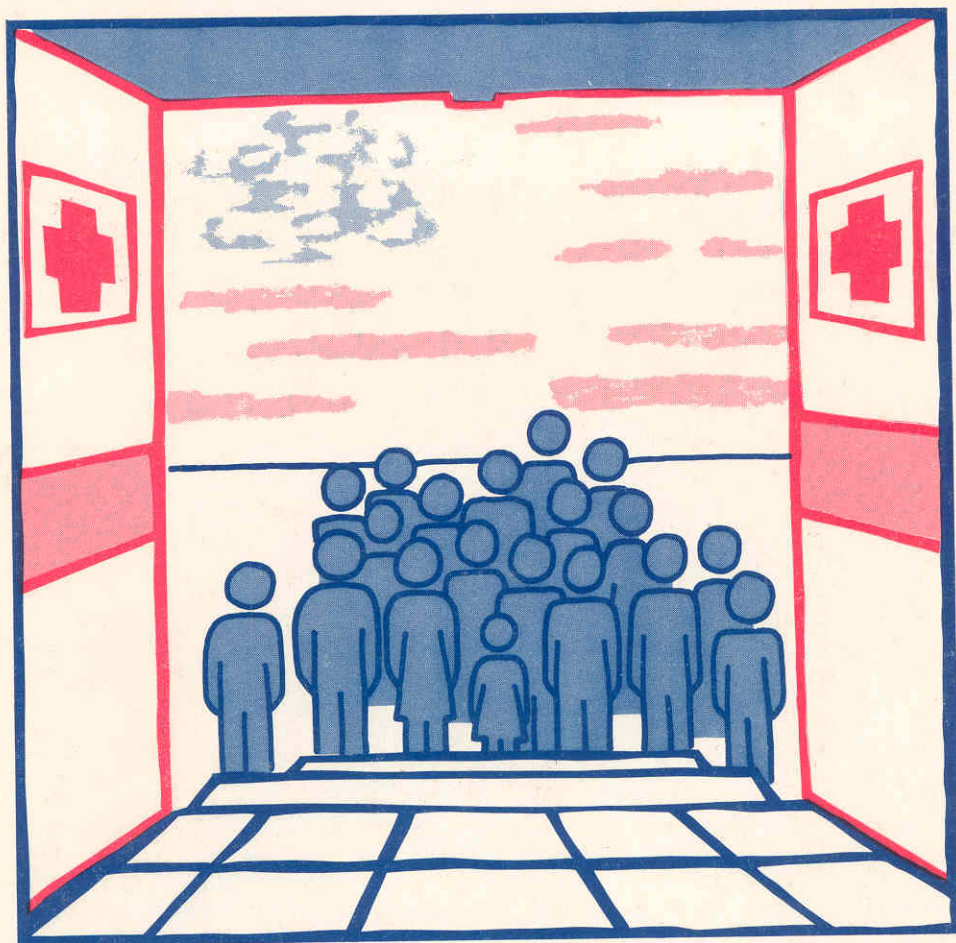

Securing Access to Health Care

The Ethical Implications
of Differences in
the Availability of
Health Services

Volume One: Report



President's Commission for the Study of
Ethical Problems in Medicine and
Biomedical and Behavioral Research

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A Report on the Ethical
Implications of
Differences in the
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Services

Volume One: Report

March 1983

President's Commission for the Study of
Ethical Problems in Medicine and
Biomedical and Behavioral Research

**President's Commission for the Study of Ethical
Problems in Medicine and Biomedical and
Behavioral Research**

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Ethical Problems in Medicine and Biomedical and Behavioral Research
Suite 555, 2000 K Street, N.W., Washington, DC 20006 (202) 653-8051

March 28, 1983

The President
The White House
Washington, D.C. 20500

Dear Mr. President:

On behalf of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, I am pleased to transmit our Report on Securing Access to Health Care. This is one of several subjects that Public Law 95-622 directs the Commission to study and regarding which we are to report to the President, the Congress, and relevant departments of government.

This report responds to the mandate that we report on the ethical implications of "differences in the availability of health services" among various groups in the United States. As we have examined the problems people face in obtaining health care, we have nonetheless been mindful of the system's notable accomplishments. Over the course of this century, the burgeoning powers of medicine and people's greater access to it have contributed to a dramatic improvement in the average American's prospects for having such a long and healthy life.

In examining the special nature of health care, we discern in our country's traditional commitment to fairness, an ethical obligation on the part of society to ensure that all Americans have access to an adequate level of care without the imposition of excessive burdens. This obligation does not require that everyone receive all health care that he or she may want or even all that could conceivably be of benefit. Instead, it is a moral responsibility to see that adequate care is accessible, a commitment that recognizes the competing claims on available resources of other worthwhile social goals.

The obligation we have described is one of all to all not a special standard that applies only to the poor. This does not mean, however, that the Federal government need be involved in the health care of all Americans. Most people rely on their own resources and insurance for health care; and charitable institutions and state and local programs contribute to making the benefits of health care widely available. Thus, in practical terms, the responsibility that ultimately rests with the Federal government is to make sure that those who otherwise could not obtain adequate care are able to do so and that the costs of care are shared equitably.

This responsibility may be discharged in any number of ways, through a combination of public and private efforts. It is clearly not the Commission's job to attempt to choose among them. Many changes in the organization and financing of health care are currently being discussed, particularly proposals to restrain health care costs. As attempts are made to improve the fiscal and scientific aspects of the system, we urge that attention also be paid to the ethical precepts elaborated in this Report.

We are pleased to have had the opportunity to contribute to improving public understanding of this important topic.

Respectfully,

A handwritten signature in dark ink, appearing to read "Morris B. Abram".

Morris B. Abram
Chairman



President's Commission for the Study of
Ethical Problems in Medicine and Biomedical and Behavioral Research
Suite 555, 2000 K Street, N.W., Washington, DC 20006 (202) 653-8051

March 28, 1983

The Honorable George Bush
President
United States Senate
Washington, D.C. 20510

Dear Mr. President:

On behalf of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, I am pleased to transmit our Report on Securing Access to Health Care. This is one of several subjects that Public Law 95-622 directs the Commission to study and regarding which we are to report to the President, the Congress, and relevant departments of government.

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Morris B. Abram
Chairman



President's Commission for the Study of
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Suite 555, 2000 K Street, N.W., Washington, DC 20006 (202) 653-8051

March 28, 1983

The Honorable Thomas P. O'Neill, Jr.
Speaker
U. S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

On behalf of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, I am pleased to transmit our Report on Securing Access to Health Care. This is one of several subjects that Public Law 95-622 directs the Commission to study and regarding which we are to report to the President, the Congress, and relevant departments of government.

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Morris B. Abram
Chairman

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Introduction

The prevention of death and disability, the relief of pain and suffering, the restoration of functioning: these are the aims of health care. Beyond its tangible benefits, health care touches on countless important and in some ways mysterious aspects of personal life that invest it with significant value as a thing in itself. In recognition of these special features, the President's Commission was mandated to study the ethical and legal implications of differences in the availability of health services.¹ In this Report to the President and Congress, the Commission sets forth an ethical standard: access for all to an adequate level of care without the imposition of excessive burdens. It believes that this is the standard against which proposals for legislation and regulation in this field ought to be measured.

In fulfilling its mandate from Congress, the Commission discusses an ethical response to differences in people's access to health care. To do so, it is necessary both to examine the extent of those differences and to try to understand how they arise. This focus on the problems of access ought not to obscure the great strengths of the American health care system. The matchless contributions made by America's biomedical scientists to medical knowledge and techniques, the high skill and compassionate devotion of countless physicians and other health professionals, the extensive financial protection against health care costs available to most people, the great generosity with time and funds of many individuals and organizations—these are the hallmarks of health care in the United States. Therefore, the objective here is not to disparage the system but merely to encourage responsible

¹ 42 U.S.C. § 300v-1(a)(1)(D)(Supp. 1981).

decisionmakers—in the private sector and at all levels of government—to strive to ensure that every American has a fair opportunity to benefit from it.

Health care is a field in which two important American traditions are manifested: the responsibility of each individual for his or her own welfare and the obligations of the community to its members. These two values are complementary rather than conflicting; the emphasis on one or the other varies with the facts of a particular situation. In the field of health care, personal responsibility is a corollary of personal self-determination, which the Commission discussed in its recent report on informed consent.² At the same time, ill health is often a matter of chance that can have devastating consequences; thus, concern has long been expressed that health care be widely available and not unfairly denied to those in need.

Since the nineteenth century, the United States has acted—through the founding of the Public Health Service and of hospitals for seamen, veterans, and native Americans, and through special health programs for mothers and infants, children, the elderly, the disabled, and the poor—to reaffirm the special place of health care in American society. With the greatly increased powers of biomedical science to cure as well as to relieve suffering, these traditional concerns about the special importance of health care have been magnified.

In both their means and their particular objectives, public programs in health care have varied over the years. Some have been aimed at assuring the productivity of the work force, others at protecting particularly vulnerable or deserving groups, still others at manifesting the country's commitment to equality of opportunity. Nonetheless, most programs have rested on a common rationale: to ensure that care be made accessible to a group whose health needs would otherwise not be adequately met.³

The consequence of leaving health care solely to market forces—the mechanism by which most things are allocated in American society—is not viewed as acceptable when a significant portion of the population lacks access to health services. Of course, government financing programs, such as Medicare and Medicaid as well as public programs that provide care directly to veterans and the military and through

² President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *MAKING HEALTH CARE DECISIONS*, U.S. Government Printing Office, Washington (1982).

³ Although public programs have generally rested on this rationale, some have been structured so as to include people who could obtain adequate care on their own without excessive burdens. Medicare, for example, covers virtually all of the elderly, not only those who cannot afford the cost of care.

local public hospitals, have greatly improved access to health care. These efforts, coupled with the expanded availability of private health insurance, have resulted in almost 90% of Americans having some form of health insurance coverage. Yet the patchwork of government programs and the uneven availability of private health insurance through the workplace have excluded millions of people. The Surgeon General has stated that “with rising unemployment, the numbers are shifting rapidly. We estimate that from 18 to 25 million Americans—8 to 11 percent of the population—have no health insurance coverage at all.”⁴ Many of these people lack effective access to health care, and many more who have some form of insurance are unprotected from the severe financial burdens of sickness.

Nor is this a problem only for the moment. The Secretary of Health and Human Services recently observed that despite the excellence of American medical care, “we do have this perennial problem of about 10% of the population falling through the cracks.”⁵ What is needed now are ethical principles that offer practical guidance so that health policymakers in Federal, state, and local governments can act responsibly in an era of fiscal belt tightening without abandoning society’s commitment to fair and adequate health care.

Summary of Conclusions

In this Report, the President’s Commission does not propose any new policy initiatives, for its mandate lies in ethics not in health policy development. But it has tried to provide a framework within which debates about health policy might take place, and on the basis of which policymakers can ascertain whether some proposals do a better job than others of securing health care on an equitable basis.

⁴ *Interview with Dr. C. Everett Koop, U.S. Surgeon General*, U.S. NEWS & WORLD REPORT 35, 36 (June 28, 1982). The Director of the Congressional Budget Office recently stated that almost 11 million former workers and their dependents have already lost their coverage under their employers’ health insurance plan because of unemployment, and that more will lose coverage as their extended benefits expire. This is in addition, she points out, to roughly 20 million persons who are uninsured for other reasons. Alice M. Rivlin, *Health Insurance and the Unemployed*, Statement before the Subcomm. on Health and the Environment, Comm. on Energy and Commerce, U.S. House of Representatives (Jan. 24, 1983).

⁵ Larry Frederick, *Schweiker on Health Policy*, MEDICAL WORLD NEWS 61, 69 (July 19, 1982).

In 1952, the President's Commission on the Health Needs of the Nation concluded that "access to the means for the attainment and preservation of health is a basic human right."⁶ Instead of speaking in terms of "rights," however, the current Commission believes its conclusions are better expressed in terms of "ethical obligations."

The Commission concludes that society has an ethical obligation to ensure equitable access to health care for all. This obligation rests on the special importance of health care: its role in relieving suffering, preventing premature death, restoring functioning, increasing opportunity, providing information about an individual's condition, and giving evidence of mutual empathy and compassion. Furthermore, although life-style and the environment can affect health status, differences in the need for health care are for the most part undeserved and not within an individual's control.

In speaking of society, the Commission uses the term in its broadest sense to mean the collective American community. The community is made up of individuals who are in turn members of many other, overlapping groups, both public and private: local, state, regional, and national units; professional and workplace organizations; religious, educational, and charitable institutions; and family, kinship, and ethnic groups. All these entities play a role in discharging societal obligations.

The societal obligation is balanced by individual obligations. Individuals ought to pay a fair share of the cost of their own health care and take reasonable steps to provide for such care when they can do so without excessive burdens. Nevertheless, the origins of health needs are too complex, and their manifestation too acute and severe, to permit care to be regularly denied on the grounds that individuals are solely responsible for their own health.

Equitable access to health care requires that all citizens be able to secure an adequate level of care without excessive burdens. Discussions of a right to health care have frequently been premised on offering patients access to all beneficial care, to all care that others are receiving, or to all that they need—or want. By creating impossible demands on society's resources for health care, such formulations have risked negating the entire notion of a moral obligation to secure care for those who lack it. In their place, the Commission proposes a standard of "an adequate level of care," which should be thought of as a floor below which no one ought to fall, not a ceiling above which no one may rise.

A determination of this level will take into account the value of various types of health care in relation to each other

⁶ 1 PRESIDENT'S COMMISSION ON THE HEALTH NEEDS OF THE NATION, U.S. Government Printing Office, Washington (1953) at 3.

as well as the value of health care in relation to other important goods for which societal resources are needed. Consequently, changes in the availability of resources, in the effectiveness of different forms of health care, or in society's priorities may result in a revision of what is considered "adequate."

Equitable access also means that the burdens borne by individuals in obtaining adequate care (the financial impact of the cost of care, travel to the health care provider, and so forth) ought not to be excessive or to fall disproportionately on particular individuals.

When equity occurs through the operation of private forces, there is no need for government involvement, but the ultimate responsibility for ensuring that society's obligation is met, through a combination of public and private sector arrangements, rests with the Federal government. Private health care providers and insurers, charitable bodies, and local and state governments all have roles to play in the health care system in the United States. Yet the Federal government has the ultimate responsibility for seeing that health care is available to all when the market, private charity, and government efforts at the state and local level are insufficient in

The cost of achieving equitable access to health care ought to be shared fairly. The cost of securing health care for those unable to pay ought to be spread equitably at the national level and not allowed to fall more heavily on the shoulders of particular practitioners, institutions, or residents of different localities. In generating the resources needed to achieve equity of access, those with greater financial resources should shoulder a greater proportion of the costs. Also, priority in the use of public subsidies should be given to achieving equitable access for all before government resources are devoted to securing more care for people who already receive an adequate level.⁷

Efforts to contain rising health care costs are important but should not focus on limiting the attainment of equitable access for the least well served portion of the public. The achievement of equitable access is an obligation of sufficient moral urgency to warrant devoting the necessary resources to it. However, the nature of the task means that it will not be achieved immediately. While striving to meet this ethical obligation, society may also engage in efforts to contain total health costs—efforts that themselves are likely to be difficult and

⁷ Although the Commission does not endorse devoting public resources to individuals who already receive adequate care, exceptions arise for particular groups with special ethical claims, such as soldiers injured in combat, to whom the nation owes a special debt of gratitude.

time-consuming. Indeed, the Commission recognizes that efforts to rein in currently escalating health care costs have an ethical aspect because the call for adequate health care for all may not be heeded until such efforts are undertaken. If the nation concludes that too much is being spent on health care, it is appropriate to eliminate expenditures that are wasteful or that do not produce benefits comparable to those that would flow from alternate uses of these funds. But measures designed to contain health care costs that exacerbate existing inequities or impede the achievement of equity are unacceptable from a moral standpoint. Moreover, they are unlikely by themselves to be successful since they will probably lead to a shifting of costs to other entities, rather than to a reduction of total expenditures.

Overview of the Report

The Commission was instructed by Congress to study the “ethical and legal implications of differences in the availability of health services as determined by the income or residence of the person receiving the service.”⁸ To translate “differences in availability” into ethical terms, it is necessary to develop standards of equity of access to health care. The term “equity” means different things to different people. Does equity, for example, require that all individuals receive all potentially beneficial health care, or whatever health care is available to others, or some other level of care? Does it require only that the government ensure that people have the financial means for obtaining care, whether or not the services are available? Or does it encompass an obligation, as well to see that health services are available should the market fail to provide them? In Chapter One of this Report, the Commission attempts to respond to such questions and presents an ethical framework as a foundation for evaluating current patterns of access to health care and recommendations for change.

Chapter Two shows that differences in the ability to pay for health care and in the distribution of health care services have been reduced substantially in the past 15 years. However, inequities related to income, place of residence, race, and ethnicity still exist in the financial protection people have against the cost of care, in the availability of health professionals and facilities, in the use of services, and in the quality of care received.⁹

⁸ 42 D.S.C. § 300v-1(a)(1)(D)(Supp. 1981). Early in its deliberations, the Commission decided to include race and ethnic origin as other factors to be examined in evaluating differences in the availability of health care.

⁹ While the statistics in Chapter Two establish the existence of disparities based on race and ethnicity, they appear to result from many interrelated factors and not necessarily from conscious racial

Chapter Three of the Report examines the impact of a range of existing government policies and programs on access to health care. Some of the improvement over the past few decades can be attributed to Federal, state, and local government policies that both directly and indirectly affect people's ability to secure health services. These actions themselves raise important—albeit sometimes unrecognized—ethical questions. For example, public policies have subsidized the purchase of health services for some individuals but have failed to help others with comparable needs who are unable to pay for health care. The impact of government actions on the costs of health care itself has ethical implications since increased expenditures for health care mean that fewer resources can be devoted to other important social endeavors. Chapter Three also addresses a concern common to all public policy: to what extent have government efforts affected individual choice?

The final chapter examines the problems of achieving equitable access within the context of rising health care costs and expenditures. The Commission believes that efforts to improve equity need not conflict with strategies to halt the rapid escalation of health care costs and to bring the benefits derived from health care into proportion with the resources devoted to it. Indeed, such efforts offer policymakers an excellent opportunity to implement changes that could make health care not only more efficient and less costly but also more equitable.

Through an application of the Commission's analysis to several possible remedies for current problems, Chapter Four offers further refinements in the ethical framework by which policymakers in the Congress and Executive agencies can judge proposals in the health care arena. The policies discussed were chosen not because of any particular importance attached to them, but because the Commission hopes that a review of several ideas currently under consideration will demonstrate the importance of taking into account ethical implications—in addition to biomedical, economic, social, and political factors—when health policy is being framed.

The Process of the Commission's Study

In conducting its study, the Commission has drawn on a wide range of resources. During September 1980, Commissioners and staff met with recognized experts and scholars in the

discrimination. Commissioner Moran believes that such disparities may perhaps exist but does not think the evidence presented here substantiates this conclusion; for the views of Commissioner Ballantine, see his dissenting statement, pp. 199-204 *infra*.

health field to discuss initial plans for its study of access to health care. A preliminary outline by the Commission staff of the major areas to be studied was adopted in November 1980, and revised outlines were considered and accepted by the Commissioners in May and July 1981.

In this study, the Commission drew on the results of several national surveys. Although these contributed greatly to the Report, the limits of their data must be acknowledged. As with most data from large-scale national surveys, further refinements would be needed to account fully for the complex set of relationships that govern attempts to seek and obtain care. Comparisons among such broad categories as race, income, and place of residence mask very important differences within these general classifications. Furthermore, these data do not explain how social and cultural differences influence a person's orientation toward health and use of the health care system. Yet despite these and other shortcomings, the Commission believes that the statistical information presented in this Report correctly represents the magnitude of the ethical problems in securing equitable access to health care, if not their precise contours.¹⁰

In its effort to look beyond these statistics, the Commission also relied on the testimony of consumers and health care professionals. In relating their own experiences, these witnesses brought a personal element to the deliberations of the Commission. Although the anecdotal information is not necessarily representative, it allowed the Commission to learn firsthand how problems in obtaining and paying for care established by the statistical data actually affect people's lives.¹¹

The views of consumers and experts from the fields of public health, economics, philosophy, insurance, medicine, nursing, and law were received at four Commission meetings. At the March 1981 hearing, witnesses examined the broad contours of questions about access to health care, including empirical information on trends in access, quality of care, and the relationship of health to patterns of access. The Commissioners also heard testimony about the social, historical, and ethical perspectives of equity in health care.

