York City shelters are native inhabitants of the city,[39] I would like to bifurcate the question and respond from the perspective of a homeless woman and from the perspective of a woman who is an illegal alien.

Recent immigrants to the United States refrain from contacting professionals and people in official positions, out of a fear that they will be deported. Even though I believe hospitals in New York City have made a concerted effort to combat immigrants' fears of deportation, the fear is entrenched in the immigrant community. As a result, many women in this city do not seek medical assistance.[40]

For homeless women, the scenario has changed rather dramatically in the past five years. In the late 1980s, a study conducted by Dr. Wendy Chavkin found that homeless women were getting virtually no prenatal

36. Michael D. Kogan, Greg R. Alexander, Milton Kotelchuck & David A. Nagey, *Relation of the Content of Prenatal Care to the Risk of Low Birth Weight*, 271 JAMA 1340, 1340 (1994).

37. *See, e.g.*, George A. Gellert, *US Health Care Reform and the Economy of Prevention*, 2 ARCHIVES FAM. MED. 563, 565 (1993); Marianne C. Fahs, *Public Health in Crisis: The Economic Consequences of Inaction on Preventive Medicine*, 59 MT. SINAI J. MED. 469, 474 (1992).

38. The costs of the intensive-care technology required to achieve survival of low birth-weight babies is estimated to average between $30,000 and $70,000. Marie C. McCormick, Judy C. Bernbaum, John M. Eisenberg, Sharon Lee Kustra & Emily Finnegan, *Costs Incurred by Parents of Very Low Birth Weight Infants After the Initial Neonatal Hospitalization*, 88 PEDIATRICS 533, 533 (1991).

39. Homeless families have been characterized as predominantly single-parent families with two or three children. In Boston, New York City, and Los Angeles, homeless families are predominantly female-headed, single-parent, minority families. Allison J. Page, Allan D. Ainsworth & Marjorie A. Pett, *Homeless Families and Their Children's Health Problems: A Utah Urban Experience*, 158 W. J. MED. 30, 30 (1993). *See also* Peter H. Rossi, *Troubling Families: Family Homelessness in America*, 37 AM. BEHAVIORAL SCIENTIST 342 (1994).

40. *See* Marsha F. Goldsmith, *Hispano/Latino Health Issues Explored*, 269 JAMA 1603, 1603 (1993).

care.[41] At present, homeless women are receiving much better treatment. However, in the process of establishing this new, successful system of health care delivery, a bureaucracy directed at people in Tier II[42] facilities and shelters has emerged to institutionalize homelessness.[43]

III
Emergency and Acute Care

Dr. Sidel: Robert Rich has a heart attack in the middle of the night in his Upper East Side apartment. Rebecca dials 911. What role, if any, does Emergency Medical Service (EMS) play in access to care? What access problems might Robert face?

Dr. Anastos: In terms of proffering emergency care, one of the basic failings of our health care system is the lack of emphasis on continuity of primary care services.[44] Continuity of primary care services means what most of us expect as our due in good health care, such as a provider who knows you and accessible medical records. Primary care medicine also involves issues of often social, rather than purely medical, problems.[45] For example, because primary care physicians cannot prescribe nutritious food or decent housing, they are resigned to cope with medical manifestations of problems they are incapable of addressing.

I do a lot of HIV primary care, and I find that my HIV-infected patients have to call the ambulance more frequently than other patients. They get in the ambulance and say, "My doctor is at Bronx Lebanon Hospital. Please take me to Bronx Lebanon." Most of the time they are not transported to Bronx Lebanon, because EMS is required to drive to the nearest city hospital.[46] If a patient is really lucky, she will be assisted by EMS people who will bend the rules. But most of the time a patient goes

41. Wendy Chavkin, Alan Kristal, Cheryl Seabron & Pamela E. Guigli, *The Reproductive Experience of Women Living in Hotels for the Homeless in New York City*, 87 N.Y. St. J. Med. 10 (1987).

42. After homeless families in New York City have been screened and assessed at a Tier I shelter, they are usually sent to a Tier II shelter, which provides numerous additional services for the homeless. N.Y. Comp. Codes R. & Regs. tit. 18, § 900.2(c) (1993).

43. *See* Linda F. Weinreb & Ellen. L. Bassuk, *Health Care of Homeless Families: A Growing Challenge for Family Medicine*, 31 J. Fam. Prac. 74, 78 (1990).

44. Failure to maintain continuity in primary care services leads to duplicate procedures and inferior quality of care. Ginzberg, *supra* note 34, at 465.

45. *See* Norman Hearst, Suzanne Kotkin-Jaszi, Emilie Osborn, Nedra A. Overall, Arthur Reingold, Alex Swedlow & Julie Williamson, Community Oriented Primary Care in Action: A Practical Manual for Primary Care Settings 1-3 (Nedra A. Overall & Julie Williamson eds., 1989).

46. New York City EMS policy ordinarily requires ambulances to transport patients to the nearest hospital designated as a 911 receiving hospital. At the request of a patient in stable condition, EMS may travel to any hospital that is no more than ten minutes from the closest 911 receiving hospital. Patients with unique medical needs may be transported to specialty facilities, such as trauma and burn centers. City of New York Emergency Medical Service Operating Guide, Procedure No. 115-8 (1994).

to another hospital, and nobody calls the primary care physician to gather information on the patient.

Follow-up makes a big difference in the quality and cost of care that a patient receives. A patient's medical history is invaluable to a doctor trying to diagnose or treat a new patient. A patient can be kept in the hospital for days before her medical history is discovered.[47] Such dilatory communication results in huge costs from duplication of tests or mismanagement of the patient's care.

Furthermore, for many New Yorkers, EMS has become a form of primary care. Studies have demonstrated that for some people it is easier to get 911 to come to their assistance than to visit a doctor.[48] Such practices hinder EMS from servicing people such as Robert, who are experiencing an acute medical emergency.

Dr. Sidel: What happens to Robert when he arrives at the emergency room?

Dr. Anastos: Without a doubt, in an affluent community, the necessary high-tech intervention and therapies would be administered.[49] Physicians generally seek to minimize the use of invasive procedures, because of the stress that they place upon the body. In an affluent community, however, if doctors conclude that high-tech therapy is necessary, the resources are available to begin treatment. This is not always the case in low-income communities, because treatment is very expensive.[50]

Dr. Sidel: What would happen to Robert if universal health care coverage is achieved?

Mr. O'Sullivan: Given the critical nature of Robert's health, the first issue to consider is whether the ambulance service is properly funded and

---

47. The information super-highway may provide the solution to the current inefficiencies in the dissemination of medical information; however, the collection and electronic transmission of personal medical data may pose risks to patients' privacy. *See* Lawrence O. Gostin, Joan Turek-Brezina, Madison Powers, Rene Kozloff, Ruth Faden & Dennis D. Steinauer, *Privacy and Security of Personal Information in a New Health Care System*, 270 JAMA 2487, 2488 (1993).

48. A recent study revealed that of the approximately 883,000 calls for service received in 1989 by the EMS, 462,000 (52 percent) were classified by EMS standards as "low priority" medical needs. JAMES R. KNICKMAN, DENNIS SMITH & CAROLYN BERRY, IMPROVING AMBULANCE USE IN NEW YORK CITY: A FINAL REPORT 6 (1991). A panel of physicians concluded that 25 percent of a sample of calls could have been handled without the use of an ambulance. *Id.* at 47. This overuse of EMS results, in part, from lack of access to local primary care providers. *Id.* at 75.

49. A recent study found that privately insured hospital patients were more likely to receive high-cost or high-discretion procedures and extended hospital stays for certain diagnoses. Jack Hadley, Earl P. Steinberg & Judith Feder, *Comparison of Uninsured and Privately Insured Hospital Patients: Condition on Admission, Resource Use and Outcome*, 265 JAMA 374, 378-79 (1991).

50. *See* Ginzberg, *supra* note 37, at 464. Of four cities studied by Ginzberg and his colleagues, New York ranked highest in its commitment to providing care for the poor. This finding was attributed to a relatively generous state Medicaid program, as well as to the state's special funding for financially distressed hospitals in high-need areas.

trained. Secondly, the state of the emergency treatment centers must be assessed. In some sections of London, for example, a hospital may temporarily close its emergency rooms because they are full. Thus, although access is free, a patient may have to travel some distance to reach a functioning emergency facility where, based on the nature of the illness, the patient will either wait a very long time or receive immediate treatment.

Dr. Sidel: Would the problems in the United Kingdom you are talking about be alleviated if Britain spent more than its current relatively low percentage of GNP on health care?

Mr. O'Sullivan: Yes. Emergency care very specifically relates to the level of funding that exists in the British system. Britain spends only 6.5 percent of its GNP on health services.[51] All the money comes from taxation,[52] thus any increase in medical expenditures is a big issue for taxpayers. A nation contemplating instituting universal health care must reach a consensus on its commitment to the level of funding it will provide.

IV
Racism and Discrimination

Dr. Sidel: If a patient coming into an emergency room is a person of color and, in addition, is dressed either shabbily or in blue collar work clothes, how is the reception that this patient receives likely to be affected? What attitudes from emergency room personnel is this person likely to encounter?

Professor Roberts: I think the critical question does not arise during emergency room care, because if someone is suffering from an acute heart attack, the hospital staff is probably going to provide treatment. Starting on the next day of hospitalization, however, many differences may be observable.

Studies show that black people are much less likely to get surgery for heart disease than white people.[53] Extensive and expensive treatment may

---

51. The preliminary figure for the total health expenditures as a percent of GDP for the United Kingdom was 6.6 percent in 1991. U.S. Dep't of Health and Human Serv., Health United States 1993 220 (1994).