¹⁰ During the course of its investigation, the Commission solicited a number of papers from scholars, policy analysts, and others with special expertise in the health care field. These presentations supplemented available information and provided new data and analysis on the topics under study. These papers appear in Volumes Two and Three of this Report.

¹¹ Commissioner Moran objects to the use of anecdotal material in the text of the Report. For the views of Commissioner Ballantine see his dissenting statement. pp. 199-204 *infra*.

At the October 1981 meeting, the Commissioners explored in detail a number of philosophical issues in health care. In addition to reports by members of a panel of philosophers,¹² who had been studying the subject for the Commission, witnesses from medicine and law joined in discussing such topics as the right to health care, the concept of adequate care, health care needs and deserts, and providers' and patients' freedom of choice.

The November 1981 meeting dealt with ethical issues in the allocation of health care resources. The discussion considered how decisions that limit available care are made within different delivery settings (hospitals and health maintenance organizations) and about various types of services (end-stage renal disease, adult and neonatal intensive care, and hypertension screening and treatment), as well as what the role of third party payers is in this process. The hearing concluded with testimony about the implications of the law with regard to questions of equity of access to health care.

The final hearing on this subject was held in Atlanta, Georgia, in April 1982, when the Commission heard from health care consumers about their difficulties in securing and paying for health services. In addition, a panel of physicians and a hospital administrator spoke about problems in delivering health care to the poor, and several state officials and heads of voluntary organizations described access patterns and policies. The first day's session concluded with a visit by the Commissioners to a Federally supported primary care center serving a largely low-income urban neighborhood. Testimony was also heard in Atlanta on a study that had been commissioned on insurance coverage and the use of health services. Other witnesses described innovative solutions to the maldistribution of health care providers, including state and Federal programs to bring nurses and physicians into rural areas.

In addition to hearing testimony, the Commission deliberated on the subject at several meetings. In May, July, September, and November 1982, the testimony that had been heard and the drafts of this Report were discussed, and the final draft

¹² The panel members were Professors Dan W. Brock of Brown University, Allen Buchanan of the University of Arizona, Norman Daniels of Tufts University, David Gauthier of the University of Pittsburgh, and Alan Gibbard of the University of Michigan. For a complete list of witnesses at the Commission meetings on this subject, see *The Commission's Process*, pp. 207-13 *infra*. Their contributions appear in the Appendices (Sociocultural and Philosophical Studies), Volume Two of this Report, with an introduction by Professor Daniel Wikler of the University of Wisconsin, who, while serving during 1980-81 as the Commission's staff ethicist, coordinated the studies conducted by the panel.

was discussed and approved by a vote of ten to one on December 14, 1982, subject to specified corrections.

An Ethical Framework for Access to Health Care

1

A half century ago a national Committee on the Costs of Medical Care concluded that “many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physical pain and mental anguish, needless deaths, economic inefficiency, and social waste.”¹ Although much progress has been made in the past 50 years through the advent of private health insurance and public programs, problems of access remain and are compounded by the perceived need to respond to rapidly rising health care costs and expenditures. As that earlier committee observed, “The United States has the economic resources, the organizing ability, and the technical experience to solve this problem.”² The question now is whether the country’s formidable health care resources can be applied in away that is fair to all—be they patient, provider, or taxpayer.

Most Americans believe that because health care is special, access to it raises special ethical concerns. In part, this is because good health is by definition important to well being. Health care can relieve pain and suffering, restore functioning, and prevent death; it can enhance good health and improve an individual’s opportunity to pursue a life plan; and it can provide valuable information about a person’s overall health. Beyond its practical importance, the involvement of health care with the most significant and awesome events of life—birth, illness, and death—adds a symbolic aspect to health care: it is

¹ Committee on the Costs of Medical Care, *MEDICAL CARE FOR THE AMERICAN PEOPLE* (1932), Dept. of Health, Education, and Welfare, U.S. Government Printing Office, Washington (reprinted 1970) at 2.

² *Id.*

special because it signifies not only mutual empathy and caring but the mysterious aspects of curing and healing.

Furthermore, while people have some ability—through choice of life-style and through preventive measures—to influence their health status, many health problems are beyond their control and are therefore undeserved. Besides the burdens of genetics, environment, and chance, individuals become ill because of things they do or fail to do—but it is often difficult for an individual to choose to do otherwise or even to know with enough specificity and confidence what he or she ought to do to remain healthy. Finally, the incidence and severity of ill health is distributed very unevenly among people. Basic needs for housing and food are predictable, but even the most hardworking and prudent person may suddenly be faced with overwhelming needs for health care. Together, these considerations lend weight to the belief that health care is different from most other goods and services. In a society concerned not only with fairness and equality of opportunity but also with the redemptive powers of science, there is a felt obligation to ensure that some level of health services is available to all.

There are many ambiguities, however, about the nature of this societal obligation. What share of health costs should individuals be expected to bear, and what responsibility do they have to use health resources prudently? Is it society's responsibility to ensure that every person receives care or services of as high quality and as great extent as any other individual? Does it require that everyone share opportunities to receive all available care or care of any possible benefit? If not, what level of care is "enough"? And does society's obligation include a responsibility to ensure both that care is available and that its costs will not unduly burden the patient?

The resolution of such issues is made more difficult by the specter of rising health care costs and expenditures. Americans annually spend over 270 million days in hospitals,³ make over 550 million visits to physicians' offices,⁴ and receive tens of millions of X-rays.⁵ Expenditures for health care in 1981 totaled \$287 billion—an average of over \$1225 for every American.⁶ Although the finitude of national resources demands that trade-offs be made between health care and other social goods,

³ National Center for Health Statistics, *HEALTH UNITED STATES*, 1981, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1981) at 162.

⁴ Unpublished data from the National Ambulatory Medical Care Survey, National Center for Health Statistics, U.S. Dept. of Health and Human Services (1982).

⁵ *Id.*

⁶ Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures: 1981*, 4 *HEALTH CARE FINANCING REV.* 1 (Sept. 1982).

there is little agreement about which choices are most acceptable from an ethical standpoint. In this chapter, the Commission attempts to lay an ethical foundation for evaluating both current patterns of access to health care and the policies designed to address remaining problems in the distribution of health care resources.

The sheer size and complexity of the enterprise encourages abstract thinking about large-scale issues of social policy. But every significant issue of social policy dealt with in this Report, no matter how abstract and impersonal it seems, derives its ethical and social importance from its bearing on the ability of the health care system to respond appropriately to the individual seeking care—whether it be a pregnant woman in need of prenatal and obstetrical care, a worker disabled by arthritis, or an injured motorist who requires emergency treatment.

To explore “differences in the availability of health care,” as required by the Commission’s mandate, is to raise issues of profound ethical importance. There is no question that differences in access to health care in the United States do exist, though there is disagreement about the nature and magnitude of these differences. Describing these differences is a factual task that rests on empirical research, but to conclude that certain differences constitute inequities is to make an ethical judgment that access to health care is unfair or otherwise morally unacceptable. Plainly, then, findings of equity must be based on a standard of what constitutes equity. This chapter does not offer a policy blueprint for health care, but it seeks to provide an ethical framework for determining when differences in access to health care are inequitable and to identify who is responsible for addressing these inequities.

Historical Perspective

Historically, inequity in access to health care was not often perceived as a major social concern for three reasons. First, before the development of scientifically grounded medical technology, health care was of little value in the treatment of most illnesses. Second, much of the care that was provided by health care professionals could be supplied by laypeople. Until the beginning of this century, for example, virtually all drugs used by physicians were available to the general public without prescriptions. Third, for centuries care for the sick and dying was considered to be the responsibility of families, private charities, and religious organizations rather than society as a whole.⁷

⁷ Henry J. Aaron, *Economic Aspects of the Role of Government in Health Care*, in J. van der Gaag and Mark Perlman, eds., *HEALTH*.

When concerns about health care did arise in a Federal context, it was originally out of a desire to promote the collective good more than individual welfare. The earliest governmental efforts were to provide health care to merchant seamen, under the 1798 Act For the Relief of Sick and Disabled Seamen, and to members of the armed forces.

The goals were strategic and economic. Health services were secondary to more immediate social priorities—in the case of the merchant marine, that of keeping the shipping industry of the country vital. As the armed forces developed, the emergence of a medical branch maintaining a basic standard of readiness in both army and navy represented a policy very different from any modern concept of [concern for] welfare...

Isolation in special institutions of those with infectious diseases or with other potentially dangerous social traits, including mental illness, led, particularly during the nineteenth century, to the development of institutions whose purpose was as much for the protection of the healthy population as care for the unhealthy.⁸

In the last half of the nineteenth century, the provision of health services became an important area of government policy in Western Europe. This development was not motivated primarily by ethical concern about inequities in access nor by an appreciation of the value of health care to the individual. Instead, the goals of government policy were to achieve a more productive labor force and a healthier general populace for purposes of national defense and, in some cases, to ameliorate social unrest through reform rather than revolution.

Broadened governmental responsibility for health care was only one element of a growing commitment to social services ranging from public education to unemployment insurance and income assistance programs. In the United States, a tradition of greater reliance on individual responsibility and a commitment to the ideal of a limited national government accounted, in part, for a reluctance to follow the European model. Though equality has always been an important American value, the traditional emphasis has been on equal civil and political liberties rather than on economic equality. Because health care was regarded as a special case for reasons of productivity and national security, and because the need to protect the populace from contagious diseases proved compelling, the cumulative result was an identifiable

ECONOMICS, AND HEALTH ECONOMICS, Elsevier-North Holland Pub. Co., New York (1981) at 15-32, reprinted in General Series Reprint 382, The Brookings Institution, Washington (1982).

⁸ Rosemary A. Stevens and Robert Stevens, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID, The Free Press, New York (1974) at 15.

role for government in health care independent of any explicit assumption of a more general government responsibility for promoting individual welfare.

Then, as health care became more efficacious in the late nineteenth and early twentieth centuries, a heightened sensitivity about its equitable distribution arose. The shift in political thought and eventually in public policy to an emphasis on equal access to services began only [when] Americans accepted professional claims of special competence and enacted laws regulating medical practice. Only when a consensus emerged about the superior effectiveness of scientific medicine did earlier *differences* in medical care loom as *inequalities*.⁹

In recent decades, there has been an increasing emphasis on the benefits of health care to the individual and a growing recognition that society as a whole has a moral obligation to ensure that these benefits are distributed equitably. After World War II, the failure of many men to pass the physical examination required for entry into the armed forces led to increased awareness of barriers to health care. At the same time, the growing commitment in this country to equality of opportunity served to highlight existing inequities in many aspects of American life, including health care. Greater attention to issues of equity continued to be nurtured by prudential arguments that some inequities in access to medical care endangered social cohesion and lessened the productivity of the labor force.

In the past several years, however, three developments have shifted concern away from issues of access—the belief that government programs have already filled the gaps in access; the emergence of an extreme view that denies the efficacy of sophisticated health care, especially high-technology medical intervention; and a growing awareness that factors other than health care (including environment and life-style) exert an important influence on individual health status.

The Commission believes that none of these developments diminishes the ethical importance of the principle of fairness in access to health care. Local, state, and Federal programs have made laudable gains, yet there are still millions of Americans who lack equitable access to health services. The dimensions of the problem are spelled out in the next chapter.

Similarly, although skepticism about the efficacy of many medical practices may be justified—and useful when it provokes needed reexamination about the “received wisdom”—medical care has been effective in improving functioning and lengthening life for many people, particularly those who only recently obtained access to care. By the same token, the

⁹ Paul Starr, *Medical Care and the Pursuit of Equality in America* (1982), Appendix A, in Volume Two of this Report, at section one.

Commission applauds efforts to discover the influence of lifestyle and environment on health and believes that responsible health policy must take these factors into account. But recognizing the importance of such factors does not deny the role health care plays in achieving and preserving personal health.

The Special Importance of Health Care

Although the importance of health care may, at first blush, appear obvious, this assumption is often based on instinct rather than reasoning. Yet it is possible to step back and examine those properties of health care that lead to the ethical conclusion that it ought to be distributed equitably.

Well-Being. Ethical concern about the distribution of health care derives from the special importance of health care in promoting personal well-being by preventing or relieving pain, suffering, and disability and by avoiding loss of life. The fundamental importance of the latter is obvious; pain and suffering are also experiences that people have strong desires to avoid, both because of the intrinsic quality of the experience and because of their effects on the capacity to pursue and achieve other goals and purposes. Similarly, untreated disability can prevent people from leading rewarding and fully active lives.

Health, insofar as it is the absence of pain, suffering, or serious disability, is what has been called a primary good, that is, there is no need to know what a particular person's other ends, preferences, and values are in order to know that health is good for that individual. It generally helps people carry out their life plans, whatever they may happen to be. This is not to say that everyone defines good health in the same way or assigns the same weight or importance to different aspects of being healthy, or to health in comparison with the other goods of life. Yet though people may differ over each of these matters, their disagreement takes place within a framework of basic agreement on the importance of health. Likewise, people differ in their beliefs about the value of health and medical care and their use of it as a means of achieving good health, as well as in their attitudes toward the various benefits and risks of different treatments.

Opportunity. Health care can also broaden a person's range of opportunities, that is, the array of life plans that is reasonable to pursue within the conditions obtaining in society.¹⁰ In the United States equality of opportunity is a widely accepted value that is reflected throughout public

¹⁰ Norman Daniels, *Health Care Needs and Distributive Justice*, 10 PHIL. & PUB. AFF. 146 (1981).

policy. The effects that meeting (or failing to meet) people's health needs have on the distribution of opportunity in a society become apparent if diseases are thought of as adverse departures from a normal level of functioning. In this view, health care is that which people need to maintain or restore normal functioning or to compensate for inability to function normally. Health is thus comparable in importance to education in determining the opportunities available to people to pursue different life plans.

Information. The special importance of health care stems in part from its ability to relieve worry and to enable patients to adjust to their situation by supplying reliable information about their health. Most people do not understand the true nature of a health problem when it first develops. Health professionals can then perform the worthwhile function of informing people about their conditions and about the expected prognoses with or without various treatments. Though information sometimes creates concern, often it reassures patients either by ruling out a feared disease or by revealing the self-limiting nature of a condition and, thus, the lack of need for further treatment. Although health care in many situations may thus not be necessary for good physical health, a great deal of relief from unnecessary concern and even avoidance of pointless or potentially harmful steps is achieved by health care in the form of expert information provided to worried patients. Even when a prognosis is unfavorable and health professionals have little treatment to offer, accurate information can help patients plan how to cope with their situation.

The Interpersonal Significance of Illness, Birth, and Death. It is no accident that religious organizations have played a major role in the care of the sick and dying and in the process of birth. Since all human beings are vulnerable to disease and all die, health care has a special interpersonal significance: it expresses and nurtures bonds of empathy and compassion. The depth of a society's concern about health care can be seen as a measure of its sense of solidarity in the face of suffering and death. Moreover, health care takes on special meaning because of its role in the beginning of a human being's life as well as the end. In spite of all the advances in the scientific understanding of birth, disease, and death, these profound and universal experiences remain shared mysteries that touch the spiritual side of human nature. For these reasons a society's commitment to health care reflects some of its most basic attitudes about what it is to be a member of the human community.

The Concept of Equitable Access to Health Care

The special nature of health care helps to explain why it ought to be accessible, in a fair fashion, to all.¹¹ But if this ethical conclusion is to provide a basis for evaluating current patterns of access to health care and proposed health policies, the meaning of fairness or equity in this context must be clarified. The concept of equitable access needs definition in its two main aspects: the level of care that ought to be available to all and the extent to which burdens can be imposed on those who obtain these services.

Access to What? “Equitable access” could be interpreted in a number of ways: equality of access, access to whatever an individual needs or would benefit from, or access to an adequate level of care.

Equity as equality. It has been suggested that equity is achieved either when everyone is assured of receiving an equal quantity of health care dollars or when people enjoy equal health. The most common characterization of equity as equality, however, is as providing everyone with the same level of health care. In this view, it follows that if a given level of care is available to one individual it must be available to all. If the initial standard is set high, by reference to the highest level of care presently received, an enormous drain would result on the resources needed to provide other goods. Alternatively, if the standard is set low in order to avoid an excessive use of resources, some beneficial services would have to be withheld from people who wished to purchase them. In other words, no one would be allowed access to more services or services of higher quality than those available to everyone else, even if he or she were willing to pay for those services from his or her personal resources.

As long as significant inequalities in income and wealth persist, inequalities in the use of health care can be expected beyond those created by differences in need. Given people with the same pattern of preferences and equal health care needs, those with greater financial resources will purchase more health care. Conversely, given equal financial resources, the different patterns of health care preferences that typically exist in any population will result in a different use of health services by people with equal health care needs. Trying to prevent such inequalities would require interfering with people’s liberty to use their income to purchase an important good like health care while leaving them free to use it for frivolous or inessential ends. Prohibiting people with higher incomes or stronger preferences for health care from purchasing more care

¹¹ For a discussion of other important factors, the uneven distribution of need, and its largely underserved nature, see pp. 23-25 *infra*.

than everyone else gets would not be feasible, and would probably result in a black market for health care.

Equity as access solely according to benefit or need. Interpreting equitable access to mean that everyone must receive all health care that is of any benefit to them also has unacceptable implications. Unless health is the only good or resources are unlimited, it would be irrational for a society—as for an individual—to make a commitment to provide whatever health care might be beneficial regardless of cost. Although health care is of special importance, it is surely not all that is important to people. Pushed to an extreme, this criterion might swallow up all of society’s resources, since there is virtually no end to the funds that could be devoted to possibly beneficial care for diseases and disabilities and to their prevention.

Equitable access to health care must take into account not only the benefits of care but also the cost in comparison with other goods and services to which those resources might be allocated. Society will reasonably devote some resources to health care but reserve most resources for other goals. This, in turn, will mean that some health services (even of a lifesaving sort) will not be developed or employed because they would produce too few benefits in relation to their costs and to the other ways the resources for them might be used.

It might be argued that the notion of “need” provides a way to limit access to only that care that confers especially important benefits. In this view, equity as access according to need would place less severe demands on social resources than equity according to benefit would. There are, however, difficulties with the notion of need in this context. On the one hand, medical need is often not narrowly defined but refers to any condition for which medical treatment might be effective. Thus, “equity as access according to need” collapses into “access according to whatever is of benefit.”

On the other hand, “need” could be even more expansive in scope than “benefit.” Philosophical and economic writings do not provide any clear distinction between “needs” and “wants” or “preferences.” Since the term means different things to different people, “access according to need” could become “access to any health service a person wants.” Conversely, need could be interpreted very narrowly to encompass only a very minimal level of services—for example, those “necessary to prevent death.”¹²

¹² The Federal government employed this criterion in the mid-1970s when it dropped requirements providing dental care for adult public program beneficiaries under Medicaid. It claimed that dental services were not services whose absence could be considered as “life-threatening.”

Equity as an adequate level of health care. Although neither “everything needed” nor “everything beneficial” nor “everything that anyone else is getting” are defensible ways of understanding equitable access, the special nature of health care dictates that everyone have access to *some* level of care: enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life. That level can be termed “an adequate level of health care.” The difficulty of sharpening this amorphous notion into a workable foundation for health policy is a major problem in the United States today. This concept is not new; it is implicit in the public debate over health policy and has manifested itself in the history of public policy in this country. In this chapter, the Commission attempts to demonstrate the value of the concept, to clarify its content, and to apply it to the problems facing health policymakers.

Understanding equitable access to health care to mean that everyone should be able to secure an adequate level of care has several strengths. Because an adequate level of care may be less than “all beneficial care” and because it does not require that all needs be satisfied, it acknowledges the need for setting priorities within health care and signals a clear recognition that society’s resources are limited and that there are other goods besides health. Thus, interpreting equity as access to adequate care does not generate an open-ended obligation. One of the chief dangers of interpretations of equity that require virtually unlimited resources for health care is that they encourage the view that equitable access is an impossible ideal. Defining equity as an adequate level of care for all avoids an impossible commitment of resources without falling into the opposite error of abandoning the enterprise of seeking to ensure that health care is in fact available for everyone.

In addition, since providing an adequate level of care is a limited moral requirement, this definition also avoids the unacceptable restriction on individual liberty entailed by the view that equity requires equality. Provided that an adequate level is available to all, those who prefer to use their resources to obtain care that exceeds that level do not offend any ethical principle in doing so. Finally, the concept of adequacy, as the Commission understands it, is society-relative. The content of adequate care will depend upon the overall resources available in a given society, and can take into account a consensus of expectations about what is adequate in a particular society at a particular time in its historical development. This permits the definition of adequacy to be altered as societal resources and expectations change.¹³

¹³ There are practical as well as ethical reasons for a nation like the United States, which possesses resources to provide a high level of services, not to take a narrow view of “adequacy.” A lesser level of

With What Burdens? It is not enough to focus on the care that individuals receive; attention must be paid to the burdens they must bear in order to obtain it—waiting and travel time, the cost and availability of transport, the financial cost of the care itself. Equity requires not only that adequate care be available to all, but also that these burdens not be excessive.

If individuals must travel unreasonably long distances, wait for unreasonably long hours, or spend most of their financial resources to obtain care, some will be deterred from obtaining adequate care, with adverse effects on their health and well-being. Others may bear the burdens, but only at the expense of their ability to meet other important needs. If one of the main reasons for providing adequate care is that health care increases welfare and opportunity, then a system that required large numbers of individuals to forego food, shelter, or educational advancement in order to obtain care would be self-defeating and irrational.

The concept of acceptable burdens in obtaining care, as opposed to excessive ones, parallels in some respects the concept of adequacy. Just as equity does not require equal access, neither must the burdens of obtaining adequate care be equal for all persons. What is crucial is that the variations in burdens fall within an acceptable range. As in determining an adequate level of care, there is no simple formula for ascertaining when the burdens of obtaining care fall within such a range. Yet some guidelines can be formulated. To illustrate, since a given financial outlay represents a greater sacrifice to a poor person than to a rich person, “excessive” must be understood in relation to income. Obviously everyone cannot live the same distance from a health care facility, and some individuals choose to locate in remote and sparsely populated areas. Concern about an inequitable burden would be appropriate, however, when identifiable groups must travel a great distance or long time to receive care—though people may appropriately be expected to travel farther to get specialized care, for example, than to obtain primary or emergency care.

Although differences in the burdens individuals must bear to obtain care do not necessarily represent inequities, they may trigger concern for two reasons. Such discrepancies may

care would make it extremely difficult to establish a desirable mix of services; narrow limits would foster intense competition among different types of care and possibly skew the adequate level toward life-threatening care to the exclusion of other very beneficial forms of care such as preventive medicine. An inadequate level, accompanied by a private market in alternative treatments, would generate inequities by encouraging the flight of resources (as is now the case with physicians who choose to serve privately insured patients to the exclusion of noninsured and publicly insured individuals).



indicate that some people are, in fact, bearing excessive burdens, just as some differences in the use of care may indicate that some lack adequate care. Also, certain patterns of differences in the burdens of obtaining care across groups may indicate racial or ethnic discrimination.

Whether any such discrepancies actually constitute an inequitable distribution of burdens ultimately depends upon the role these differences play in the larger system under which the overall burdens of providing an adequate level of care are distributed among the citizens of this country. It may be permissible, for example, for some individuals to bear greater burdens in the form of out-of-pocket expenses for care if this is offset by a lower bill for taxes devoted to health care. Whether such differences in the distribution of burdens are acceptable cannot be determined by looking at a particular burden in isolation.

A Societal Obligation

Society has a moral obligation to ensure that everyone has access to adequate care without being subject to excessive burdens. In speaking of a societal obligation the Commission makes reference to society in the broadest sense—the collective American community. The community is made up of individuals, who are in turn members of many other, overlapping groups, both public and private, local, state, regional, and national units; professional and workplace organizations; religious, educational, and charitable organizations; and family, kinship, and ethnic groups. All these entities play a role in discharging societal obligations.

The Commission believes it is important to distinguish between society, in this inclusive sense, and government as one institution among others in society. Thus the recognition of a collective or societal obligation does not imply that government should be the only or even the primary institution involved in the complex enterprise of making health care

available. It is the Commission's view that the societal obligation to ensure equitable access for everyone may best be fulfilled in this country by a pluralistic approach that relies upon the coordinated contributions of actions by both the private and public sectors.

Securing equitable access is a societal rather than a merely private or individual responsibility for several reasons. First, while health is of special importance for human beings, health care—especially scientific health care—is a social product requiring the skills and efforts of many individuals; it is not something that individuals can provide for themselves solely through their own efforts. Second, because the need for health care is both unevenly distributed among persons and highly unpredictable and because the cost of securing care may be great, few individuals could secure adequate care without relying on some social mechanism for sharing the costs. Third, if persons generally deserved their health conditions or if the need for health care were fully within the individual's control, the fact that some lack adequate care would not be viewed as an inequity. But differences in health status, and hence differences in health care needs, are largely undeserved because they are, for the most part, not within the individual's control.

Uneven and Unpredictable Health Needs. While requirements for other basic necessities, such as adequate food and shelter, vary among people within a relatively limited range, the need for health care is distributed very unevenly and its occurrence at any particular time is highly unpredictable. One study shows 50% of all hospital billings are for only 13% of the patients, the seriously chronically ill.¹⁴

Moreover, health care needs may be minor or overwhelming, in their personal as well as financial impact. Some people go through their entire lives seldom requiring health care, while others face medical expenses that would exceed the resources of all but the wealthiest. Moreover, because the need for care cannot be predicted, it is difficult to provide for it by personal savings from income. Under the major program that pays for care for the elderly, 40% of aged enrollees had no payments at all in 1977 and 37% fell into a low payment group (averaging only \$129 per year), while 8.8% averaged \$7011 in annual expenditures.¹⁵

Responsibility for Differences in Health Status. Were someone responsible for (and hence deserving of) his or her need for health care, then access to the necessary health care

¹⁴ C.J. Zook and F.D. Moore, *High-Cost Users of Medical Care*, 302 NEW ENG. J. MED. 996 (1982).

¹⁵ Karen Davis, *Medicare Reconsidered*, Duke University Medical Center Private Sector Conference, Durham, N.C., March 15-16, 1982.

might be viewed as merely an individual concern. But the differences among people's needs for health care are for the most part not within their control, and thus are not something for which they should be held accountable. Different needs for care are largely a matter of good or bad fortune—that is, a consequence of a natural and social lottery that no one chooses to play.

In a very real sense, people pay for the consequences of the actions that cause them illness or disability—through the suffering and loss of opportunity they experience. The issue here is a narrower one: to what extent is the societal responsibility to secure health care for the sick and injured limited by personal responsibility for the need for health care? It seems reasonable for people to bear the foreseeable consequences (in terms of health care needs) of their informed and voluntary choices. Indeed, as an ethical matter, the principle of self-determination implies as a corollary the responsibility of individuals for their choices.

However, to apply the notion of personal responsibility in a fair way in setting health care policy would be a complex and perhaps impossible task. First, identifying those people whose informed, voluntary choices have caused them foreseeable harm would be practically as well as theoretically very difficult. It is often not possible to determine the degree to which an individual's behavior is fully informed regarding the health consequences of the behavior. Efforts to educate the public about the effects of life-style on health status are desirable, but it must also be acknowledged that today people who conscientiously strive to adopt a healthy life-style find themselves inundated with an enormous amount of sometimes contradictory information about what is healthful. Voluntariness is also especially problematic regarding certain behaviors that cause some people ill health, such as smoking and alcohol abuse.¹⁶ Moreover, there are great difficulties in determining the extent of the causal role of particular behavior on an individual's health status. For many behaviors, consequences appear only over long periods of time, during which many other elements besides the particular behavior have entered into the causal process that produces a disease or disability. For example, the largely unknown role of genetic predispositions for many diseases makes it difficult to designate particular behaviors as their "cause."

Second, even if one knew who should be held responsible for what aspects of their own ill health, policies aimed at institutionalizing financial accountability for "unhealthy behavior" or at denying the necessary health care for those who

¹⁶ Daniel Wikler, *Persuasion and Coercion for Health*, 56 MILBANK MEMORIAL FUND Q./HEALTH & SOCIETY 303 (1978).

have “misbehaved” are likely to involve significant injustices and other undesirable consequences. Leaving people free to engage in health-risky behavior only if they can afford to pay for its consequences is fair only if the existing patterns of income distribution are fair, and if the payment required fully accounts for all the costs to society of the ill health and its treatment. Moreover, since some unhealthy behavior can be monitored more easily than others, problems of discrimination would inevitably arise; even when feasible, monitoring such behavior would raise serious concerns about the invasion of privacy. Finally, the ultimate sanction—turning away from the hospital door people who are responsible for their own ill health—would reverberate in unwanted and perhaps very harmful ways in the community at large. The Commission concludes that within programs to secure equitable access to health care, serious practical and ethical difficulties would follow attempts to single out the consequences of behavior and to make individuals of health-risky behavior solely responsible for those consequences.

However, even if it is inappropriate to hold people responsible for their health status, it is appropriate to hold them responsible for a fair share of the cost of their own health care. Society’s moral obligation to provide equitable access for all and the individual responsibility for bearing a share of the costs of achieving equity rest on the same considerations of fairness. Individuals who—because they know that others will come to their aid—fail to take reasonable steps to provide for their own health care when they could do so without excessive burdens would be guilty of exploiting the generosity of their fellow citizens. The societal obligation is therefore balanced by corresponding individual obligations.

In light of the special importance of health care, the largely undeserved character of differences in health status, and the uneven distribution and unpredictability of health care needs, society has a moral obligation to ensure adequate care for all. Saying that the obligation is societal (rather than merely individual) stops short, however, of identifying who has the ultimate responsibility for ensuring that the obligation is successfully met.

Who Should Ensure that Society’s Obligation is Met?

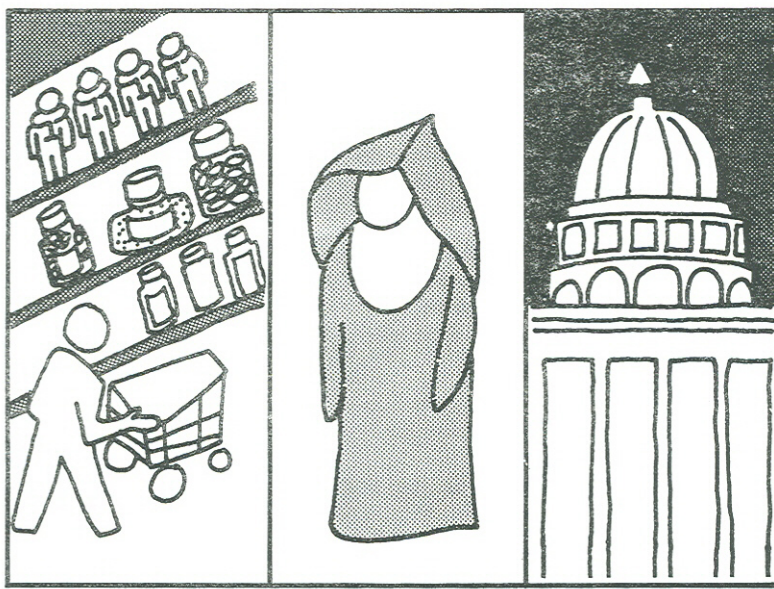
In this country, the chief mechanism by which the cost of health care is spread among individuals is through the purchase of insurance. Another method of distributing health care costs is to rely on acts of charity in which individuals, such as relatives and care givers, and institutions assume responsibility for absorbing some or all of a person’s health care expenses. These private forces cannot be expected to achieve equitable

access for all, however, States and localities have also played important roles in attempting to secure health care for those in need. To the extent that actions of the market, private charity, and lower levels of government are insufficient in achieving equity, the responsibility rests with Federal government. The actual provision of care may be through arrangements in the private sector as well as through public institutions, such as local hospitals.

Market Mechanisms in Health Care. One means societies employ for meeting needs for goods and services that individuals cannot produce by themselves is the complex legal and economic mechanism known as a market. When health care is distributed through markets, however, an acceptable distribution is not achieved; indeed, given limitations in the way markets work, this result is practically inevitable.

The inability to ensure adequate care. First, many people lack the financial resources to obtain access to adequate care. Since American society encompasses a very wide range in income and wealth, distributing goods and services through markets leads to large differences in their consumption. The variations in need for health care do not, however, match variations in ability to purchase care. The market response to variable risk is insurance. Insurance has long existed for certain calamities—such as fire damage to property—and in the past 30 years, a huge market in health insurance has developed that enables people to share some of the financial risk of ill health. The relevant question for determining equity of access thus becomes: Is everyone able to afford access to adequate care through some combination of insurance and direct payment?

Admittedly, “ability to afford” is an ambiguous concept, given different attitudes toward risk and the importance of health care, and, even more important, possibly insufficient information about the likelihood of ill health and about the possible effects of care. For example, people may want an adequate level of care and may be able to afford to pay for it, but they may lack information about the amount of coverage needed to secure adequate care. As a result, the insurance market may not do a good job of providing plans that actually do protect people adequately. And, of course, some people who can afford to pay for their health care (and who would if they knew they would have to go without it otherwise) fail to make sufficient provisions because they rely on others not being willing to let them suffer. Furthermore, the cost of basic health insurance (which does not even guarantee financial access to adequate care in all cases) is high enough to place it beyond



the reach of many families by *any* reasonable standard of affordability.¹⁷ Ironically, those who need the most care will find it most difficult to obtain it, both because their disease or disability impairs their opportunities for accumulating financial resources and because insurers will charge them higher rates.

Second, many people will be unable to obtain adequate care if the distribution of care is left exclusively to the market because services are not available in the areas in which they live. These geographical availability problems are often really financial problems: in certain areas with a high proportion of poor people, there are not enough personnel and facilities because the residents cannot afford to pay to use them. Even when people do have the ability to pay, however, they may be unable to obtain services. The area may be too sparsely populated to provide enough demand to support a practitioner or a facility; or even though the demand is sufficient, providers may not respond. In health care, decisions are often made by nonprofit institutions, whose decisions may not be keyed to market forces, or by health care professionals, who are influenced by factors other than financial incentives. Such decisions can leave some areas inadequately served. Thus in a market system, people will not necessarily obtain adequate care, and lack of access to such care will be correlated with income and place of residence.

¹⁷For a detailed discussion of insurance costs, see pp. 90-100 *infra*.

While some people lack access to very essential care, many will receive not just an adequate level, but more than they themselves would want to have if they were well informed about the benefits of care and took its full cost into account. In deciding whether a service is worth having, an insured individual will tend to consider only what he or she must pay out-of-pocket, rather than the total costs. In the long run, additional use raises premiums, but the extra cost is spread over all policyholders, a situation known as the phenomenon of moral hazard.¹⁸ These incentives mean that policyholders pay higher total costs for health care than they would choose to pay if they had to weigh its full costs to themselves against the benefits they receive.

The patient's lack of information and consequent reliance on professional advice for many of his or her health care decisions may make this problem more serious, depending on what practitioners consider to be their professional duty. Most believe that it is their duty to do all they can for their patients. Even uninsured patients may find it difficult to convey their preferences about trade-offs between financial costs and the benefits of care to providers who believe strongly in the value of medical care. It follows that merely giving people money (to pay their medical bills directly or to buy insurance) to assure them access to adequate care may be a very expensive proposition.

To summarize, if the distribution of health care were left solely to the market, some people would not get an adequate amount and others would get too much—not just more than an adequate level but more than they themselves really want given the costs they bear directly and through insurance premiums. The first is an ethical issue; the second, though not a moral problem, makes the solution of the first more difficult.

The inequities in costs and burdens. In the absence of insurance, a market puts the cost of goods and services on those who consume them. Normally this seems appropriate; the person who wants to see a movie or to buy an automobile must pay for it. In the case of health care, this is not so appealing: the person who suffers the largely undeserved burden of ill health also suffers the financial burdens of obtaining and paying for health care. Those who lack financial resources may suffer severely.

Private insurance markets only spread the financial risk to a limited extent. Whenever they can, insurance companies will

¹⁸ The classic illustration of this arises when some people dine out and agree in advance to split the check evenly. Each person has an incentive to order more expensively than that individual would if he or she were paying only for their own meal. Yet in the end each individual, as a member of the group, actually bears the cost of the collective “over-ordering.”

set premiums in accord with a person's risk of experiencing ill health. At the outer limit, certain people (for example, those with preexisting disabilities) may find it nearly impossible to obtain insurance at any price—or at least to get insurance that will encompass care for their disabilities.

The private market does not adjust the financial burden of care to differences in income. Yet poverty and ill health are correlated—with the causal factors working in both directions. Therefore, the poor are in a double bind: they need more medical care but they have less money to purchase it or less insurance protection to secure it.

The market determines a geographical distribution of care that reflects providers' preferences (about where they want to live for example), the differential cost of providing services in different places, and the distribution of ill health and ability to pay. Even when it works efficiently—when the geographical distribution of services reflects the real costs of geographical location—it may result in heavy burdens on some individuals in time and cost to get to care. And, as already discussed, the process may not work efficiently, and can produce arbitrarily great differences in the burdens of obtaining care in different geographical settings. For example, in a sparsely populated state, some residents might have to travel long distances for hospital care because it is uneconomic to build a larger number of smaller hospitals and spread them evenly throughout the state. Or a state may have a small number of large hospitals because the philanthropists and hospital administrators who make the investment decisions prefer large hospitals for prestige reasons, and the market forces that would normally counteract such preferences are too weak to do so.

Private Charity as a Source of Care. There is a strong tradition of private charity in the United States, including free services by health professionals, and charitable organizations continue to play an important role in health care research and delivery. Yet, as discussed in Chapter Two, charitable efforts have not achieved equity of access.

The most obvious explanation of the inadequacy of charity is the countervailing pressure of self-interest. Especially in an acquisitive society, even the best of intentions to aid others may fall short of action. It is not necessary, however, to assume that Americans are unduly self-interested to understand why charity alone has not provided everyone with an adequate level of health care. There are two other explanations, neither of which presupposes selfishness. The first is the pervasiveness of what has been called "limited altruism." The difficulty is not that individuals are only concerned about their own interests, but rather that the focus of their concern tends to be limited to those who are near at hand, such as family and friends.

The second, less obvious factor is that effective charitable action, particularly in an area such as health care where large-scale capital investment is required, needs the coordinated efforts of many people. Unless potential contributors can be assured that a sufficient number of other people will also contribute to some appropriately identified goal, they may conclude either that they should not contribute at all or that their resources would be better used in some private act of charity, even though this will not be as effective as a coordinated action. In this sense, charity—like national defense or energy conservation—has the characteristic features of a public good in the technical sense. In general, the problems of supplying public goods illustrate the limits of private voluntary action and often provide a legitimate reason for government action.¹⁹ Furthermore, it has often been noted that while the charitable impulses are laudable, recipients sometimes feel demeaned by their dependence on the benevolence of others. (This unfortunate feature, which is affected by the manner and setting in which aid is rendered, can be a problem not only for private but also for governmental programs, as discussed in the next section.)

A Role for Government. The extent of governmental involvement in securing equitable access to care depends on the extent to which the market and private charity achieve this objective. The limitations that have just been enumerated are not absolute barriers. Although it is clear that—even for those with adequate resources—the purchase of health care differs from other market transactions, the market (which includes private health insurance) is capable of providing many people with an adequate level of health care. However, when the market and charity do not enable individuals to obtain adequate care or cause them to endure excessive burdens in doing so, then the responsibility to ensure that these people have equitable access to health care resides with the local, state, and Federal governments.

Locating responsibility. Although it is appropriate that all levels of government be involved in seeing that equitable access to health care is achieved, the ultimate responsibility for ensuring that this obligation is met rests with the Federal government. The Commission believes it is extremely important to distinguish between the view that the Federal government ought to provide care and the view that the Federal government is ultimately responsible for seeing that there is equitable access to care. It is the latter view that the Commission endorses. It is not the purpose of this Report to

¹⁹ Allen Buchanan, *Philosophical Foundations of Beneficence*, in Earl E. Shelp, ed., *BENEVICENCE AND HEALTH CARE*, Reidel Publishing Co., Dordrecht, Holland (1982) at 33.

assign the precise division of labor between public and private provision of health care. Rather, the Commission has attempted here only to locate the ultimate responsibility for ensuring that equitable access is attained.

A view that has gained wide acceptance in this country is that the government has a major responsibility for making sure that certain basic social goods, such as health care and economic security for the elderly, are available to all. Over the past half-century, public policy and public opinion have increasingly reflected the belief that the Federal government is the logical mechanism for ensuring that society's obligation to make these goods available is met. In the case of health care, this stance is supported by several considerations. First, the obligation in question is society-wide, not limited to particular states or localities; it is an obligation of all to achieve equity for all. Second, government responsibility at the national level is needed to secure reliable resources. Third, only the Federal government can ultimately guarantee that the burdens of providing resources are distributed fairly across the whole of society. Fourth, meeting society's obligation to provide equitable access requires an "overview" of efforts. Unless the ultimate responsibility has been clearly fixed for determining whether the standard of equitable access is being met, there is no reason to believe it will be achieved.