52. Kurtz & Chalfant, *supra* note 27, at 191.

53. *See* Lance B. Becker, Ben H. Han, Peter M. Mayer, Fred A. Wright, Karin V. Rhodes, David W. Smith, John Barrett & The CPR Chicago Project, *Racial Differences in the Incidence of Cardiac Arrest and Subsequent Survival*, 329 New Eng. J. Med. 600, 603 (1993) (reporting that the incidence of out-of-hospital cardiac arrest among people of all ages in Chicago is significantly higher for blacks than for whites, and the survival rate of blacks is significantly lower); Jeff Whittle, Joseph Conigliaro, C.B. Good & Richard P. Lofgren, *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 New Eng. J. Med. 621, 623 (1993) (finding that white patients are significantly more likely than black patients to undergo major coronary procedures, such as coronary angioplasty and coronary artery bypass-graft surgery); John Z. Ayanian, I. Steven Udvarhelyi, Constantine A. Gatsonis, Chris L. Pashos & Arnold M. Epstein, *Racial Differences in the Use of Revascularization Procedures After Coronary Angiography*, 269 JAMA 2642, 2645 (1993) (concluding that white men and women were more

be not given, apparently, because of race. Then, also, there may be an effort to transfer the patient to another hospital. There is federal legislation against patient "dumping,"[54] but it is not enforced very well.[55]

In terms of interpersonal relationships, it is important to have a physician who is your advocate and friend. A person who can trust her doctor is in a much better position than a person who has to face an impersonal institution alone. The psychological advantages that accrue to a patient who knows that someone will fight for quality care, as opposed to a patient who encounters hostility, are undeniably relevant to the patient's response to treatment. I think that if Mr. Rich were Mr. Poor or Mr. Black, the treatment provided would be quite different, and the patient's resilience would be greatly diminished.

Dr. Anastos: I want to point out a difference that is not always immediately apparent between a stable hospital and a financially distressed hospital. Even though the staff of the financially distressed hospital is committed to providing the very best care, operational activities that are out of its control still impede its ability to provide optimum care. For example, if an inner-city distressed hospital lacks adequate supplies, the job of nurses and doctors is unnecessarily complicated.[56] Consequently, a poor patient still stands a greater chance of inadequate care in a financially distressed hospital than in a financially secure hospital.

In every circumstance we have discussed, the emotional impact on the patient reflects the treatment received from health care providers. Such contacts are a major source of stress for people who go into an emergency room and, for reasons of race, are treated poorly.[57] Maria Morales, the pregnant woman, would not only be treated badly, but she would be treated as if she were irresponsible for not seeking prenatal care for the baby she is carrying. Such attitudes, although perhaps not spoken, are manifested in the provider's reaction to the patient. This, in turn, exacerbates the patient's condition.

Audience member: All of the discussions have verified the fact that equal access is not necessarily the full cure for equity of treatment. What

---

likely than black men and women to receive a revascularization procedure after undergoing a coronary angiography; however, the study did not assess whether differing rates of the procedure represent a racial bias or whether race is a proxy for socio-economic factors).

54. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires hospitals receiving Medicare funds to take certain steps prior to transferring unstable patients or women in labor. COBRA was intended to stop the transfer of patients on economic grounds. *See* 42 U.S.C. § 291c(e) (1994).

55. *See* Arthur L. Kellermann & Bela B. Hackman, *Patient 'Dumping' Post-COBRA*, 80 AM. J. PUB. HEALTH 864, 866 (1990).

56. *See* Linda A. Headrick & Duncan Neuhauser, *Quality Health Care*, 271 JAMA 1711, 1711 (1994) (noting that urban health centers in California reported that a frequent lack of proper supplies adversely affected gynecological procedures).

57. David R. Williams & Risa Lavizzo-Mourey, *The Concept of Race and Health Status in America*, 109 PUB. HEALTH REP. 26, 30 (1994).

are the other elements that have to be included in a health care system to ensure that all persons receive equal quality care?

Peter Holland, Consumer Affairs Director, Lambeth Family Health Authority, London, England: Certainly, removing the financial barrier to care does not ensure access to care, much less equity of provision. In England, we work within a underfunded system in which resources are constrained. Given that we have a fixed percent of our GDP allocated to health care,[58] we have to make decisions about how those resources are allocated. Legislators and providers must choose which services to provide and when.

Our system is very provider dominated and very professionally dominated. Decisions tend to be made by doctors when they see patients, and that leads to questions of racism and sexism. We must expose the decision-making process to patients, as well as to other voices. We must remember that we are debating social policies for which everybody is responsible, since everyone's needs must be a factor in the allocation of resources.

Mr. O'Sullivan: Power is crucial for ensuring equity. If people are powerful, they get looked after and they get treated. Issues of racism, just as much as sexism or classism, affect access to care and provision of treatment. One way of avoiding the possibility that treatment decisions are motivated by undesirable social attitudes is to educate caregivers and sensitize them to issues of diversity.[59] To endorse Mr. Holland's view, education is empowerment. Educated individuals will be prepared to make decisions about their own care.[60]

V
Child Care and Immunization

Dr. Sidel: Tommy Toddler is a strong, healthy child from the South Bronx. How can it be ensured that he receives the required childhood immunizations and other preventive care and medical care when needed?

Dr. Anastos: Immunizations are extremely important components of disease prevention in children as well as adults. This treatment may be far more important than any other treatments in improving public health in the United States. It is very hard to demonstrate the impact of certain

58. *See supra* note 51 and accompanying text.