The limitations of relying upon the government. Although the Commission recognizes the necessity of government involvement in ensuring equity of access, it believes that such activity must be carefully crafted and implemented in order to achieve its intended purpose. Public concern about the inability of the market and of private charity to secure access to health care for all has led to extensive government involvement in the financing and delivery of health care. This involvement has come about largely as a result of ad hoc responses to specific problems; the result has been a patchwork of public initiatives at the local, state, and Federal level. These efforts have done much to make health care more widely available to all citizens, but, as discussed in Chapters Two and Three, they have not achieved equity of access.

To a large extent, this is the result of a lack of consensus about the nature of the goal and the proper role of government in pursuing it. But to some degree, it may also be the product of the nature of government activity. In some instances, government programs (of all types, not just health-related) have not been designed well enough to achieve the purposes intended or have been subverted to serve purposes explicitly not intended.

In the case of health care, it is extremely difficult to devise public strategies that, on the one hand, do not encourage the misuse of health services and, on the other hand, are not so restrictive as to unnecessarily or arbitrarily limit available

care. There is a growing concern, for example, that government assistance in the form of tax exemptions for the purchase of employment-related health insurance has led to the overuse of many services of only very marginal benefit. Similarly, government programs that pay for health care directly (such as Medicaid) have been subject to fraud and abuse by both beneficiaries and providers. Alternatively, efforts to avoid misuse and abuse have at times caused local, state, and Federal programs to suffer from excessive bureaucracy, red tape, inflexibility, and unreasonable interference in individual choice. Also, as with private charity, government programs have not always avoided the unfortunate effects on the human spirit of “discretionary benevolence,” especially in those programs requiring income or means tests.

It is also possible that as the government role in health care increases, the private sector’s role will decrease in unforeseen and undesired ways.²⁰ For example, government efforts to ensure access to nursing home care might lead to a lessening of support from family, friends, and other private sources for people who could be cared for in their homes. Although these kinds of problems do not inevitably accompany governmental involvement, they do occur and their presence provides evidence of the need for thoughtful and careful structuring of any government enterprise.

A Right to Health Care? Often the issue of equitable access to health care is framed in the language of rights. Some who view health care from the perspective of distributive justice argue that the considerations discussed in this chapter show not only that society has a moral obligation to provide equitable access, but also that every individual has a moral right to such access. The Commission has chosen not to develop the case for achieving equitable access through the assertion of a right to health care. Instead it has sought to frame the issues in terms of the special nature of health care and of society’s moral obligation to achieve equity, without taking a position on whether the term “obligation” should be read as entailing a moral right. The Commission reaches this conclusion for several reasons: first, such a right is not legally or Constitutionally recognized at the present time; second, it is not a logical corollary of an ethical obligation of the type the Commission has enunciated; and third, it is not necessary as a

²⁰ Similarly, sometimes governmental decisions decrease the private sector’s role in foreseeable ways. For example, the advent of Medicare was accompanied by a sharp alteration in the types and amount of private health insurance available to persons over 65 years of age. In 1965, 57% of this age-group had some form of private insurance. At present, 57% have private insurance but the current policies are designed to fill in the gaps in Medicare coverage and not to cover basic costs.

foundation for appropriate governmental actions to secure adequate health care for all.

Legal rights. Neither the Supreme Court nor any appellate court has found a constitutional right to health or to health care.²¹ However, most Federal statutes and many state statutes that fund or regulate health care have been interpreted to provide statutory rights in the form of entitlements for the intended beneficiaries of the program or for members of the group protected by the regulatory authority. As a consequence, a host of legal decisions have developed significant legal protections for program beneficiaries. These protections have prevented Federal and state agencies and private providers from withholding authorized benefits and services. They have required agencies and providers to deliver health care to eligible individuals—the poor, elderly, handicapped, children, and others.²²

In addition, Federal statutes protecting the civil rights of all citizens and the constitutional provisions on equal protection and due process have been interpreted to apply both to governmental agencies and to private health care providers in certain circumstances. Decisions affecting beneficiaries and providers must be made through orderly and fair processes, and there can be no discrimination based on race, sex, handicap, or age in the allocation of resources and operation of the health care programs.²³ A recent study by the Institute of Medicine presents evidence showing the continuing existence

21 See *Harris v. McRae*, 448 U.S. 297, 318 (1980) (publicly funded abortions); *Maher v. Roe*, 432 U.S. 464, 469 (medical treatment).

22 The majority of the litigation has focused on the Medicare and Medicaid programs. One line of cases concerns questions of eligibility, such as *Schweiker v. Gray Panthers*, 453 U.S. 1 (1981) (“deeming” resources as available to the beneficiary for purposes of determining eligibility). Another line concerns limitations in services, such as *White v. Beal*, 413 F.Supp. 1141, *aff’d* 555 F.2d 1146 (3rd Cir. 1977) (impermissibly reducing Medicaid services by identifying mandatory services as optional). Still another line concerns the procedures that states are required to follow in administering the programs, such as *Elder v. Beal*, 609 F.2d 695 (3rd Cir. 1979) (requiring the state to notify beneficiaries adequately of reduction in services).

23 The courts have differed, however, in their determinations of what constitutes prohibited discrimination. Thus, *Cook v. Ochsner*, 61 F.R.D. 354 (E.D. La. 1972), holds that HEW was obligated to require private hospitals, funded partly by Federal Hill-Burton funds, to accept Medicaid patients, regardless of conflicting hospital policies. The court in *NAACP v. Wilmington Medical Center*, 453 F.2d 1247 (3rd Cir. 1979), found that the plaintiffs had not proved discrimination, but also held that an inner-city hospital receiving Medicaid reimbursement could relocate its services to the suburbs only if it demonstrated that no alternatives existed that would produce less of a discriminatory impact on the hospital’s minority, aged, and handicapped inner-city patients.

of distinctive, separate, or segregated patterns in the sources of care and the amount of care received. These patterns were found to be influenced by such factors as patient income, source of payment for care, geographic location, race, and ethnicity.²⁴

Moral obligations and rights. The relationship between the concept of a moral right and that of a moral obligation is complex. To say that a person has a moral right to something is always to say that it is that person's due, that is, he or she is morally entitled to it. In contrast, the term "obligation" is used in two different senses. All moral rights imply corresponding obligations, but, depending on the sense of the term that is being used, moral obligations may or may not imply corresponding rights. In the broad sense, to say that society has a moral obligation to do something is to say that it ought morally to do that thing and that failure to do it makes society liable to serious moral criticism. This does not, however, mean that there is a corresponding right. For example, a person may have a moral obligation to help those in need, even though the needy cannot, strictly speaking, demand that person's aid as something they are due.

The government's responsibility for seeing that the obligation to achieve equity is met is independent of the existence of a corresponding moral right to health care. There are many forms of government involvement, such as enforcement of traffic rules or taxation to support national defense, to protect the environment, or to promote biomedical research, that do not presuppose corresponding moral rights but that are nonetheless legitimate and almost universally recognized as such. In a democracy, at least, the people may assign to government the responsibility for seeing that important collective obligations are met, provided that doing so does not violate important moral rights.²⁵

As long as the debate over the ethical assessment of patterns of access to health care is carried on simply by the assertion and refutation of a "right to health care," the debate will be incapable of guiding policy. At the very least, the nature of the right must be made clear and competing accounts of it compared and evaluated. Moreover, if claims of rights are to guide policy they must be supported by sound ethical reason-

24 Institute of Medicine, *HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS*, National Academy of Sciences, Washington (1981).

25 Where a basic right is concerned, such as the right to free speech, even an increase in social welfare is not a sufficient reason for stifling the exercise of that right. However, both the legal system and sound ethical tradition recognize that people have no absolute moral or legal right to use their property as they see fit. This right is limited by government's authority to tax, so long as the requirements of due process are satisfied.

ing and the connections between various rights must be systematically developed, especially where rights are potentially in conflict with one another. At present, however, there is a great deal of dispute among competing theories of rights, with most theories being so abstract and inadequately developed that their implications for health care are not obvious. Rather than attempt to adjudicate among competing theories of rights, the Commission has chosen to concentrate on what it believes to be the more important part of the question: what is the nature of the societal obligation, which exists whether or not people can claim a corresponding right to health care, and how should this societal obligation be fulfilled?²⁶

Meeting the Societal Obligation

How Much Care is Enough? Before the concept of an adequate level of care can be used as a tool to evaluate patterns of access and efforts to improve equity, it must be fleshed out. Since there is no objective formula for doing this, reasonable people can disagree about whether particular patterns and policies meet the demands of adequacy. The Commission does not attempt to spell out in detail what adequate care should include. Rather it frames the terms in which those who discuss or critique health care issues can consider ethics as well as economics, medical science, and other dimensions.

Characteristics of adequacy. First, the Commission considers it clear that health care can only be judged adequate in relation to an individual's health condition. To begin with a list of techniques or procedures, for example, is not sensible: A CT scan for an accident victim with a serious head injury might be the best way to make a diagnosis essential for the appropriate treatment of that patient; a CT scan for a person with headaches might not be considered essential for adequate care. To focus only on the technique, therefore, rather than on the individual's health and the impact the procedure will have on that individual's welfare and opportunity, would lead to inappropriate policy.

Disagreement will arise about whether the care of some health conditions falls within the demands of adequacy. Most people will agree, however, that some conditions should not be

²⁶ Whether the issue of equity is framed in terms of individual rights or societal obligation, it is important to recall that society's moral imperative to achieve equitable access is not an unlimited commitment to provide whatever care, regardless of cost, individuals need or that would be of some benefit to them. Instead, society's obligation is to provide adequate care for everyone. Consequently, if there is a moral right that corresponds to this obligation, it is limited, not open-ended.

included in the societal obligation to ensure access to adequate care. A relatively uncontroversial example would be changing the shape of a functioning, normal nose or retarding the normal effects of aging (through cosmetic surgery). By the same token, there are some conditions, such as pregnancy, for which care would be regarded as an important component of adequacy. In determining adequacy, it is important to consider how people's welfare, opportunities, and requirements for information and interpersonal caring are affected by their health condition.

Any assessment of adequacy must consider also the types, amounts, and quality of care necessary to respond to each health condition. It is important to emphasize that these questions are implicitly comparative: the standard of adequacy for a condition must reflect the fact that resources used for it will not be available to respond to other conditions. Consequently, the level of care deemed adequate should reflect a reasoned judgment not only about the impact of the condition on the welfare and opportunity of the individual but also about the efficacy and the cost of the care itself in relation to other conditions and the efficacy and cost of the care that is available for them. Since individual cases differ so much, the health care professional and patient must be flexible. Thus adequacy, even in relation to a particular health condition, generally refers to a range of options.

The relationship of costs and benefits. The level of care that is available will be determined by the level of resources devoted to producing it. Such allocation should reflect the benefits and costs of the care provided. It should be emphasized that these "benefits," as well as their "costs," should be interpreted broadly, and not restricted only to effects easily quantifiable in monetary terms. Personal benefits include improvements in individuals' functioning and in their quality of life, and the reassurance from worry and the provision of information that are a product of health care. Broader social benefits should be included as well, such as strengthening the sense of community and the belief that no one in serious need of health care will be left without it. Similarly, costs are not merely the funds spent for a treatment but include other less tangible and quantifiable adverse consequences, such as diverting funds away from other socially desirable endeavors including education, welfare, and other social services.

There is no objectively correct value that these various costs and benefits have or that can be discovered by the tools of cost/benefit analysis. Still, such an analysis, as a recent report of the Office of Technology Assessment noted, "can be very helpful to decision makers because the process of analysis gives structure to the problem, allows an open consideration of

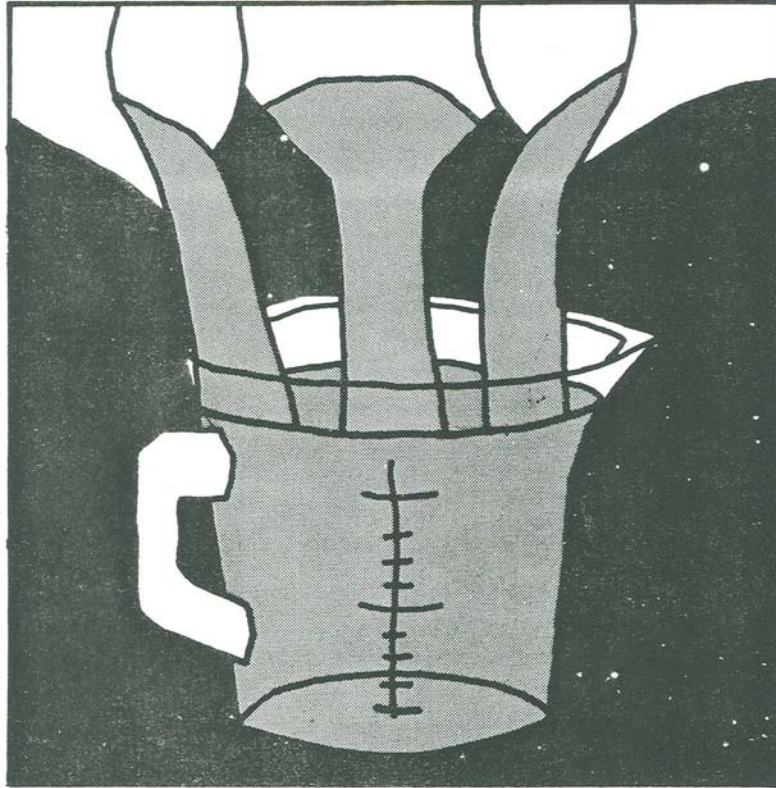
all relevant effects of a decision, and forces the explicit treatment of key assumptions.”²⁷ But the valuation of the various effects of alternative treatments for different conditions rests on people’s values and goals, about which individuals will reasonably disagree. In a democracy, the appropriate values to be assigned to the consequences of policies must ultimately be determined by people expressing their values through social and political processes as well as in the marketplace.

Approximating adequacy. The intention of the Commission is to provide a frame of reference for policymakers, not to resolve these complex questions. Nevertheless, it is possible to raise some of the specific issues that should be considered in determining what constitutes adequate care. It is important, for example, to gather accurate information about and compare the costs and effects, both favorable and unfavorable, of various treatment or management options. The options that better serve the goals that make health care of special importance should be assigned a higher value. As already noted, the assessment of costs must take two factors into account: the cost of a proposed option in relation to alternative forms of care that would achieve the same goal of enhancing the welfare and opportunities of the patient, and the cost of each proposed option in terms of foregone opportunities to apply the same resources to social goals other than that of ensuring equitable access.

Furthermore, a reasonable specification of adequate care must reflect an assessment of the relative importance of many different characteristics of a given form of care for a particular condition. Sometimes the problem is posed as: What *amounts* of care and what *quality* of care? Such a formulation reduces a complex problem to only two dimensions, implying that all care can readily be ranked as better or worse. Because two alternative forms of care may vary along a number of dimensions, there may be no consensus among reasonable and informed individuals about which form is of higher overall quality. It is worth bearing in mind that adequacy does not mean the highest possible level of quality or strictly equal quality any more than it requires equal amounts of care; of course, adequacy does require that everyone receive care that meets standards of sound medical practice.

Any combination of arrangements for achieving adequacy will presumably include some health care delivery settings that mainly serve certain groups, such as the poor or those covered by public programs. The fact that patients receive care in different settings or from different providers does not itself

²⁷ Office of Technology Assessment, U.S. Congress, THE IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS OF MEDICAL TECHNOLOGY, SUMMARY, U.S. Government Printing Office, Washington (1980) at 8.



show that some are receiving inadequate care. The Commission believes that there is no moral objection to such a system so long as all receive care that is adequate in amount and quality and all patients are treated with concern and respect.

At this point, the complexity of the problem of deciding what constitutes adequate care is apparent. However, clear and useful conclusions can emerge even when there is no agreement on the details of adequacy. In the case of pregnant women, for example, there is a consensus in the United States that some prenatal care, the attention of a trained health professional during labor and delivery, and some continuity between the two are all essential for an adequate level of care.

A stronger consensus is required if proposals for change are to be evaluated. Some of the processes that may be used to develop a societal consensus on adequacy are already a familiar feature of the health care system, and do in fact play a

role in determining the amount of care that is provided, especially to beneficiaries of public programs.²⁸

Professional judgment. Physicians and other professionals who provide health care are familiar with human needs for care, so that the first means that might be employed in defining an adequate level of health care would be a reliance on individual health care practitioners' judgment of the "medical necessity" of any particular service. However, sole reliance on professional judgment in setting limits is not appropriate because of professionals' tendency to provide all possible medically beneficial care. At the very least, the extent and manner in which professionals exercise judgment to limit the use of care that is of little benefit (relative to cost) varies widely. Thus, without substantial changes in individual health care professionals' present practices, this method of defining adequate health care is likely to result in an uncertain and overly inclusive definition.

Another way that professional judgment might be used to define adequacy is to rely on the standards of medical practice as adopted by the professional community through, for example, consensus conferences. The advantage of such an approach is the specialized knowledge of the effects of care that such people have. However, there are also serious disadvantages.

Professionals have no special expertise in deciding how the effects of medical care ought to be valued, either with respect to the relative value of different dimensions of care or, particularly, the value attached to health care relative to other goods. In the last two or three decades, for example, there have been major changes in prenatal and obstetrical care, in many cases in response to the preferences of parents: changes in the use of anesthesia; the kind of contact possible between mother, father, and infant in the hospital; the information provided to the family about the birth process; support for breast-feeding as opposed to formula-feeding. These changes were never shown to be harmful or uniformly beneficial, but rather represent differences in the valuing of benefits.²⁹

Professionals often have no special knowledge of the costs of different alternatives and perhaps little appreciation of the other goods foregone for the sake of health care. Studies show

28 For a discussion of determinations of the amount and type of care under public programs, see Chapter Three *infra*, although the processes now used would not necessarily have the same role in the determinations of adequacy recommended here.

29 In many cases there is now a medical consensus that the new practices are in fact superior. Nevertheless, strong pressure from consumers was required to bring some of them about.

that practitioners are frequently unaware of the financial costs of many of the tests and procedures that they order.³⁰

Finally, their involvement with the delivery of care may sometimes create a barrier to full consideration of all options. Many observers have noted a bias in health care in this country toward the introduction of expensive, high-technology-based procedures delivered by existing institutions and against the introduction of alternative ways to provide services at lower cost.³¹

Because of these factors, professional judgment cannot stand alone as the determinant of adequate care, but the specialized knowledge of health care professionals about the effects of health care is essential as part of any process of determining adequacy.

Average current use. The United States at present has a sophisticated health care system and there is reason to suppose that the average American obtains an adequate total amount of care. Defining adequacy in terms of the level of care presently enjoyed by the average person has the advantage of realism: it reflects the outcome of the health care system as it now operates—what actually happens as a result of patient-

³⁰“Indeed, there is ample evidence that medical students, interns, residents, and even medical faculty are equally uninformed about the prices of the tests and treatments they order.” Anthony L. Komaroff, *The Doctor, the Hospital, and the Definition of Proper Medical Practice* (1981), Appendix U, in Volume Three of this Report, at *Education*, in section five. Komaroff cites a number of studies as examples: S.P. Kelly, *Physicians’ Knowledge of Hospital Costs*, 6 J. FAM. PRAC. 171 (1978); S.J. Dresnick *et al.*, *The Physician’s Role in the Cost-Containment Problem*, 241 J.A.M.A 1606 (1979); J.K. Skipper *et al.*, *Medical Students’ Unfamiliarity with the Cost of Diagnostic Tests*, 50 J. MED. EDUC. 683 (1975); L.R. Kirkland, *The Physician and Cost Containment*, 242 J.A.M.A 1032 (1979).

³¹ Dean David Mechanic of Rutgers University gives the following example of this:

One of the most prevalent conditions among children is sore throats, and it is routine to take a throat culture before treatment to assess whether the cause is a streptococcal infection. Typically, the mother is required to bring the child to a pediatrician for the culture, often involving inconvenience and considerable expense. As an experiment at the Columbia Medical Plan has demonstrated, mothers can be effectively instructed to take a throat culture at home, negating the need for physician and nurse care in most instances and increasing the convenience and satisfaction of the mother. The barriers to individual responsibility *built in to* medical care must be reviewed carefully, and efforts should be made to modify them.

David Mechanic, *FUTURE ISSUES IN HEALTH CARE: SOCIAL POLICY AND THE RATIONING OF MEDICAL SERVICES*, The Free Press, New York (1979) at 37 (citation omitted).

provider interaction, not merely what planners believe ought to happen.

Nevertheless, there are good reasons to pause before adopting “current use” as the benchmark of adequacy. Many distortions in people’s true preferences for health care affect the average level of care received—for example, those whose access is now unduly limited bring down the average, while those who overspend for health care because of insurance and tax advantages (discussed in Chapter Three) inflate the average. Also, structural characteristics of the delivery system can mean that even people with good access do not necessarily receive an appropriate mix of services.

A possible variation of the concept of average use is to adopt as a point of reference the care received by people of average financial means who live in areas that are sufficiently provided with health care resources. This approach could incorporate a broader dimension of preferences, including an explicit consideration of the value of care relative to its cost. Unlike most approximations of adequacy this concept is more amenable to measurement. In fact, a modification of average use—people with similar health conditions receiving the same volume of care at a standard acceptable to middle-class Americans—is now employed by the Robert Wood Johnson Foundation in determining when adequacy is achieved.³²

Unfortunately, this approach also has its weaknesses. Again, in making choices about health care, patients may inappropriately evaluate those costs that are covered by insurance. Moreover, recognizing their lack of knowledge, patients generally rely heavily on their practitioner’s judgment, which as noted earlier may favor care that is disproportionately costly relative to its benefits. On the other hand, if a patient makes an independent choice it may be an uninformed one that rejects care that is actually of significant benefit relative to its cost. Thus, people of average means may lack some care that ought to be part of an adequate level while they receive some care that ought not to be included in it.

Nevertheless, this concept also has a role to play in determining adequacy. In particular, if some of the distorting factors could be lessened, the care sought by well-educated people of average means might be a reasonable benchmark, at least for the treatment of serious conditions.

List of services. Another alternative is to attempt to specify a list of services to be included within an adequate level of health care. An example is the list of “basic health services” in the Health Maintenance Organization (HMO) Act of 1973 (as amended), which includes physician services,

³² Testimony of Robert J. Blendon, transcript of 24th meeting of the President’s Commission (Sept. 10, 1982) at 21.

inpatient and outpatient hospital services, emergency health services, short-term outpatient mental health services (up to 20 visits), treatment and referral for drug and alcohol abuse, laboratory work and X-rays, home health services, and certain preventive health services.³³

The broad categories on this list might be broken down into more specific services. However, such a list of services is no more a specification of an adequate level of care than a list of foods is an adequate diet. What makes the HMO list into an “adequate level” specification is its combination with a delivery mechanism that relies on professional judgment to determine the appropriate amounts of services on a case-by-case basis, with organizational and financial incentives to weigh the benefits of services against cost. Other approximations in this same spirit include insurance contracts that incorporate reviews of the appropriateness of services received.

Overall evaluation. It would, of course, be possible to combine several approaches—by specifying categories of services that must be available as part of adequate care, for example, while placing limits on the overall use of services through a health insurance package valued at a specified amount. Another variation of this approach would involve an effort by the medical profession to redefine standards of practice to incorporate some assessments of the costs and benefits of acceptable alternative therapies. This might be achieved through medical education, consensus conferences, and other methods. Such determinations would, of course, take place within a process that allowed an interplay between the health care professions and political and other social factors.

The Commission cites these alternatives as examples of possible initial approaches to approximating an adequate level of health care that should be available to all Americans. There are both theoretical and practical differences between these approaches, yet each has something to offer, separately and together. For the purpose of health policy formulation, general theories as well as ordinary views of equity do not determine a unique solution to defining adequate care but rather set some broad limits within which that definition should fall. It is reasonable for a society to turn to fair, democratic political procedures to make a choice among just alternatives. Given the great imprecision in the notion of adequate health care, however, it is especially important that the procedures used to define that level be—and be perceived to be—fair.

When Are Burdens Excessive? As in the definition and assessment of adequacy, reasonable people may hold a range

³³ Health Maintenance Organization Act of 1973 (Pub. L. No. 93-222).

of views about what is an excessive or disproportionate burden in obtaining care under particular circumstances. Virtually unanimous agreement can be expected in judging some burdens to be too great, but a consensus on others will be more difficult to achieve.

It is reasonable to assume, for example, not only that adequacy includes the availability of a health care professional at the delivery of a baby, but also that women living in rural communities should generally not have to travel so far that their health or that of their infants is endangered. Obviously every rural county need not have a tertiary-care medical center. Rather, initial access to a basic range of services should be reasonably available. A referral system should be in place for more specialized services not locally available. This may require providing transportation to the more specialized provider as well as other ancillary and support services.

Some reasonable assumptions can also be made about the level at which the financial burden incurred in obtaining adequate care becomes excessive. The financial outlay for a medical procedure can be considered excessive if it drains the family's resources and precludes the purchase of other necessities such as food or shelter. Individual circumstances are also important in evaluating a financial burden: the cost of obtaining adequate care will fall differently on families of similar income, for example, if one family has six children and another has none.

Wide variations in the proportion of income devoted to securing adequate care among families of different incomes do not necessarily constitute inequities. However, such differences should trigger concern that inequities could exist and should be carefully scrutinized to determine if this is the case.

What Distribution of Cost is Fair? Equity not only requires that no one bear an excessive burden to obtain care; it also requires fairness in the distribution of the cost to achieve this situation. If an individual does not shoulder the full cost of obtaining the care that he or she uses (through out-of-pocket payments, insurance premiums, and taxes) then someone else will bear a share of the cost. Where the cost of care should fall is a political decision, but it should be guided by ethical principles that reflect the societal concern about the fair distribution of health care in the first place.

A fundamental conclusion from these principles is that the healthy should share in the cost of adequate care for those who are less healthy. In light of the importance of health care and the fact that differences in the need for care are largely undeserved, the cost of illness should be spread broadly without regard to people's actual or probable use of care. In practical terms, this means out-of-pocket payments for health

care should be minimized and insurance premiums or health care taxes should be independent of a person's state of health.

This argument applies only to adequate care; it does not mean that the cost of care above the level of adequacy ought to be spread widely.³⁴ However, special moral arguments exist for providing extra care to certain individuals; for example, society has shown a sense of obligation to provide more extensive care to soldiers injured in combat. Each category needs to be evaluated on its merits. Outside of these special situations, the Commission believes that the moral obligation to ensure adequate care to all ought to be fulfilled before public resources are used to provide care above this level. Moreover, the Commission believes that the moral obligation to ensure equitable access to health care should take precedence over other public activities that are legitimate matters for public concern but that are of lesser moral significance.

Although spreading the cost of care broadly is desirable in that it lessens the burdens imposed on those who need health care, the disadvantages of this approach cannot be ignored. Whenever insurance is provided, individuals have little or no personal incentive to limit their consumption; therefore, this way of redistributing costs is likely to increase total expenditures on the activity. To address this difficulty, it is acceptable to take measures to limit "overuse"—including direct charges to individuals for the care they use—as long as these measures neither prevent people from receiving adequate care nor impose excessive burdens.³⁵

Unfortunately, it is difficult to devise measures that can make the necessary distinctions. It is difficult to develop insurance contracts that insure people for just an adequate level of care and no more, or delivery systems that deliver just adequate care. The result is that individuals are covered for too little or too much; in fact, the combination of cost-sharing and third-party coverage (private and public) that most people have usually does both at the same time. They receive too

³⁴ Although it would not be immoral to fail to provide additional beneficial care, society might be better served if it were provided, and there may be sound practical reasons for doing so collectively rather than leaving it to private initiative. For example, there may be benefits to society as a whole as well as to the individuals who receive the care. Everyone could benefit from a healthier work force, for example, or a healthier soldiery. Moreover, individuals may wish to guarantee themselves access to these benefits through voluntary private insurance arrangements, or a collective decision could be taken to provide additional care at public expense to some or all individuals.

³⁵ The moral implications of measures such as cost-sharing differ when they are limiting access to adequate, rather than more-than-adequate, care. The cost of securing adequate care should be spread as broadly as possible; the cost of more-than-adequate care ought normally to fall in relation to actual or probable use.

much care for some conditions and/or bear too little of the cost; for other conditions, they receive too little care and/or bear too much of the cost. A major point of ethical evaluation of any health policy must be the way in which it distinguishes adequate from more-than-adequate care and spreads the cost of each appropriately.

People with greater financial resources should share the cost of adequate care for those with fewer financial resources. Just as those who have higher incomes can afford a greater financial outlay for their own care without excessive sacrifice, so can they bear a greater share of the cost of adequate care for the low income. A fair distribution of cost across income groups may be brought about in many different ways—through various combinations of insurance premiums, out-of-pocket payments, taxes, and publicly and privately provided free care. The issue of ethical significance is the equity of the total distribution of costs across individuals at different income levels.³⁶

Direct payment of insurance premiums and of charges for care at the time of use are possible mechanisms to restrain overuse and to foster an appreciation of the cost of the care received. However, special attention must be paid to finding a level of personal payment that will be high enough to achieve the desired results but not so great as to prevent poorer patients from receiving adequate care or as to saddle such patients with excessive costs. One method is to scale premiums or out-of-pocket charges to patients' incomes.

The cost of adequate care for people of varying health status and income should be shared on a national basis. A sick person in Mississippi imposes as much of a moral obligation on a taxpayer in Connecticut as a sick person in Connecticut does. There are both practical and ethical reasons why cost should be distributed broadly among parts of the country as among individuals. People, goods, and financial resources move freely throughout the United States. The prosperity of each section of the country rests to a considerable extent on what happens in the rest of the country. Furthermore, the number of people who need help to obtain health care in a given state or locality is often partly the result of national policies. The number of unemployed auto workers in Detroit, for example, or of Cuban and Haitian refugees in Florida is influenced by national policies on interest rates and immigration. It would be unfair, therefore, for all governmental health care funds to be raised on a state or local basis, since that would force some people to

³⁶ Although wealthy individuals can contribute more for the care of others without excessive sacrifice, people in the middle class, a far larger part of the population, are likely to be the major source of the funds required to secure equitable access because of their greater numbers.

face a much higher share of such costs because they live in an area that is adversely affected by national policies. It would also provide an incentive for states to set such low health care budgets for their care that some people might feel that they will be able to obtain adequate care only by moving to another state.³⁷

This does not mean, however, that all the institutions designed to help bring about equitable access to care must be governmental, or, when they are governmental, that they must be Federal. What is important is who ultimately bears the cost. There are many different combinations of public and private mechanisms that could spread the cost of guaranteeing equitable access appropriately across individuals of different health statuses and financial resources without regard to place of residence. There may be excellent reasons for locating the administration of policies and programs at lower levels of government and requiring the use of local fiscal resources. Nevertheless oversight is required at the highest level of government to ensure that the resulting distribution of cost is, in fact, equitable.³⁸

Limitations on Individuals' Choices. Every system for organizing an activity places some limitations on individual choice. In the existing health care system, for example, many Americans are unable to choose the source or type of health care they would prefer or are even unable to obtain care because they do not have adequate health insurance. The difficulties created by lack of care can in turn limit individuals' freedom if their ill health deprives them of opportunities. Restricted alternatives also regularly confront health care practitioners and hospital administrators—for example, whether to turn away those who cannot pay for care or to absorb the cost of treating them (sometimes by shifting the burden to their paying patients). Moreover, lack of adequate care itself greatly limits individuals' freedom of choice when illness deprives them of opportunities.

Thus, the issue is what kinds of limitations on choice are most consistent with fulfilling society's moral obligation to provide equitable access to health care for all. Certain types of

³⁷ This is not to say that individual localities, following the usual democratic processes, are not free to choose to support the provision of care over and above an adequate level for their residents. But Federal support of the latter should not be provided until access to adequate care without excessive burdens is assured nationwide.

³⁸ It would also be inequitable were some health care providers to be penalized financially because society has failed to fulfill its obligation to secure equitable access to care. For example, in a rural area with limited medical services, a physician may be forced to choose between leaving some poor patients without care and absorbing costs that should be spread more equitably.

restrictions appear to be acceptable. For example, the freedom of people to seek or to provide health care is limited by licensure, in order to protect against quackery. Similarly, since an adequate level is something less than all care that might be beneficial, patients' choices will be limited to that range unless they are able to pay for care that exceeds adequacy.

Any pursuit of equity entails some limitations on choice. However, limitations that occur in pursuit of equity are more ethically acceptable than those that occur when no principle of comparable importance is being advanced.

Patterns of Access to Health Care

2

Most Americans have access to a variety of highly trained health care providers, sophisticated medical institutions, and a vast array of preventive, restorative, and therapeutic services. Yet access to care is limited for millions of citizens—most notably working families of modest income, the very poor, members of racial and ethnic minorities, and people who live in very rural and inner-city communities. Thus, despite recent improvements, the United States remains a nation of contrasts: the life span of the average person has increased, but infants born to mothers with limited access to care die within the first year of life at inordinately high rates; sophisticated life-saving technologies have been developed, yet many Americans fail to receive basic preventive services; most citizens are insured against the high cost of medical care, but millions of families lack the financial resources to purchase health services.

The Benefits of Health Care

Because the Commission was mandated to study differences in the availability of health care, this chapter focuses on the nature and magnitude of existing disparities in access to health care and their relationship to the ethical standards set forth in Chapter One. Yet the Commission's attention to this task should neither overshadow the great contribution that health care has made to improving well-being in this country nor obscure the impressive progress, particularly of the last two decades, in making health care more widely available.

Improved Health. Although many developments—such as improvements in nutrition, housing, sanitation, and education—have played large parts in the dramatic advances in the overall health of the American public over the last 100 years, medical care and research have made particularly significant

contributions to the control of disease, increased longevity, and improved quality of life. Clear proof of medicine's contribution to improved health came with the control of a variety of acute infectious diseases in the middle of this century.¹ Epidemics that once annihilated whole communities are merely memories. Many Americans recall the death of family members or neighbors from pneumonia or influenza before the discovery of antibiotics. Vaccines have dramatically reduced the incidence of poliomyelitis, measles, and a host of crippling diseases and now provide permanent protection (see Figures 1 and 2).² Diphtheria, smallpox, tuberculosis, and many other infectious diseases that were leading causes of death at the turn of the century no longer threaten the nation's health.

The increased ability of medical science to treat and cure infectious diseases and control other conditions has contributed to longer life expectancy. In 1900, the life expectancy at birth was 47 years; children born today can expect to live to the age of 74 (see Figure 3). The overall infant mortality rate has also decreased dramatically: in 1950, 29 of every 1000 infants born died within the first year of life; today, that number has dropped to below 13.³ And modern obstetrics has vastly reduced the historically ubiquitous fear of maternal death from childbearing.

The development and diffusion of medical technology since the third decade of this century has revolutionized the delivery of medical care and played a significant role in improving the overall health of Americans. Medical technology has enabled such diagnostic and therapeutic advances as noninvasive (CAT) scanning, hemodialysis, bone marrow and organ transplantation, coronary artery bypass surgery, total hip replacement, and cataract extraction and retinal surgery.

These improvements in the health of Americans and the delivery of care have been accompanied by a shift in the profile of illness. Today, the major impediments to health are diseases of a chronic nature. Better management of such conditions as hypertension and certain neoplastic diseases has resulted in increased longevity, reduced risk of severe complications, and diminished pain and suffering. The prevention and control of conditions such as diabetes and heart disease present a significant challenge to the biomedical community and will require long-term, continuing research.

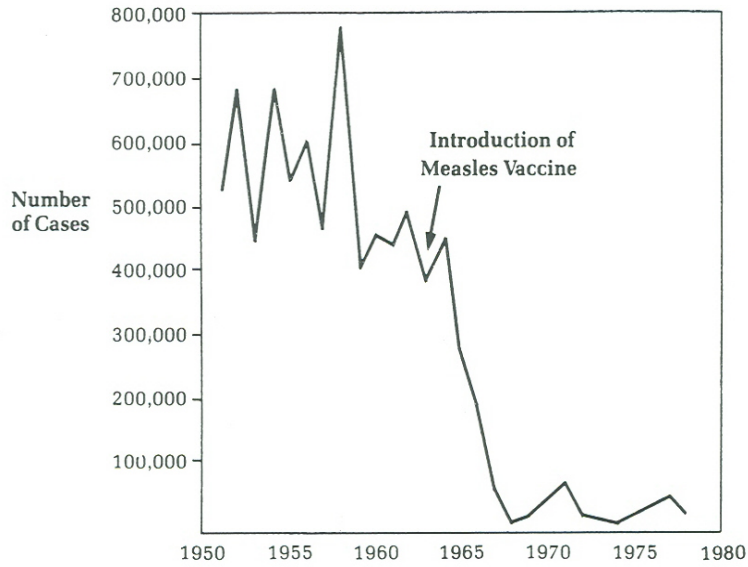
1 Judith Walzer Leavitt and Ronald L. Numbers, eds., *SICKNESS AND HEALTH IN AMERICA*, The Univ. of Wisconsin Press, Madison, Wisc. (1978).

2 John M. Last, ed., *PUBLIC HEALTH AND PREVENTIVE MEDICINE*, Appleton-Century-Crofts, New York (11th ed. 1980).

3 National Center for Health Statistics, *HEALTH UNITED STATES*, 1982, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1982) at 53 (hereinafter cited as *HEALTH U.S.* 1982).

Figure 1: Incidence of Reported Measles, 1951-1978*

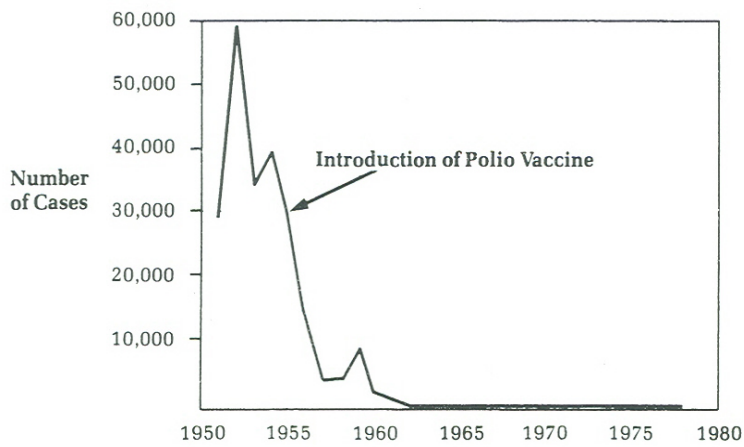
Source: Dept. of Health, Education, and Welfare, HEALTHY PEOPLE, U.S. Government Printing Office, Washington (1979) at 94.



*1978 data preliminary.

Figure 2: Incidence of Reported Poliomyelitis, 1951-1978*

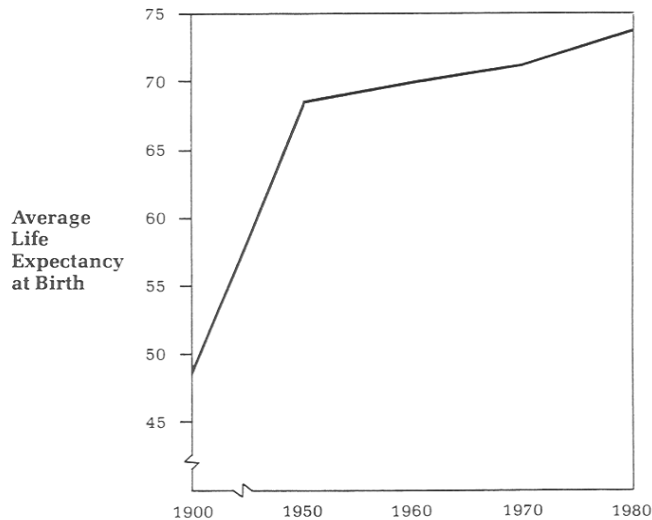
Source: Dept. of Health, Education, and Welfare, HEALTHY PEOPLE, U.S. Government Printing Office, Washington (1979) at 94.



*Incidence dropped below 1000 cases annually in 1962. Data for 1978 preliminary.

**Figure 3: Average Life Expectancy at Birth,
Selected Years, 1900-1980***

Source: National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES 1982, U.S. Government Printing Office, Washington (1982) at 53.



*Graph reflects intervals of decades until 1975. Figure for 1980 is provisional.