59. *Cf.* Kellerman & Hackman, *supra* note 55, at 866 (explaining that despite federal legislation prohibiting the transfer of patients for economic reasons, private hospitals continue to reassign poor and nonpaying patients to public facilities).

60. With respect to the issue of patient as consumer, Sylvia Kleinman of the National Gray Panthers related a story about a 78-year-old woman on Medicaid who was sent home after receiving inadequate care at an emergency room. The woman subsequently returned and informed the hospital that she was aware of her rights under the Hill-Burton Act, which requires federally funded hospitals to provide a "reasonable volume of services to persons unable to pay." 42 U.S.C. § 291c(e) (1988). The woman's treatment immediately improved. Ms. Kleinman ended her story by stressing that consumers must be educated of their rights.

kinds of health care, but the impact of proper immunization and prenatal care is easily demonstrated.[61]

Children are immunized against measles, mumps, rubella, diphtheria, tetanus, pertussis (whooping cough), and polio.[62] My pediatrician told me that I should have my children immunized against hepatitis B. That is actually quite an expensive vaccine. It is injectable, and it has to be given at zero time, then at one month, and then again at six months. You might not realize, but getting a child to the doctor at the specified times is easier said than done.[63] This is especially true when both parents work or when only one parent is responsible for the child.

The first step towards a solution is to recognize that this country's failure to provide vaccines is avoidable. Similar problems have been solved in nations far less wealthy than ours, so it is not that we lack the resources to change the situation.

Dr. Sidel: As Dr. Anastos indicated, parental responsibility is a factor in childhood immunization rates. There are, however, other societal factors, such as the cost of vaccines[64] and access to providers, that must be addressed.

Dr. Padgug: In this country, we made a gross error fifty years ago of basing our financing system on a private insurance model, rather than on the social insurance model, which is used in many countries. In the private insurance model, procedures whose administration depends upon the recipient's choice often are not covered. Immunizations, therefore, are not insured.[65]

Dennis Rivera, President, Local 1199, New York State Health Care Workers Union: Only about 10 to 15 percent of the children in America's

---

61. Dr. Anastos also pointed to the public health impact of the availability of clean water, which is extrinsic to the responsibilities of the medical profession.

62. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1992 AND HEALTHY PEOPLE 2000 REVIEW 87 (1993) [hereinafter REVIEW].

63. Various reminder-recall systems, such as house calls and phone calls, have proven effective in increasing clinic attendance rates. Paul A. Stehr-Green, Eugene F. Dini, Mary Lou Lindegren & Peter A. Patriarca, *Evaluation of Telephoned Computer-Generated Reminders to Improve Immunization Coverage at Inner-City Clinics*, 108 PUB. HEALTH REP. 426, 429 (1993 & Supp. 1993).

64. *Cf.* Chester A. Robinson, Stephen J. Sepe & Kimi F. Y. Lin, *The President's Child Immunization Initiative: A Summary of the Problem and the Response*, 108 PUB. HEALTH REP. 419, 421 (1993) (noting that an estimated 50 percent of the country's children are provided with immunizations for a nominal administrative fee of five dollars).

65. One study found that parents are often unaware that their insurance covers or partially covers the cost of vaccines. Tracy A. Lieu, Mark D. Smith, Paul W. Newacheck, Dottie Langthorn, Pravina Venkatesh & Ruth Herradora, *Health Insurance and Preventive Care Sources of Children at Public Immunization Clinics*, 93 PEDIATRICS 373, 374-75 (1994). The study also found that parents who do have health insurance still seek vaccines at low-cost public immunization clinics, due to the inadequacy of their coverage and the availability of walk-in appointments at these clinics. *Id.* at 375.

inner cities are immunized.[66] For every one dollar we invest in immunization we save four dollars in terms of the future cost of taking care of those who are not immunized.[67] We have made a strong request of President Clinton to launch a massive nationwide program to immunize all children in America, and we have a strong feeling that at least some kind of initiative will be forthcoming.[68] The problem is, again, the cost.

We should have a society that establishes a minimum requirement for children immunization, ensures that children receive a certain set of vaccines, and keeps records of treatment. Parents should be accountable for ensuring that their children receive the proper preventive medicines. Society should facilitate this responsibility by providing accessible clinics and by maintaining a system to monitor parental accountability.

The commitment to provide the resources and the will to hold people accountable is presently missing from our system. Prevention reaps an enormous amount of 'down-the-road' savings.[69] From economic and social perspectives, it is better to invoke preventive measures rather than curative treatments.

Dr. Sidel: Let me pick up on two issues that Mr. Rivera just mentioned. We need community organizations that guarantee that no child is left out of the program. For example, if you visit a polyclinic in Cuba, you will observe walls covered with maps, charting every household in the neighborhood served by the polyclinic. The staff in the polyclinic is aware of every child within that neighborhood and keeps detailed records on the immunization of every child within its regional domain.[70]

This organizational feature is a necessary part of any policy that seeks to reach every child. Parental cooperation cannot be ignored, but in a society that makes caring for a child very difficult, is it not hypocritical to condemn parents for failing to care properly for their children?