Many of the improvements in health care are subtle and go unrecorded in the statistics used to measure health status. For example, advances in the clinical capability to pin broken hips have contributed significantly to improving the functioning and quality of life of the elderly.⁴ These intangibles may be partially reflected in such measures as self-assessments of health, but their impact is not generally recorded in traditional health status statistics. Their importance is revealed in the changing nature of the definition of health in post-industrial societies, as described at the 1980 meeting of the Institute of Medicine:

Traditionally, improvements in medical care have been, in the public mind, synonymous with decreases in death rates and increased life expectancy. However, during the last several decades most of what we do as health professionals has shifted from a simple focus on the prevention of death to efforts to restore individuals who are physically or mentally below par to their maximal

⁴ James C. Butler, ed., SPECIAL REPORT/NUMBER ONE, The Robert Wood Johnson Foundation, Princeton, N.J., (1978) at 5.

potential function within the larger society. We have moved well beyond the concerns of simply preserving or extending life per se, to deal primarily with technologies and treatments aimed at improving the capacities of individuals within their lifespan to assume more fully their work and family roles.⁵

Better Access to Care. In addition to the improvements in health caused by biomedical advances, others can be traced to the impressive strides made in ensuring more Americans access to the benefits of the health care system. The major public financing programs that were introduced two decades ago have broadened the system's ability to respond to unmet health care needs. Two leading commentators on the health care system have noted that following the enactment of these programs: "More people attained regular access to health services than ever before. A backlog of long-neglected needs, especially among the elderly and the poor, was specifically addressed, although their special problems were not fully resolved."⁶

Furthermore, a recent study shows that the increased use of medical care is positively associated with a decrease in mortality.⁷ Historically, age-adjusted mortality rates have been highest among the underserved. However, since the introduction in the mid-1960s of public programs targeted at people with restricted access to care, premature death rates have dropped dramatically. Between 1970 and 1978, age-adjusted adult mortality dropped twice as fast as it did between 1960 and 1969.⁸ Declining death rates from specific conditions also coincided with the increased use of medical care by public program beneficiaries: between 1968 and 1980, for example, overall deaths from influenza and pneumonia dropped by 53%, from tuberculosis by 52%, from diabetes by 31%, and during childbirth by 72%.⁹

5 David E. Rogers, Linda H. Aiken, and Robert J. Blendon, *Personal Medical Care: Its Adaptation to the 1980s*, Institute of Medicine, Washington, mimeo. (1980) at 21-23.

6 Anne R. Somers and Herman M. Somers, *HEALTH AND HEALTH CARE: POLICIES IN PERSPECTIVE*, Aspen Systems Corporation, Germantown, Md. (1977) at 108.

7 Jack Hadley, *MORE MEDICAL CARE, BETTER HEALTH? AN ECONOMIC ANALYSIS OF MORTALITY RATES*, Urban Institute Press, Washington (1982).

8 *Id.* at 2-3.

9 David E. Rogers, Robert J. Blendon, and Thomas W. Maloney, *Who Needs Medicaid?*, 307 *NEW ENG. J. MED.* 13, 16 (1982). Although these figures reflect drops in mortality for the entire U.S. population, they evidence a period in time when the use of medical services by beneficiaries of public programs

Similar improvement has occurred in the overall rate of infant mortality. Infant death rates remained relatively unchanged in the decade prior to the 1965 enactment of the Medicaid program, which made medical services available to many poor mothers and their infants.¹⁰ Since then the overall infant death rate has declined from 24.7 per 1000 live births to 12.5 in 1980.¹¹ Also, the disparity between the white infant death rate and that of others has narrowed since 1965 (see Figure 4). Of course, the overall drop in both adult and infant death rates cannot be attributed only to an improvement in rates among the underserved, but gains by this group have played a role in the overall decline.

A recent national analysis shows that publicly supported health centers, designed to increase access for those not receiving adequate care, have had a substantial impact in reducing infant mortality rates.¹² Limited evidence from several independent studies leads to a similar conclusion. In one poor, rural area served by a Federally funded health center, infant mortality dropped by 40% in the four years following the center's establishment. After the opening of a community health center in another Southern county, the infant mortality rate for blacks (most of whom used the health center) declined by 38%.¹³ Similar results can be seen among the urban poor: a 25% decrease in infant mortality was attributed to the presence of a neighborhood health center network in Denver.¹⁴ In Alabama, the infant mortality rate dropped from 20 per 1000 live births in 1976 to approximately 13 in 1981. This drop was not accompanied by a change in birth-weight distribution or other demographic shifts. Experts believe that this consider-

10 National Center for Health Statistics, *HEALTH UNITED STATES*, 1981, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1981) at 112 (hereinafter cited as *HEALTH U.S.* 1981). *See also* Congressional Budget Office, U.S. Congress, *MEDICAID: CHOICES FOR 1982 AND BEYOND*, U.S. Government Printing Office, Washington (1981) at 19-23.

11 *HEALTH U.S.* 1982, *supra* note 3, at 54; 1980 figure is provisional.

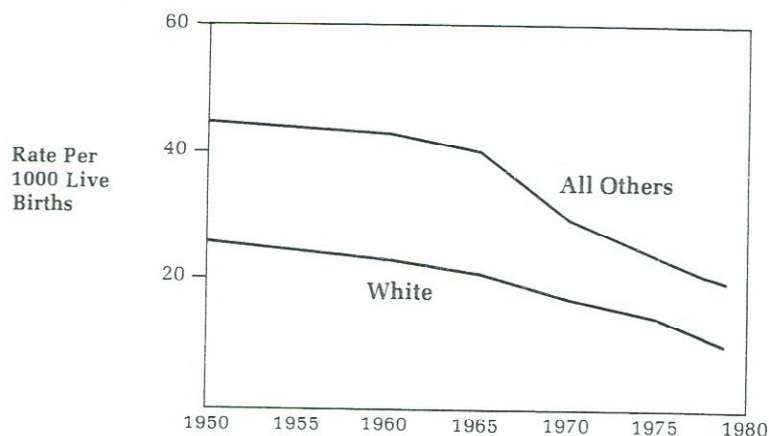
12 Fred Goldman and Michael Grossman, *The Responsiveness and Impacts of Public Health Policy: The Case of Community Health Centers*, at the 109th Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981.

13 Robert E. Anderson and Susan Morgan, *Comprehensive Health Care: A Southern View*, Southern Regional Council, Atlanta, Ga. (1973), reviewed by Karen Davis, *Primary Care for the Medically Underserved: Public and Private Financing*, at American Health Planning Association and National Association of Community Health Centers, Symposium on Changing Roles in Serving the Underserved: Public and Private Responsibilities and Interests, Leesburg, Va., Oct. 11-13, 1981, at 20-21.

14 A. Chabot, *Improved Infant Mortality Rates in a Population Served by a Comprehensive Neighborhood Health Program*, 47 *PEDIATRICS* 989 (1971).

Figure 4: Infant Mortality Rates by Race, 1950-1979

Source: National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES 1982, U.S. Government Printing Office, Washington (1982) at 54.



able drop in infant mortality was chiefly due to a concerted effort by the state of Alabama to improve access to care for pregnant women and their newborns.¹⁵ Similarly, the improved medical care provided by the Indian Health Service is credited with much of the 70% reduction in infant mortality rates of American Indians that occurred between 1960 and 1979.¹⁶

The contribution of increased health care to improved health can be significant, albeit not precisely measurable. A person's health reflects a composite of life-style, living standards, nutrition, education, and environment as well as health and medical care. The fact that the contribution of each cannot be independently isolated does not diminish the evidence that improved health has paralleled the broadening of access to care. If the current mortality rates were the same as those in 1965, each year 41,000 babies who now live would die, and 600 women who now survive would die as a result of a pregnancy or childbirth.¹⁷

15 Statement submitted by Dr. Robert L. Goldenberg, *Access to Medical Care in Alabama-Pregnant Women and Infants*, for 19th meeting of the President's Commission, Atlanta, Ga., mimeo. (April 2, 1982).

16 National Center for Health Statistics, HEALTH IN THE UNITED STATES: CHARTBOOK, Dept. of Health, Education, and Welfare, U.S. Government Printing Office, Washington (1980) at 12-13; 1979 figure, unpublished data from National Center for Health Statistics.

17 Karen Davis, *Medicaid and Health Care of the Poor*, Statement before a joint hearing of the Subcomm. on Oversight and Investiga-

Although the problem of inequitable access has not been solved, its proportions have been greatly diminished. Yet progress in closing the remaining gaps in access to care may be harder because it is often more difficult to make marginal changes than to marshal support for eliminating glaring problems. This task presents a particular challenge in light of the high level of public funds already devoted to health care. Although Americans have placed great value on improving access to health services, the pressures of continually rising health care costs and adverse economic conditions could interfere with attempts to achieve equity of access. Progress toward this end may not be sustained and past gains may be further eroded in the years ahead unless there is both a firm commitment to the objective and a realistic means of achieving it.

Assessing Differences in Access

Evaluating the ethical implications of current patterns of access to health care is a difficult and complex task: when does a “difference” become an “inequity”? Some of the disparities described in this chapter would not be regarded as inequities by everyone, but all would agree that certain situations are inequitable. Moreover, not all inequities are equally significant; some are more tolerable than others from an ethical standpoint.

Chapter One provided two ethical criteria for determining whether existing disparities are inequitable: are individuals able to secure adequate care, and if so, are the burdens exacted in order to receive this care excessive? The criteria are stated as ideals, to be fleshed out over time and in the context of specific policy discussions. The data are sufficient, however, to provide a basis for some relative judgments about the “ethical implications of differences in the availability of health care” among various population groups, as mandated in the Commission’s authorizing statute.

The Meaning of Availability. The “availability of health care” can be understood in different ways. Narrowly construed, it concerns only the extent that a particular service is physically available to the consumer. This interpretation emphasizes the supply and distribution of health professionals, facilities, and institutions among communities. One section of this chapter is specifically devoted to examining these factors.

Taking into account whether individuals actually have access to care, and whether they in fact secure it when needed,

tions and Subcomm. on Health and the Environment, Comm. on Energy and Commerce, U.S. House of Representatives, July 27, 1981, at 8.

leads to a fuller definition of availability. The accessibility of health care is typically measured in the negative, by the absence of barriers to someone's ability to receive health services. Some of these obstacles are straightforward: individuals without health insurance coverage are acknowledged to be at a disadvantage in securing health care. One section of this chapter is specifically devoted to the issue of payment for health care. Other impediments—such as a person's capacity to "negotiate" the system (being able and willing to wait long hours in a public hospital clinic, for example, or to secure transportation to a health care provider)—are more subtle. These and other obstacles are noted in this chapter, particularly in the section on the use of health services.

Context and Limitations of the Data. In order to place the information presented in this chapter in perspective several demographic characteristics of the U.S. population must first be noted. In 1980, the nation's population exceeded 226 million people, an increase of 11% during the preceding decade.¹⁸ About 82% of Americans are white, 12% black, and 6% Hispanic or another minority group. Three-quarters of the people in the United States live in metropolitan areas.

The median annual household income in 1980 was \$17,710. The Federally established poverty level that year for a nonfarm family of four was \$8414. About 13% of all U.S. households are classified as poor; 11 % of all white households fall below the poverty line while 33% of black and 25% of Hispanic households are impoverished according to government standards. Because a high proportion of these minorities have low incomes, it is often unclear whether comparisons among racial and ethnic groups reflect the effects of income or of race and ethnicity per se.

Existing statistical data and information on differences in health care based on income, race, ethnicity, or residence are not sufficiently precise to paint a complete picture. Much of the data dealing with disparities between racial and ethnic groups, for example, are collected only for whites and blacks, excluding other minorities. Information on income is often based on arbitrary categories; Federal poverty guidelines, for instance, have been criticized as inadequate and unrealistic assessments of poverty. Some argue that Federally defined poverty levels are so low as to encompass only the poorest of the poor; others contend that the poverty threshold tells only part of the story

¹⁸ Demographic information presented in the following two paragraphs is derived from 1979 and 1980 U.S. Census Bureau data; racial information, from U.S. Bureau of the Census, *STATISTICAL ABSTRACT OF THE UNITED STATES*, 1981, U.S. Government Printing Office, Washington (1981); income data, from U.S. Bureau of the Census, *CURRENT POPULATION REPORTS: CONSUMER INCOME*, Series P-60, No. 131, U.S. Government Printing Office, Washington (1982) at 7.

since it fails to acknowledge in-kind assistance such as food stamps, rental supplements, and health services available under public programs. Much of the data presented here on regional differences highlights conditions in the South, in part because the Commission's hearing in Atlanta permitted a closer look at that region and in part because the demography of that area (especially its high proportion of poor people) makes problems related to access to health care more visible and more acute.¹⁹ Nonetheless, the problems of accessibility are not confined to one racial/ethnic group, one income level, or one region; they transcend all demographic boundaries.

The data also suffer from other important shortcomings: they fail, for example, to do justice to the fact that individuals of varying race, ethnicity, religion, and social class have different orientations toward their health, medical care, and the health care system. The United States is a richly diverse, pluralistic country in which the use of health services is heavily influenced by social and cultural factors. Thus access issues cannot be defined only in economic or political terms, but also must encompass a sociocultural dimension.

There is a large body of literature on the impact of sociocultural factors on health care. A patient's socioeconomic background or ethnicity can affect that person's perception and characterization of symptoms; whether, when, and where the person seeks care; the interaction between the patient and the health care provider; the nature of the diagnosis; and the type and course of treatment prescribed. One study in the Southwest found, for example, that Anglos tended to seek care from traditional medical sources while Spanish-speaking residents tended to rely on a lay network of healers, practitioners of folk medicine, and their own families.²⁰ Similar preferences for folk remedies have been noted among native Americans and Hispanics.²¹

A study of emergency room patients showed marked differences in the likelihood of hospital admission that were

¹⁹ Examples of personal experiences are used to give a human face too much of the chapter's statistical data. These examples are not themselves evidence of the nature and magnitude of problems of access, yet they convey—in a way the data cannot—how people's lives can be affected by the financial, geographic, social, and cultural barriers that influence access to health care. See note 11, Introduction *supra*.

²⁰ Lyle Saunders, *Healing Ways in the Spanish Southwest*, in E. Gartly Jaco, ed., *PATIENTS, PHYSICIANS AND ILLNESS*, The Free Press, New York (1958) at 189.

²¹ Robert E. Roberts and Eun SuI Lee, *Medical Care Use by Mexican-Americans: Evidence from the Human Population Laboratory Studies*, 18 MED. CARE 266 (1980); Thomas Stewart, Philip May, and Anita Muneta, *A Navaho Health Consumer Survey*, 18 MED. CARE 1183 (1980).

related to the patient's race and socioeconomic status. Of 59 diagnoses of myocardial infarction, only 4 were in black patients, although blacks made nearly half of all visits. The patients' descriptions of their symptoms were found to be a determining factor in the accurate and timely diagnosis of a myocardial infarction; while white patients complained more frequently of chest pains, black patients tended to characterize their symptoms as difficulty in breathing. The study concluded that socioeconomic and cultural factors influence not only how patients present their symptoms, but how providers interact with patients and respond with different treatments.²²

Levels of Health

The ethical commitment to equitable access to health care does not amount to guaranteeing equality of health. Equal health status is not a feasible goal since levels of health will vary among individuals, even if all receive adequate care. Nonetheless, measures of levels of health across the public are relevant starting points in an examination of differences in access to health care. First, a determination that some groups are less healthy than others is useful in assessing their relative need for services. Second, disparities in health may also indicate a lack of access to health services, although differences in life-style, living conditions, attitudes about the value and need for health care, and education and knowledge about the use of the health care system can also influence individual health.

Periodically conducted national surveys provide a great deal of information about rates of death, the prevalence of disease, and levels of morbidity. Although these data do not directly record the intangible functions of health care—improvements in the quality of life, caring, and reassurance—that make up a large proportion of what the health care system offers patients, they do provide useful information about several important dimensions of well-being. Major national surveys have documented disparities between varying population groups in adult and infant death rates, disability and limitation of activity, and self-assessments of health. A brief summary of these survey results serves as a backdrop for considering the ethical aspects of differences in access to care.

Mortality rates are used to measure levels of premature death as well as differences in the rates at which people die from particular causes. Although these rates serve as useful indicators of differences in mortality, they disclose little about why these differences actually occur. Mortality data are not

22 Gerald T. Perkoff and Margaret Strand, *Race and Presenting Complaint in Myocardial Infarction* (Letter), 85 AM. HEART J. 716 (1973).

broken down by income group but information is available by race, place of residence, and cause of death. As already noted, the overall mortality rate is declining, yet the age-adjusted death rate is almost 48% higher for blacks than for whites,²³ with black men experiencing the highest overall mortality rate. The mortality rate for black children aged one to four is 60% higher than for white children in the same age-group.²⁴

Infant mortality is a traditional indicator of the overall health of the maternal population, of health practices during the pregnancy period, and of general access to health services. Studies suggest that as much as half of all infant mortality and morbidity is preventable by better access to or improved medical care.²⁵

Childbearing during early adolescence entails high health and social risks and poses special problems. Maternal morbidity and mortality are higher, and adolescents' newborns are at higher risk of being born prematurely or at a low birth weight.²⁶

23 HEALTH U.S. 1982, *supra* note 3, at 51-52. The overall age-adjusted death rates by race are an average of the rates for males and females within each race category.

24 *Id.*

25 Goldenberg, *supra* note 15. See also Robert L. Goldenberg *et al.*, *Neonatal Mortality in Alabama II: Policy and Research Implications Derived from A Comparison of Neonatal Mortality Rates*, AMER. J. OBSTET. GYNECOL. (forthcoming); J. Courtland Robinson, M.D., *City Medical Society Sponsored Perinatal Mortality Committee*, at the 110th Annual Meeting of the American Public Health Association, Montreal, Nov. 14-19, 1982; Robert Usher, *Changing Mortality Rates With Perinatal Intensive Care and Regionalization*, 1 SEMINARS IN PERINATOLOGY 309 (1977).

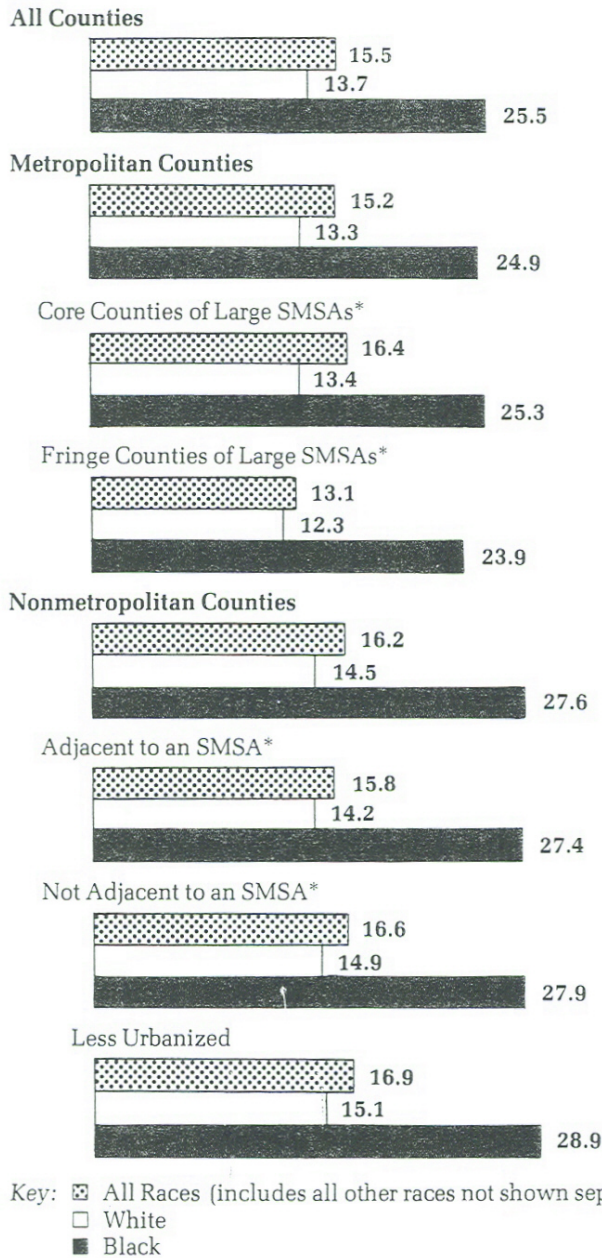
26 Although adolescent fertility rates, and the proportion of births to this group of women, have been declining for the past decade, see Select Panel for the Promotion of Child Health, 3 BETTER HEALTH FOR OUR CHILDREN: A NATIONAL STRATEGY, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1981) at 9, serious problems persist in this age-group.

The high incidence of LBW [low birth weight] infants among teenage mothers may be explained by both biological and socioeconomic factors. In general, very young teenage mothers have the double disadvantage of being physiologically immature for pregnancy and having low socioeconomic status. Furthermore, in 1978, 59 percent of white infants and 91 percent of black infants born to mothers under 18 years of age were out-of-wedlock. Infants born to unmarried women have a higher incidence of LBW than those born to married women.