Professor Roberts: In our society, very often we blame the mother for not getting adequate prenatal care, for not taking her child to the doctor, or for not getting the child immunized. This focus on the parent detracts from

66. In inner-cities less than 50 percent, and in some cases as few as 10 percent, of preschoolers have been fully immunized by the age of two. Robinson, Sepe & Lin, *supra* note 64, at 420. According to the Center for Disease Control and Prevention, only 77.6 percent of American children one to four years of age were immunized against measles, mumps, and rubella in 1991. *See* REVIEW, *supra* note 62, at 87 (1993).

67. Current statistics indicate that every dollar of preventive vaccines saves 14 dollars in societal costs. Robinson, Sepe & Lin, *supra* note 64, at 419-20.

68. In 1993, President Clinton proclaimed the last week in April National Preschool Immunization Week. Proclamation No. 6542, 58 Fed. Reg. 19317 (1993). In 1994, President Clinton renamed the week the National Infant Immunization Week, as part of an effort to combat statistics that show that less than two-thirds of American children under the age of two are immunized. Proclamation No. 6675, 59 Fed. Reg. 19125 (1994).

69. Robinson, Sepe & Lin, *supra* note 64, at 419-20.

70. The immunization legislation proposed by President Clinton provided for state and federal tracking of the immunization histories of children. *Id.* at 424.

the main issue of health care in the United States. I agree with Mr. Rivera's suggestion that, first and foremost, society must make immunizations available to parents within a community. Only then is it appropriate to hold parents responsible for having their child immunized. In our society we have reversed our priorities. We have avoided making care available, and we have avoided confronting the issue of unhealthy children by blaming mothers for not producing healthy children. In some instances, we are even punishing mothers for having unhealthy children and unhealthy pregnancies.[71]

Let us first make an effort to provide the treatment, make it accessible, and then reach out to mothers to make sure they are aware that the treatment is available.

Unidentified speaker: I have come to believe that a myriad of the issues we are facing will be addressed only once we have community health outreach via public health nursing.[72] It is difficult to convince people to make full use of the preventive systems that are available to them. Sending out a public health nurse who knows that a child is due for a vaccine is a relatively inexpensive way of providing such treatment.[73]

Unidentified speaker: I cannot overemphasize the importance of access to information. I never remember when I have my regular gynecological exams. My doctor calls or mails me a reminder. I think it is necessary for the maintenance of public health to educate and remind parents of their responsibility. To this end, the media and community outreach efforts are important sources for information.

Mr. O'Sullivan: The issue of parental responsibility is quite challenging, but so is the issue of professional responsibility. Clearly, a system must incorporate all the powers that be to guarantee that children are immunized at the right time.

Britain dealt with this not by forcing parents to get their children immunized, not by giving children an absolute right to immunizations, but by giving financial incentives to primary health care givers to make sure that their population is treated. For example, a primary health care giver who has X number of people on her list will be given a financial reward if she immunizes 80 percent of her patients. This lucrative incentive has bolstered immunization rates in Britain. Interestingly, it has not been a success in every region, because the 80 percent threshold is a very high figure

71. *See* Wendy Chavkin & Stephen R. Kandall, *Between a "Rock" and a Hard Place: Perinatal Drug Abuse*, 85 AM. ACAD. PEDIATRICS 223, 224 (1990) (documenting women who are penalized when their drug use during pregnancy results in the birth of unhealthy babies).

72. The speaker pointed to Mr. O'Sullivan's description of the British system of public nursing outreach for new mothers.

73. *But see* Stehr-Green et al., *supra* note 64, at 429-30 (commenting that the staffing cost makes house visits an impractical strategy for reminding parents of immunization requirements).

for a doctor working in an inner-city with a transient population. In such environments, doctors are unable to effectively reach out to patients. Moreover, the doctors who practice in such depressed zones often have a poorly funded practice. From the start, therefore, these doctors forsake the notion of immunizing 80 percent of the population. Consequently, the financial incentives fail to ensure immunization efforts. Once the British system realizes this and initially lowers the thresholds to 30 or 50 percent, the system will improve.

On the issue of parental responsibility, clearly there is a need for parents to assume responsibility and be accountable for the health of their children. Before parents are held accountable, however, the health care system must allow easier access to immunization procedures.

Once availability is achieved, the question of how parents should be held accountable arises. What sort of incentives or deterrents should be in place to ensure that parents keep up their end of the bargain?

Again, at the risk of repetition, community outreach efforts appear to be the most practical solution. Even if the British incentive program was based on a graded scale to reach more inner-city children, the goal of providing full immunization falls short.

VI
Geriatric Care

Dr. Sidel: Elizabeth Elder is an eighty-year-old woman who finds living alone increasingly difficult. She cannot turn to her children for support because they are struggling to make ends meet. How is Elizabeth going to secure care as she progresses through life?