...Within both race groups, teenage mothers and mothers with low educational attainment were much less likely to receive early prenatal care. Thus, mothers at highest risk of having a LBW infant are least likely to begin prenatal care early. The reasons for these differences in use of prenatal care are many. Availability or convenience of prenatal care services may need

Figure 5: Infant Mortality by Race and Level of Urbanization, Selected Counties, 1974-1977

Source: National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES 1980, U.S. Government Printing Office, Washington (1980) at 31.



*Standard Metropolitan Statistical Area.

Low birth weight infants have reduced survival chances and greater risk of serious neurological impairment.²⁷

Although the infant mortality rate has declined for both blacks and whites over the past 30 years, black infants continue to die within the first year of life almost twice as frequently as white infants.²⁸ Infant death rates for both blacks and whites vary by state: for 1975-1977, for example, the highest state rate for blacks was 50% above the lowest state rate.²⁹ Variations are less marked when viewed by level of urbanization (see Figure 5), although rates for both blacks and whites in less urbanized counties not adjacent to large urban centers are about 20% greater than rates in suburban counties adjacent to such centers.³⁰ Disparities in infant mortality rates appear to be associated more with socioeconomic factors than with geography as such. For example, a comprehensive study of health care in the rural South revealed that both blacks and whites living in nonmetropolitan areas where more than 35% of the population were poor averaged 27.2 deaths per 1000 live births compared with 19.8 in counties where less than 15% of the residents were poor.³¹

Another widely used measure of health status is the average number of days spent in bed as a result of illness. This index of "bed days" is considered to be chiefly a measure of acute conditions. People with low incomes spend 60% more days bedridden per year than those with high incomes, regardless of race (see Figure 6). In addition, data show the number of days during the year in which a person is unable to carry out his or her usual activity (attend school, go to work, and so forth) because of illness or injury. People in poor

improvement. Adequate health education to promote awareness of and motivation for the need to seek early care is another area that may improve the level of care.

Joel C. Kleinman, *Trends and Variations in Birth Weight*, in HEALTH U.S. 1981, *supra* note 10, at 7, 10, 12.

²⁷ Samuel S. Kessel, Judith P. Rooks, and Irvin M. Cushner, *A Child's Beginning*, in Select Panel For the Promotion of Child Health, 4 BETTER HEALTH FOR OUR CHILDREN: A NATIONAL STRATEGY, U.S. Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1981) at 199, 203.

²⁸ HEALTH U.S. 1982, *supra* note 3, at 1.

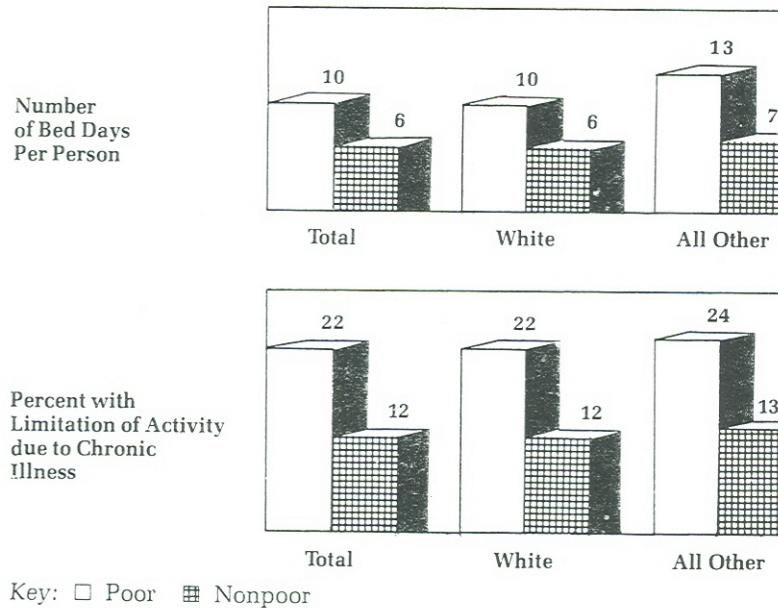
²⁹ Joel C. Kleinman and Samuel S. Kessel, *The Recent Decline in Infant Mortality*, in National Center for Health Statistics, HEALTH UNITED STATES, 1980, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1980) at 29, 33 (hereinafter cited as HEALTH U.S. 1980).

³⁰ *Id.* at 33.

³¹ Karen Davis and F. Ray Marshall, *Rural Health Care in the South: Preliminary Report*, in INCREASING THE OPTIONS, Southern Regional Council, Atlanta, Ga. (1977).

Figure 6: Health Characteristics by Race and Income, 1979*

Source: Unpublished data from the National Health Interview Survey, National Center for Health Statistics, Dept. of Health and Human Services, Washington.



*Age-adjusted. Family income definitions: Poor, under \$7000; nonpoor, \$7000 and above.

families have more than twice the number of restricted activity days as those in the highest income category.³² Poor children have 30% more days of restricted activity per year than their peers and 40% more days lost from school due to acute conditions.³³ Blacks experience more days of restricted activity per year than whites.³⁴

Health status is also reflected in the proportion of the population whose activities are limited by chronic conditions. The most striking differences in these rates are found by income: the poor are nearly twice as likely as the nonpoor to experience limitations of activity (see Figure 6). Although the types of chronic illnesses restricting the activities of the poor and nonpoor are similar, the prevalence and severity of these conditions are greater for those with lower incomes.

³² HEALTH U.S. 1982, *supra* note 3, at 81.

³³ Barbara Starfield, *Child Health and Socioeconomic Status*, 72 AM. J. PUB. HEALTH 532 (1982).

³⁴ HEALTH U.S. 1982, *supra* note 3, at 81.

Table 1:

Self-Assessment of Fair or Poor Health, by Race, Income, and Residence, 1976-1978*

Source: residence data from Joel C. Kleinman, *Medical Care Use in Nonmetropolitan Areas*, in *National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES, 1981, U.S. Government Printing Office, Washington (1981) at 55, 59*; income data, unpublished information from *National Health Interview Survey, National Center for Health Statistics, 1976-1978*.

	Share in Fair or Poor Health		
	Total**	White	Black
Income			
Poor	22%	22%	23%
Near Poor	18%	17%	21%
Not Poor	8%	7%	11%
Residence			
Metropolitan	11%	10%	18%
Nonmetropolitan	15%	14%	22%
Semirural	13%	12%	20%
Rural	17%	16%	24%

* Income definition: poor, below poverty; near poor, 100-150% of poverty level; not poor, above 200% of poverty level.

** Overall, 12% of the population assessed their health as fair or poor.

People's own assessments of how well they feel is considered a useful indicator of health status.³⁵ Between 1976 and 1978, the poor were more likely than people in families of middle or high income to report themselves to be in fair or poor health, as opposed to good or excellent (see Table 1). Poor blacks and whites were two to three times as likely as the nonpoor to make such an assessment, and blacks in rural areas were the most likely to consider their health fair or poor.

Comparisons of health status on the basis of mortality rates, morbidity levels, and self-assessments raise questions about a causal relationship between poverty and health. Being disabled or limited in physical capability can restrict entry into

³⁵ Self-assessment of health has been shown to correlate well with clinical indications of the need for care and with other measures of health status. Willard G. Manning, Jr., Joseph P. Newhouse, and John E. Ware, Jr., *The Status of Health in Demand Estimation: Beyond Excellent, Good, Fair and Poor*, in Victor R. Fuchs, ed., *ECONOMIC ASPECTS OF HEALTH*, Univ. of Chicago Press, Chicago (1982) at 143. Self-assessment also provides a "very important basis of comparison of the general health of large segments of the population." Institute of Medicine, *HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS*, National Academy Press, Washington (1981) at 33.

the work force or render someone unable to work, which in turn may lead to poverty. Also, poor health may stem from an impoverished lifestyle: poor nutrition, substandard housing, restricted educational and employment opportunities, and so forth.

Although the poor are in poorer health relative to others in the population, this should not obscure recent improvements. As noted, better access to health services is associated with better health; in many cases, existing disparities are less pronounced than they were 20 years ago. Indeed, increased access to health care may be partly responsible for the identification of many health problems that were previously unrecognized or untreated.

Use of Health Services

The rates at which people actually use health services, the timeliness and appropriateness of care, and the type of settings where care is received are often used to measure how successful individuals are in securing health services. Whether someone is able to pay for health care or whether health providers are sufficiently available to supply the care affects the person's entry into the health care system. Differences in the use of services are viewed as a more intermediate or "realized" indicator of access because they represent an outcome of the quest for care.³⁶

Rates of use are also a telling indicator of people's willingness to seek health care. Clearly, not all failures to seek or receive health and medical services are the result of inability to pay, lack of available resources, differences among care settings, or other barriers related to the structure and function of the health care system. Individual attitudes, beliefs, and values concerning health and health care also play an important role in this process.

Attitudes and beliefs about whether to seek care for a particular symptom and at what point vary considerably. This was illustrated in a classic study of how people at various occupational levels perceived the need to seek health care for several symptoms.³⁷ People at higher occupational levels were likely to view chronic back pain, for example, as a reason to visit a physician, while those at lower occupational levels did not think this symptom warranted medical attention. The influence of group experience and culture on the perceptions of symptoms was echoed in another study, in which women in

³⁶ Lu Ann Aday, Ronald Anderson, and Gretchen Fleming, *HEALTH CARE IN THE U.S.: EQUITABLE FOR WHOM?* Sage Publications, Beverly Hills, Calif. (1980) at 32-34.

³⁷ E. L. Koos, *THE HEALTH OF REGIONVILLE*, Columbia Univ. Press, New York (1954).

several poor, coal-mining counties in eastern Kentucky said they consider sickness and disability a constant part of their lives.³⁸

These attitudes toward health often work in conjunction with such barriers as the cost of care to determine whether someone actually seeks medical attention when a symptom is acknowledged as an illness.³⁹ Some of the reasons for failing to see a health care practitioner include fear (“I might have to be hospitalized and have to go under the knife”), past experience (“If I have a pain in my chest when I have a cold, I don’t worry about it—I just put on a mustard plaster; I’ve had pains in the chest before when I had a cold, and doctored myself, so I know what to do”), loss of income (“Maybe, if I start being treated it will take me away from my job and my family won’t be able to live”), and group experience or culture (“If I went to the doctor for a backache, my friends would hoot me out of town”).⁴⁰ People whose family training, education, and values support seeking medical attention at the first sign of illness or disease may be more likely to seek care earlier than people from families in which medical care was considered a luxury or unnecessary except for severe conditions causing extreme pain and discomfort.

Although it is difficult to distinguish health care decisions based on the exercise of effective options and adequate information from those that are the product of circumscribed access or lack of knowledge, it is not essential to pinpoint the precise contribution of particular factors in order to make reasonable judgments about access to care. Available information suggests that when individuals are armed with knowledge and when access is not unduly restricted, they are more likely to avail themselves of health services. For example, widespread educational campaigns to alert women to the symptoms of breast cancer have contributed to the fact that 85% of all breast cancers are now diagnosed at an early stage, significantly increasing the chances of survival.⁴¹

Levels of Use. The most common indicator of access to care is the rate at which people use health services. Much of the work in this area identifies disparities in the use of

38 Bill Carlton, *A Study of the Health and Sickness Behavior of Selected Adults in Southeastern Kentucky*, 93 PUB. HEALTH REP. 356 (1978).

39 David Mechanic, *MEDICAL SOCIOLOGY*, The Free Press, New York (1968); Lois A. Maiman and Marshall H. Becker, *The Health Belief Model: Origins and Correlates in Psychological Theory*, in Marshall H. Becker, ed., *THE HEALTH BELIEF MODEL AND PERSONAL HEALTH BEHAVIOR*, Charles B. Slack, Inc., Thorofare, N.J. (1974) at 9.

40 Koos, *supra* note 37.

41 National Cancer Institute, *Decade of Discovery*, National Institutes of Health, Bethesda, Md. (Oct. 1981) at 17-28.

particular services, by measuring physician visits, for example, and attempts to determine how greatly those differences depend on factors other than the need for care. Although equity does not expect or require that all individuals with the same health condition use health services at equal levels, wide differences based on factors other than the need for care are cause for concern.

For differences in use to reflect true differences in the need for care, adjustments must be made for health status. If poor people visit physicians as often as the nonpoor, for example, one might assume that parity exists in the use of care among these groups. But since the poor are acknowledged to have a greater incidence of ill health, poor individuals have a greater need for health care and should use health services at higher rates if some measure of equity is to be achieved. Recent research in this field relies on several different methods to assess the need for physician services.⁴² Although each approach has contributed to the knowledge about and ability to evaluate existing disparities in the use of services, some appear to be more reliable than others. Adjustment for variations in use of services based on differences in health status are sensitive to small differences in the health of the population; as the state of the art improves, these measures are expected to become increasingly refined.

Visits to a physician. The number of physician visits per year, whether in response to perceived illness or for health maintenance reasons, is a key indicator of access to care. During the past few decades the increased use of services by traditionally underserved groups, especially the poor and racial and ethnic minorities, has been dramatic. Aggregate data, unadjusted for differences in need, show a substantial narrowing of the disparities in physician visits among population groups over the past 15 years. The poor now pay on average as many visits to physicians per year as the nonpoor (see Figure 7). Blacks, on average, visit the physician at rates comparable to whites.⁴³

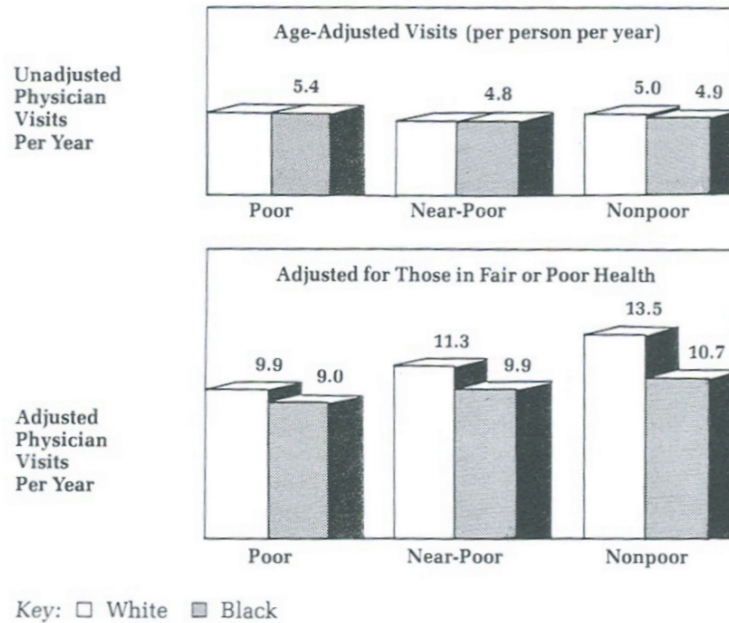
When the data are adjusted to consider differences in health status, however, these patterns change. Once visits are adjusted by perceived health status, the poor make fewer visits to a physician each year than the nonpoor, and blacks visit a doctor less frequently than whites of comparable health status (see Figure 7). More pronounced differences in the volume of physician visits when adjusted for health status are found among children and the elderly. Lower-income children who

⁴² John Yergan *et al.*, *Health Status as a Measure of Need for Medical Care: A Critique* (1981), Appendix S, in Volume Three of this Report; Joel C. Kleinman, Marsha Gold, and Diane Makuc, *Use of Medical Care by the Poor: Another Look at Equity*, 19 MED. CARE 1011 (1981).

⁴³ HEALTH U.S. 1982, *supra* note 3, at 90.

Figure 7: Overall and Adjusted Physician Visits by Race and Income, 1976-1978*

Source: Joel C. Kleinman, Marsha Gold, and Diane Makuc, *Use of Ambulatory Medical Care by the Poor: Another Look at Equity*, 19 MED. CARE 1011 (1981).



*Family income definitions: Poor, below Federal poverty level; near-poor, 150-200% of poverty level; nonpoor, above 200% of poverty level.

are in poor or fair health make half as many visits to a physician per year as affluent children.⁴⁴ Among the elderly in poor health, those with high incomes visit a doctor one-third to one-half more often per year than those with low incomes (whites and blacks, respectively).⁴⁵

Generally, rural residents still visit a physician less frequently than people living in metropolitan areas do. The differences are sharpest between very rural communities and metropolitan areas, and are most pronounced among children. Children in very rural areas, particularly black children, are more likely than those living in metropolitan areas not to have visited a physician at all over a two-year period. Of those who see a physician, rural children have fewer annual visits than

⁴⁴ Karen Davis, Marsha Gold, and Diane Makuc, *Access to Health Care for the Poor: Does the Gap Remain?*, 2 ANN. REV. PUB. HEALTH 159, 165 (1981).

⁴⁵ *Id.*

children in metropolitan areas. When the data are adjusted to compare rural and metropolitan residents with similar health conditions, in general differences in use become more visible by both rurality and race.⁴⁶

Hospitalization. The use of inpatient services by the poor and by minorities rose dramatically between 1964 and 1973 (see Table 2). The poor and nonpoor were hospitalized at comparable rates in 1964; minorities, regardless of income status, were the least frequently hospitalized group. By 1973, the poor (both whites and nonwhites) were being hospitalized at higher rates than the nonpoor. Racial differences, however, persisted: low-income whites continued to be hospitalized more often than low-income nonwhites. The increase was in part due to the fact that the poor were often more seriously, especially chronically, ill and had a backlog of unmet health

Table 2:

Hospital Discharges and Length of Stay, by Race and Income, 1964-1979*

Source: unpublished data from the National Health Interview Survey, National Center for Health Statistics, 1964-1979.

	Total		White		Nonwhite	
	Poor	Nonpoor	Poor	Nonpoor	Poor	Nonpoor
Hospital Discharges Per 100 Persons						
1964	14	13	15	13	10	10
1973	19	13	20	13	15	12
1976	19	13	19	13	17	12
1979	20	13	21	13	17	12
Average Length of Hospital Stay (days)						
1964	10	7	10	7	11	9
1973	10	7	10	7	10	9
1976	9	7	9	7	10	9
1979	9	7	9	7	10	9

		Poor	Nonpoor
* Family income definitions:	1964	under \$3000	\$3000 and over
	1973	under \$6000	\$6000 and over
	1976	under \$7000	\$7000 and over
	1979	under \$7000	\$7000 and over

⁴⁶ Joel C. Kleinman, *Medical Care Use in Nonmetropolitan Areas*, in HEALTH U.S. 1981, *supra* note 10, at 55.

needs that could be addressed in the post-Medicare-Medicaid period.⁴⁷ After 1973, the rise in hospitalization experienced by minorities and the poor began to level off and it has remained relatively stable since then.

Differences also exist in the use of hospital services between people in urban and rural areas. Rural residents are 27% more likely than urban residents to have been hospitalized during the year.⁴⁸ Once hospitalized, the poor stay on average two days longer per episode than the nonpoor (see Table 2).

Appropriate and Timely Care. In addition to variations in the amount of care, there are differences in the types or mix of services received by various populations. There is growing concern that some individuals fail to receive comparable amounts of the “right” kinds of services. Much public health policy, for example, has focused on improving access to basic primary and preventive health care as a way to ensure that everyone has entree to more-appropriate services. Primary care is viewed as people’s first contact with the health care system; an estimated 60% of all visits to physicians are for basic, primary medical care needs.⁴⁹

The benefits of appropriate care to prevent illness or avoidable death and to reduce complications are considerable in both human and economic terms. A recent study, for example, reported that black Americans are four times as likely as whites to suffer severe kidney disease requiring dialysis or transplant.⁵⁰ This higher incidence is thought to be related to uncontrolled hypertension⁵¹; high blood pressure is more frequent among blacks than among whites.⁵² This sug-

47 Lu Ann Aday and Ronald M. Anderson, *Equity of Access to Medical Care: A Conceptual and Empirical Overview* (1981), Appendix N, in Volume Three of this Report, at *Current Survey Data on Equity* in section two.

48 Kleinman, *supra* note 46, at 56.

49 David E. Rogers, *The Challenge of Primary Care*, in John H. Knowles, ed., *DOING BETTER AND FEELING WORSE: HEALTH IN THE UNITED STATES*, W.W. Norton & Co., New York (1977) at 81, 84.

50 Stephen G. Rostand *et al.*, *Racial Differences in the Incidence of Treatment for End-Stage Renal Disease*, 306 *NEW ENG. J. MED.* 1276, 1278 (1982).

51 Paul Oglesby, *The Prevention of Cardiovascular Disease*, in Public Health Service, *HEALTHY PEOPLE: THE SURGEON GENERAL’S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION (BACKGROUND PAPERS)*, Dept. of Health, Education, and Welfare, U.S. Government Printing Office, Washington (1979) at 173; Hypertension Detection and Follow-up Program Cooperative Group, *Five-Year Findings of the Hypertension Detection and Follow-up Program*, 242 *J.A.M.A.* 2572 (1979).