There is no question that the introduction of Medicare and, to a lesser extent Medicaid, in 1966 had an enormous impact on elderly peoples' access to health care. Nevertheless, people aged sixty-five and over are paying a greater percentage of their income for medical care than before Medicare was instituted.[74]

Medicare was an important step forward, but it is laden with inherent flaws. Among the defects of Medicare are its failure to cover nursing home costs, except those incurred immediately after hospital treatment, and its failure to cover prescription costs.[75]

---

74. David U. Himmelstein & Steffie Woolhandler, The National Health Program Book: A Source Guide for Advocates 35 (1994) (citing that by 1988 the average senior was spending 18.1 percent of annual income to pay for medical care, which represents a 50 percent increase since 1977 in the proportion of income spent for medical bills).

75. Medicare covers only 5 percent of nursing-home care. Janet Weiner, *Financing Long-Term Care: A Proposal by the American College of Physicians and the American Geriatrics Society*, 271 JAMA 1525, 1525 (1994).

Sylvia Kleinman, National Gray Panthers: Elizabeth is going to have a very tough time. Medicare does not cover dental expenses,[76] and it does not cover prescriptions.[77] It is a totally inadequate program. The same applies to Medicaid, because Medicaid is also a very restricted program and very difficult to access.

I just came back from Cuba. I was so impressed with their system, in which family physicians are available on a block-to-block basis. Cubans, in large part, have solved their geriatric care problems by having elderly people live with their families who look after them.[78]

Unidentified speaker: The United States' demographics are such that the problem of caring for the elderly will persist. Most people think of Medicaid as a program for the poor. That no longer is accurate. In fact, Medicaid is no longer a program, in terms of actual dollars spent, for the poor. Medicaid has become a program for elderly people, many of whom were middle class until they reached the point at which they were unable to take care of themselves.[79] Medicaid has become the last resort solution to our long-term geriatric care crisis.

Professor Law: I just want to follow up on the craze over Cuba. I am a great admirer of the Cuban health care system and the Nicaraguan health care system, and the closest organization to those two systems in this country was the Neighborhood Health Center program.[80] Many services—elderly care, prenatal care, immunization, and routine care—are best and most economically provided in a neighborhood-based clinic that integrates medical as well as social services.

The Neighborhood Health Center program recognized that many medical services can be provided by health care workers other than licensed medical doctors. These programs were successful and cost-effective;[81] unfortunately, they were curtailed during the Reagan administration.[82]

---

76. Payment for routine dental services is proscribed, except in very limited situations for medically necessary oral surgeries. Oral Health Coordinating Committee, Public Health Service, *Toward Improving the Oral Health of Americans: An Overview of Oral Health Status, Resources and Care Delivery*, 108 PUB. HEALTH REP. 657, 666-67 (1993).

77. When the Medicare Catastrophic Coverage Act was signed into law on July 1, 1988, prescription drug coverage was added. By November 1989, however, the Act was repealed, due partly to elderly voters' resistance to the plan's income-related financing. Diane Rowland & Brian Biles, *Government*, 263 JAMA 2646, 2647 (1990).

78. In the United States, volunteer caregivers provide more than 70 percent of all long-term care for the elderly. Weiner, *supra* note 75, at 1525.

79. Medicaid covers 47 percent of nursing home costs and 27 percent of home care costs. *Id.*

80. ELIZABETH J. ANDERSON, LEDA R. JUDD, JUDE THOMAS MAY & PETER K. NEW, THE NEIGHBORHOOD HEALTH CENTER PROGRAM: ITS GROWTH AND PROBLEMS: AN INTRODUCTION 73-75 (Leda R. Judd & William J. Manseau eds., 1976).

81. Howard E. Freeman, K. Jill Kiecolt & Harris M. Allen II, *Community Health Centers: An Initiative of Enduring Utility*, MILBANK MEMORIAL FUND Q. 245, 246-47 (1982).

82. *See, e.g.*, Ronald Sullivan, *Care of Poor is Cut by Private Hospitals*, N.Y. TIMES, May 30, 1982, § 1, at 26; Tessa Melvin, *Budget Cut Criticized*, N.Y. TIMES, Dec. 20, 1981,

There is a striking absence in the current reform proposals of any discussion of reviving the Neighborhood Health Center movement. If this was a good idea, how can we get it onto the current agenda?

Dr. Padgug: Since Medicare has so many gaps, most people buy private supplemental insurance. This insurance is necessary to fill in the deductibles and copayments that Medicare requires.[83]

Every time you are in the hospital, you pay a certain proportion of the first day's stay. On your physician's bills, there are fairly substantial copayments. What the federal government did—and it was a good idea—was to pass legislation that standardized all the policies, so private insurers can only sell ten types of policies.[84] Known as Medigap, they have different levels of supplementation, and they appropriately have different premium levels. That in itself, however, is not going to solve the problem, because the richest of the benefits offers an absolute maximum of $3,000 for drug costs per year.[85] If you are a chronically ill person suffering from any of a number of illnesses, besides AIDS, that require substantial pharmaceutical intervention, such coverage leaves you in a very uncomfortable position.

Thus, the problem is not solved by Medigap, nor is it solved by federal and state legislation, which has begun to limit the amount doctors are permitted to charge above what Medicare considers a fair reimbursement.[86] These laws are ineffective, because few people are aware of them. It is hard to figure out what the doctor should be charging because of the crazy-quilt way Medicare designed its reimbursement policy. Consequently, the private sector solution is very much of a stopgap.

Dr. Anastos: I think it is important to follow up on the issue of prescription drugs. Most physicians, in fact, are not familiar with the cost of prescription drugs. It can cost nearly sixty dollars for a ten-day course of antibiotics. I think that gives any of us pause. The profit motive in the pharmaceutical industries is purported to be for the development of new drugs. There are costs involved in research and development, but that is not how drug prices are set. Prices are set by what the market will bear.[87]

---

§ 11, at 11; Bertram M. Beck, *A "Formidable Challenge" For Agencies*, N.Y. TIMES, Dec. 6, 1981, § 1, at 58.

83. Seventy percent of Medicare enrollees resort to supplemental private insurance (i.e., Medigap). Eli Ginzberg & Miriam Ostow, *Beyond Universal Health Insurance to Effective Health Care*, 265 JAMA 2559, 2560 (1991).

84. 42 U.S.C. § 1395ss (p)(2)(C) (Supp. IV 1992).

85. NAT'L ASS'N OF INS. COMM'RS & HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. HCFA-02110, GUIDE TO INSURANCE FOR PEOPLE WITH MEDICARE 23 (1994) (explaining that Plan J, the most extensive Medigap plan, provides coverage for 50 percent of the cost of prescription drugs to a maximum of $3,000 after the policyholder meets an annual $250 deductible).

86. *See* Sorkin, *supra* note 33, at 189-92 (noting hospital reaction to the Tax Equity and Financial Responsibility Act (TEFRA), which was the first federal legislation designed to reduce Medicare costs).

87. The price of medicine is set at a rate that is competitive with the cost of alternative treatment. *See* John Harding, *Do We Pay Too Much for Prescriptions?*, CONSUMER REP.,

Drugs should not be priced in this fashion. Drugs should be priced according to what it costs to make them.

Geriatric care has already begun to move to home care in many instances.[88] A nurse or nursing aide provides medical treatment for an elderly individual in her own home, and also often provides services beyond the realm of traditional medical care. Home care is relatively successful in providing primary care and preserving patient autonomy. Usually, services are paid for through private insurance or out-of-pocket expenditure.[89] We should begin to consider whether this sort of care should progress beyond the realm of geriatric care, and, if so, how it should be financed.

In examining the Cuban solution to long term care, where family members care for the elderly, we must recognize that the United States and Cuba are culturally different. Therefore, what may be a very good solution to a difficult problem in Cuba may not be viable here. In the United States, there is a greater possibility that an elderly person might not want or be able to move in with her family. In such a case, how will she gain access to care and how will her care be provided and paid for, under a system like Cuba's? Moreover, a system which relies on family support works if there is a community outreach system in place, but it does not solve the elderly's problem of access to acute care or to long-term care in a nursing home.

VII
SOLUTIONS

Following the discussion of the current problems of access to health care, Dr. Sidel asked the experts to propose models that the United States could implement to achieve greater access and equity. Most of the speakers recommended universal and uniform access through the establishment of a universal health service, but some expressed skepticism about the institution of a single-payer system. Several of the experts emphasized the importance of cost-containment mechanisms and a proper funding scheme in any reform package. Some speakers articulated the need for greater consumer education and awareness as a means of encouraging the consumer to take control and responsibility within the system. Several of the experts also indicated that the government and medical professionals must take responsibility for ensuring access.

Dr. Anastos: We should adopt a system that is similar to the Canadian system. The government should be the sole payer within a system that

Oct. 1993, at 668, 671 (noting, for example, that because ulcer surgery costs $25,000, an ulcer drug that costs less would be a rational purchase).

88. *See* Allen D. Spiegel, *Home Care: Doing Right for the Wrong Reasons*, 993 N.Y. ST. J. MED. 190, 190 (1993).

89. FAMILIES U.S.A. FOUNDATION, HEALTH COST SQUEEZE ON OLDER AMERICANS: A REPORT 19 (1992) (finding that the largest single component of out-of-pocket costs for the elderly is home nursing care).

does not offer a variety of optional benefit packages. To guarantee full access, there should be one basic benefits package that everyone is entitled to receive. Even under a single-payer system, full care will remain an elusive goal; however, the means of distributing services will be fairer. Presently, health care is rationed by income. Under a single-payer system, health care rationing will be achieved based on need.

We have to move from an acute care, in-patient, high-tech model to the public health model of providing preventive and primary care to all. To succeed, we have to train more primary care physicians, train fewer subspecialty physicians, shift some of the care from physicians to less expensive caregivers, and consider why physicians' services are so expensive.

Financing for the system should come out of the tax structure, and it should involve a sliding scale based on income. In other words, funds should come from what we already pay for our insurance premiums, as well as from an increased tax base.

Ms. Dohrn: I would like to build on the single-payer model already proposed. In creating this new delivery system, primary care must be shifted away from doctors and hospitals and into community health centers. More midlevel providers should be trained.

The very definition of health care should be broadened. The American people should be called upon to build a new health care society, because it is the humane thing to do. I want to abolish the system in which health care providers are paid for performing a particular service. Health care is a basic right and it should be provided holistically to people in need.

Ms. Escalera: In a single-payer system, everyone would be covered, and there would be no differentiation between patients. All Americans would have access to care.

I would infuse this structure with educational programs, so that people can develop an awareness of medical needs and care strategies. For example, the relationship between health care and poverty must be recognized and approached from an appropriate perspective. As a nation, we should also consider alternative treatments. Lastly, we should work to increase the number of minority health care providers.

Mr. O'Sullivan: It is very important to make sure that the system is funded properly. There is a risk that a system entirely funded by taxes will have too narrow a funding base to keep it functioning at an appropriate level.

Assuming financial stability, a proper distribution of power and responsibility is necessary to ensure access and equity. First, people need to be aware of their rights in order to claim access. As far as equity maintenance is concerned, professionals must be responsible for reaching out to needy people. The system that is created cannot be so bureaucratic as to prevent criticism of those responsible for its failures. In Britain, it is the government that is politically responsible when the system fails.

The people who are spending money on health care have to start using their power. America believes in the free market. Consumers, therefore, must use their buying power.

Professor Law: To respond to my colleagues, I do not think we, as a nation, are ready to adopt a single-payer, tax-financed system. I do not think the American people will accept the inevitable tax increase. Second, we have a very pluralistic society. That is, each state has different programs and different groups of people which demand different solutions.

Nevertheless, there are a few steps we all need to follow. Repeal ERISA; do marginal cost-containment; require community rating; prohibit exclusions on the basis of preexisting conditions by all private insurers; pump a little money into the system for community health centers; and subsidize states that experiment with alternative treatment and delivery systems.

Dr. Padgug: It is a mistake to focus a discussion on reform on whether we are going to have a single-payer system or a private system. The world has shown that either system can be a success. The question that really has to be addressed is, "What are the principles that a system should embody?" Once this question is answered, the task of effectuating the goals can be initiated.

Whatever the final solution, the system has to be uniform and universal. It has to have community rating, and it has to have a risk-sharing mechanism through which risk is distributed. Community rating cannot be adjusted by health status or age or gender. It has to be adjusted by income.

As in a tax-based system, I would segregate funds, whether there is a single-payer system or not. There have to be cost controls in the system, or else the system will spin out of control. There have to be limitations on spending and rationing. In a world with finite resources, allowing some people to have everything inevitably warrants that others will have less.

Another point that should be examined is that health care, including insurance, is one of the only sectors of this economy that has grown in the last few years.[90] The issue of such growth is very important, yet nobody is paying attention to it. Insurance is our country's primary growth sector and a single-payer system will put 50 percent of it out of business.[91] Something has to be done about that, quickly.

---

90. *See* HEALTH INS. ASS'N OF AM., SOURCE BOOK OF HEALTH INSURACE DATA, 1992, 59 (citing statistics indicating that between 1990 and 1991, the national expenditures on program administration and the net cost of private insurance increased from $38.7 billion to $43.3 billion). *See also* Suzanne W. Letsch, Helen C. Lazenby, Katherine R. Levit & Cathy A. Cowan, *National Health Expenditures, 1991*, HEALTH CARE FINANCING REV., Winter 1992, at 1, 2 (noting that from 1990 to 1991 the health care sector grew greatly within the relatively slowly growing economy).

91. The estimated job losses that would result from single-payer system vary greatly. For example, the National Federation of Independent Businesses estimates that, depending on what reform plan actually passes, within one to two years 390,000 to 1.5 million jobs will be lost due to health care reform. Steven Findlay, *Health Care Reform: A Blow to Jobs and Wages*, BUS. & HEALTH, July 1993, at 26.

Mr. Rivera: There is a basic contradiction in the Clinton administration. It has attempted to deal with reform from the question of cost alone. You cannot not approach the issues of cost and access at the same time.

Professor Roberts: There are a lot of paradoxes that come from any transformation. If there is a single-payer system, the government becomes more involved in each citizen's life because along with the benefit of universal health care comes universal record keeping. Another paradox arises from saying that everyone is entitled to health care and that the government is obligated to give us health care; but that also means that the government is obligated to make decisions about rationing health care. For some people, that will mean fewer choices. As soon as we start talking about rights and entitlements, that also means greater involvement of the state in the decisions we make. There is tension between the desired autonomy and an intrusive government obligation to pay. It is important that we recognize the existence of this tension and that we address it when advocating for health care reform.

We have to ensure that choices are not based on invidious criteria like racism. We constantly must be vigilant and focus on the extent to which racism is a barrier to reform. Part of the reason why the utopian solution seems impossible is that it is unrealistic to expect that American taxpayers want to spend money on health care for black Americans. I think we have to face this problem because it is impeding health care reform.

Professor Weitzman: We obviously need some way for everyone to be insured. Nevertheless, I think I would place much more emphasis on changing the way we think of health care and the way we deliver services. I think issues regarding how society deals with undocumented people then would fall more easily into place.

We could deal with the problem of access very effectively and inexpensively by going into the communities and providing basic health care services. This is an integral step in reforming the system. If we reach out to neighborhoods, the risk that people will fall through the cracks will be greatly diminished.