52 Public Health Service, *HEALTHY PEOPLE: THE SURGEON GENERAL’S REPORT ON HEALTH PROMOTION AND DISEASE PREVENTION*, Dept. of Health, Education, and Welfare, U.S. Government Printing Office, Washington (1979) at 58.

gests that the control of high blood pressure could reduce the prevalence of kidney disease in blacks and, thus, the need for expensive dialysis and transplantation. The identification and control of hypertension are common functions of the primary care provider. In short, timely and appropriate treatment of hypertension can depend, in part, on adequate access to primary care practitioners. The lack of such care increases the probability of incurring more-severe kidney disease and the subsequent need for costlier therapy and treatment.

Disease prevention and health promotion. Preventive practices, as opposed to restorative ones, are targeted at the reduction of disease and the minimization of health risks. Vaccines, for instance, are preventive services that attempt to diminish biological risk. Occupational safety regulations and clean water standards are examples of preventive measures taken to reduce environmental hazard. Educational campaigns about early cancer signals or the adverse health effects of smoking are designed to enhance health by changing behavior. Preventive strategies are often targeted at a reduction in the combined effect of biological, occupational, educational, and life-style risks.

Differences in the rates people receive immunizations, prenatal care, and certain dental services may reflect differences in attitudes and knowledge about these preventive practices as well as disparities in access to health care. Although remarkable progress has been made in reducing the prevalence of childhood vaccine-preventable diseases, minority children are less likely than white children to be immunized against measles, rubella, diphtheria-pertussis-tetanus (DPT), polio, or mumps (see Table 3). Also, children in suburban communities are more frequently immunized than children in central-city areas are, particularly those living in impoverished inner cities. Although problems in access may account for some of the variations in immunization rates, parental education and beliefs can also be important factors. For example, twice as many minority parents as white parents believe that most children's diseases have been conquered and that there is no need for vaccinations.⁵³ Data indicate that education is a stronger determinant than income level: a child with a poorly educated mother in a high-income family is no more likely to have received medical or dental care than a child with a poorly educated mother in a low-income family.⁵⁴

Timely prenatal care (initiated in the first trimester) is received by 74% of all pregnant women, but there are differences based on education, race, and income. Women who

⁵³ 3 BETTER HEALTH FOR OUR CHILDREN, *supra* note 26, at 35.

⁵⁴ *Id.* at 33.

Table 3:**Vaccination Status of Children 1-4 Years of Age, According to Race and Location of Residence, 1979**

Source: National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES, 1982, U.S. Government Printing Office, Washington (1982) at 78.

	Measles	Rubella	DPT	Polio	Mumps
Total	64%	63%	65%	59%	55%
Race					
White	66%	65%	69%	64%	58%
All Other	51%	54%	49%	39%	46%
Location					
Central City	58%	58%	58%	52%	50%
Poverty	48%	53%	49%	44%	41%
Nonpoverty	61%	60%	61%	54%	52%
Remaining Areas					
In SMSA *	66%	65%	69%	62%	57%
Non-SMSA *	66%	64%	68%	63%	58%

* Standard Metropolitan Statistical Area.

receive timely prenatal care are more likely to have completed high school,⁵⁵ Conversely, over half the women who do not receive prenatal care have less than a high school education. Although the overall proportion of pregnant women who receive late or no prenatal care is quite small, black women were more than twice as likely as white women to be in this category.⁵⁶ The number of low-income women receiving early prenatal care has increased in recent years,⁵⁷ yet high-income women are currently 50% more likely than lower-income women to receive early prenatal care.⁵⁸

Although regular dental care is acknowledged as effective in preventing tooth decay and periodontal disease, nearly half of all Americans failed to visit a dentist in 1980. The use of dental services appears to be associated with income, race, and residence (see Table 4). As income increases, so does the likelihood of having seen a dentist in the past year. Blacks, residents of the South, and poor and near-poor individuals are most likely to have never visited a dentist.

⁵⁵ *Id.* at 14, and unpublished data from the Division of Natality Statistics, National Center for Health Statistics, Dept. of Health and Human Services, Washington (1978).

⁵⁶ HEALTH U.S. 1980, *supra* note 29, at 155.

⁵⁷ 3 BETTER HEALTH FOR OUR CHILDREN, *supra* note 26, at 24.

⁵⁸ Aday, Anderson, and Fleming, *supra* note 36, at 118.

Table 4:**Dental Visits by Race, Income, Geographic Region, and Location of Residence, 1980**

Source: National Center for Health Statistics, Dept. of Health and Human Services, HEALTH UNITED STATES, 1982, U.S. Government Printing Office, Washington (1982) at 94-95.

	Last Dental Visit Less than One Year	Never Visited a Dentist
Total	50%	11%
Race		
White	52%	10%
Black	34%	15%
Income		
Less than \$7000	37%	15%
\$ 7000- 9999	39%	14%
\$10,000-14,999	42%	14%
\$15,000-24,999	52%	10%
\$25,000 or more	65%	6%
Region		
Northeast	55%	9%
North Central	52%	10%
South	44%	13%
West	51%	11%
Location of Residence		
Within SMSA*	52%	10%
Outside SMSA*	46%	11%

* Standard Metropolitan Statistical Area.

Timely diagnosis and treatment. Timely care encourages diagnosis and treatment at the earliest possible moment in order to mitigate pain and suffering, restrain the progression of the condition, and, if possible, cure it or bring it under control. For many conditions, delayed diagnosis and treatment can result in increased pain and anxiety, disability, or premature death.⁵⁹ Attempts have been made to identify groups of people whose illness or disease is in a later stage when they enter the medical system, as it may indicate differences in access to care

59 Donald M. Steinwachs and Richard Yaffee, *Assessing the Timeliness of Ambulatory Medical Care*, 68 AM. J. PUB. HEALTH 547 (1978); Samuel Prozer and Michael Barza, *DIAGNOSTIC IMPERATIVES: THE TIMELY DETECTION OF TREATABLE DISEASE*, Thieme-Straton, Inc., New York (1981).

as well as differences in attitudes or knowledge about when to seek care.⁶⁰ Much of this research has concentrated on measuring the severity of health conditions at the time of initial treatment, particularly among cancer patients.

For many cancers, treatment in the early stages of development often increases the overall chance of survival.⁶¹ Data from the National Cancer Institute reveal that white patients have a higher percentage of their cancers diagnosed at an early stage than black patients do.⁶² Furthermore, “paying” patients have their cancers diagnosed in an earlier stage more often and have better survival rates than indigent “nonpaying” patients.⁶³ Women who are considered to be at a higher risk of cervical cancer (particularly poor, black women aged 45-64 living in nonmetropolitan areas) are less likely than other women to have had a Papanicolaou (Pap) test to screen for that disease.⁶⁴

A study of 5000 patients hospitalized for a variety of conditions found marked differences in the severity of illness at admission among those publicly and privately insured. In another study, patients insured under private plans were more likely to be hospitalized in earlier stages of their condition than those publicly insured.⁶⁵ Public beneficiaries diagnosed as having appendicitis, for example, were twice as likely as those covered by commercial insurance to have their disease be at an advanced stage when they were admitted to a hospital. A similar study compared the severity at hospital admission of 21 medical or surgical conditions that require hospitalization at the earliest possible stage; it found that publicly insured patients were more likely than privately insured patients to be admitted with conditions in advanced stages.⁶⁶

60 Joseph S. Gonnella, Daniel Z. Louis, and John J. McCord, *The Staging Concept—An Approach to the Assessment of Outcome of Ambulatory Care*, 14 MED. CARE 13 (1976).

61 Arthur G. James, CANCER PROGNOSIS MANUAL, American Cancer Society, Inc., New York (1966); *Cancer Patient Survival*, SEER Reports, U.S. Dept. of Health, Education, and Welfare, Washington (No.5, 1977).

62 Max H. Myers and Benjamin F. Hankley, *Cancer Patient Survival Experience*, U.S. Dept. of Health and Human Services, Washington (1980).

63 John W. Berg, Ronald Ross, and Howard B. Latourette, *Economic Status and Survival of Cancer Patients*, 39 CANCER 467 (1977).

64 Joel C. Kleinman and Andrea Kopstein, *Who is Being Screened for Cervical Cancer?*, 71 AM. J. PUB. HEALTH 73 (1981).

65 Joseph S. Gonnella *et al.*, *Use of Outcome Measures in Ambulatory Care Evaluation*, in Gerald A. Giebink and Nicole H. White, eds., *AMBULATORY MEDICAL CARE QUALITY ASSURANCE*, La Jolla Health Science Publications, La Jolla, Calif. (1977) at 91.

66 Gonnella, Louis, and McCord, *supra* note 60.

Source and Quality of Care. The Commission’s examination of patterns of access extended beyond differences in the amounts and types of services used. An important concern is whether some individuals are systematically receiving “second class” care of inadequate quality. Specifically, there is a concern that health services received in settings serving a disproportionate share of such groups as the poor may lead to care of lesser quality than that provided in mainstream settings. Although no ethical issue is at stake if patients choose to seek care from different providers, ethical questions are raised if the care offered in these settings systematically differs with regard to quality.

Although the vast majority of people see a physician in an office setting, differences are found in the site of care by race, income, or place of residence. Whites and people with higher incomes receive care in a physician’s office more frequently than nonwhites or those with low incomes (see Table 5). Inner-

Table 5:

Site of Last Physician Visit by Race, Income, Region, and Residence, 1978

Source: unpublished data from the National Health Interview Survey, National Center for Health Statistics, 1978.

	Doctor’s Office	Hospital ER/OPD	Other and Unknown
Total	81%	9%	9%
Race			
White	84%	8%	8%
Black	64%	20%	16%
Other	72%	13%	14%
Income			
Less than \$5000	71%	15%	14%
\$ 5000- 9999	76%	13%	11%
\$10,000-14,999	82%	10%	9%
Over \$15,000	86%	7%	8%
Region			
Northeast	79%	11%	11%
North Central	84%	8%	8%
South	80%	10%	10%
West	8c%	9%	9%
Residence			
Metropolitan			
Central city	74%	14%	12%
Outside central city	84%	8%	9%
Nonmetropolitan	85%	7%	8%

Note: Columns may not add up to 100 due to rounding.

city residents receive care in a doctor's office less often than people who live in suburban and rural areas do.⁶⁷

The hospital emergency room or outpatient clinic is a traditional source of ambulatory care for many low-income people, uninsured individuals, ethnic and racial minorities, and inner-city residents. For example, while 3% of higher-income, urban whites with insurance consider the hospital emergency room or outpatient department to be their usual source of care, 36% of poor blacks who lack insurance and live in these areas identify these hospital facilities in this way.⁶⁸

A visit to an emergency room or outpatient clinic differs from one to the doctor's office in several ways. As the president of a large private foundation commented before the U. S. Senate Subcommittee on Health and Scientific Research:

The term "physician" visit can mean many things. It can be a hurried visit to a 'Medicaid mill' in which a patient is ping-ponged among a series of doctors, nurses and others to maximize reimbursement income. It can be hours spent waiting in a crowded, noisy hospital outpatient clinic for a few minutes with a doctor you've never seen before. At the other end of the scale—and far more desirable personally and medically—is the kind of visit you and I are accustomed to: seeing a doctor we know by name and who knows us and our families.⁶⁹

The executive administrator of a large urban public hospital told the Commission that his facility is both "hospital and physician" to many black, low-income, or uninsured residents of the city and surrounding communities. His emergency room and outpatient departments accounted for 55% of all ambulatory visits made to hospitals throughout the state.⁷⁰ This point is reinforced by a recent study that found that 82% of white patients entering the hospital—compared with 65% of black patients—were admitted by a private physician.⁷¹

Hospitals serving a greater proportion of Medicaid beneficiaries and the medically indigent are less likely than those

⁶⁷ Kleinman, *supra* note 46.

⁶⁸ Statement submitted by Karen Davis, Ph.D., *Access to Health Services for the Uninsured*, for 19th meeting of the President's Commission, Atlanta, Ga., mimeo. (April 3, 1982) at 8.

⁶⁹ David E. Rogers, *Statement before Subcomm. on Health and Scientific Research, Comm. on Labor and Human Resources, U.S. Senate* (Sept. 24, 1980) at 3-4.

⁷⁰ Testimony of J.W. Pinkston, Jr., Executive Director, Grady Memorial Hospital, transcript of 19th meeting of the President's Commission, Atlanta, Ga. (April 2, 1982) at 135.

⁷¹ Office for Civil Rights, *Preliminary Results of the 1981 Short-Term, General, and Other Special Hospital Civil Rights Survey*, Dept. of Health and Human Services, Washington, mimeo. (rev. Sept. 18, 1981) at Figure 6.

whose patients are covered by private insurance or Medicare to be able to finance new medical technology, to update antiquated equipment, and to compete for staff. These problems are especially pressing for urban public hospitals, whose patients are twice as likely as those in urban voluntary hospitals to be uninsured and almost twice as likely to be minorities or Medicaid patients.⁷²

Several Commission witnesses echoed the notion that the nature and subsequent quality of care varies by setting. One witness told the Commission:

[The public hospital] is about the only place we had the opportunity to go. I know personally if I had not had to deal with the public hospital, I wouldn't have realized how bad it was. I might be one of the persons out there saying, "Well, there is a place for them to go."...But if you haven't been there, you don't know what it's like.⁷³

There is little large-scale systematic evidence about whether the technical or clinical quality of medical care varies among different care settings. However, data do show that the quality of care (excluding clinical competence) can differ by source when measured by the continuity, comprehensiveness, and coordination of services, as well as by overall satisfaction with the care process.⁷⁴ A patient may be less likely to receive orderly and appropriate referral to other providers, needed follow-up care, or the appropriate mix of services to maximize the potential benefits of health and medical care. These factors are viewed as integral components of quality health care. Their absence can lead to fragmented, episodic, and duplicated services. Hospital-based ambulatory care, particularly in emergency rooms, is of poorer quality in these and other aspects, as well as being costlier than similar care provided in physicians' offices.⁷⁵ In addition, care received outside a physician's office typically requires more time waiting at the site of care, and

⁷² Rosanna Coffey, *Patients in Public General Hospitals: Are They Poorer and More Severely Ill?* (prepublication draft), Hospital Cost and Utilization Project, Research Note 2, National Center for Health Services Research, Dept. of Health and Human Services, Washington.

⁷³ Commission Testimony, *supra* note 70, at 37.

⁷⁴ Aday, Anderson, and Fleming, *supra* note 36; Joseph S. Gonnella and Mary W. Herman, *Continuity of Care*, 243 J.A.M.A. 352 (1980); Steven Jonas, *Measurement and Control of the Quality of Health Care*, in Steven Jonas, ed., *HEALTH CARE DELIVERY IN THE UNITED STATES*, Springer Publishing Company, New York (1981) at 398.

⁷⁵ Steven Jonas, with Robert Greifinger, *Ambulatory Care*, in Jonas, *supra* note 74, at 126, 131-141; Diana B. Dutton, *Children's Health Care: The Myth of Equal Access*, in 4 *BETTER HEALTH FOR OUR CHILDREN*, *supra* note 27, at 357; Diana B. Dutton, *Explaining The Low Use of Health Services by the Poor: Costs, Attitudes, or Delivery Systems?*, 43 AM. SOC. REV. 348 (1978).

persons who do not frequent a particular physician tend to wait longer to get an appointment.⁷⁶

The quality of services may differ among office-based physicians as well, with some physicians being better trained and offering care more responsive to medical need and more respectful and caring of patients as individuals. Questions about the quality of service received in very large Medicaid practices are often related to these issues.

At times, the differences among care sources are especially pronounced and can involve wide disparities in the medical risks assumed by patients. An example of such differences was brought to the attention of the Commission by witnesses who spoke of the problems that pregnant, medically indigent women in the South face when they receive prenatal care from local health departments and then must rely on private physicians to provide care during childbirth. The availability of care has increased with the expansion of state and locally supported health services but the transition from the public to private sector is difficult for some women: private obstetricians may require large cash deposits by the seventh month of pregnancy, which is impossible for many indigent women; also, hospitals do not always accept poor women without insurance, which can mean that they must travel long distances to find a facility in which to give birth. A former state official and physician told the Commission:

For the most part, these poor women, black women in Alabama, have no single identifiable provider of care. They are provided care by systems, by health departments, often by hospitals, by one public agency or another. And when they try to shift from where they get their prenatal care, say in the county health department, to the hospital, very often there is no continuity at all. I believe that it is this lack of continuity, this breakdown in the system of care, which prevents poor women, black women in Alabama from having the same kinds of access to the system.⁷⁷

In recent years almost 27% of new mothers in Alabama, many of whom were from low-income families, received some prenatal care through county public health department clinics.⁷⁸

The structure of the U.S. delivery system is complex and may require considerable resourcefulness and persistence, even in the case of the most educated and skillful consumer. Individuals with less education or less economic clout have

⁷⁶ Aday, Anderson, and Fleming, *supra* note 36, at 56-72.

⁷⁷ Commission Testimony, *supra* note 70, at 156.

⁷⁸ Goldenberg, *supra* note 15, at 3.

been identified as being at a disadvantage in “negotiating” their way through the health care system.

It is important to note that differences in quality do not necessarily exist routinely between public and private settings. There is evidence, for example, that care provided in Federally supported community health centers is of comparable quality to that offered generally in physicians’ offices.⁷⁹ These programs are designed specifically to provide comprehensive primary care to residents of communities where practitioners are scarce.

Availability of Health Care Resources

During the 1960s, the distribution of health care resources was characterized as a “feast-or-famine” situation: while most Americans had access to a wide range of health care providers, hospitals, clinics, nursing homes, and supportive and ancillary services, the residents of many rural and inner-city communities faced serious shortages. Within the past 15 years, the geographic distribution of health care resources has improved significantly. Yet some people still encounter problems in obtaining health care because of a lack of health providers.

Distribution of Physicians. The term “health care resources” encompasses a wide range of personnel, facilities, and institutions. Over seven million people are employed in the delivery of health care which ranges from sophisticated, high-technology inpatient care to the most basic preventive health services.⁸⁰ Rather than undertake review of the availability of health care resources generally, the Commission elected to focus on the distribution of physicians. Data are more readily available on these key participants in the health care system, and the ethical issues raised by the distribution of physicians are central to the concern about access to adequate health care.

During the early 1960s the country faced a potential shortage of physicians. Although the overall supply of physicians had kept pace with the growth of the population, it was anticipated that the available supply of physicians would prove inadequate to meet the rising demands for health services.

The practice of medicine had changed dramatically—it had become far more technologically oriented, specialized, and sub-specialized; the number of medical procedures greatly increased; the number of curative techniques expanded; and

⁷⁹ Mildred A. Morehead, Rose S. Donaldson, and Mary Sevaralli, *Comparisons Between OEO Neighborhood Health Centers and Other Health Care Providers of Ratings of the Quality of Health Care*, 61 AM. J. PUB. HEALTH 1294 (1971).

⁸⁰ HEALTH U.S. 1982, *supra* note 3, at 112.

more people than ever could benefit from medical science. As a result, physicians were increasingly drawn to larger urban centers with the resources to pursue this type of medicine. As one physician and former government official pointed out to the Commission, physicians moved to metropolitan areas with good communication, greater concentrations of technological resources, and easier geographic access by patients:

Those communities less able to command those attentions...the poor, the rural, and many others...became less and less well served. The old GPs retired. The communities that old Doc Smith had served in rural Montana or wherever suddenly had no physician.⁸¹

In 1963 Congress reacted to the anticipated shortage of physicians and other health professionals by enacting legislation to increase the aggregate supply of health personnel through direct subsidies to professional educational institutions.⁸² By the late 1970s, medical school class size had almost doubled. Today, there are nearly 450,000 physicians, 126,200 dentists, and 1,163,800 registered nurses in active practice.⁸³ A report from the Graduate Medical Education National Advisory Committee predicts that by 1990 the nation will face a surplus of 70,000 physicians and recommends that medical schools reduce their entering class size by at least 10%.⁸⁴

The impact of this increased supply of health professionals on geographic distribution patterns has received a good deal of attention. From 1970 to 1978, the number of people per physician dropped substantially, from 728 to 578 nationally (see Table 6). But the effect on individual communities differed considerably. The decrease in the population-to-physician ratio in urban areas with 50,000 to 500,000 residents, for example, was at least twice that experienced in the nation's largest metropolitan centers and less populous rural areas.

81 Testimony of Dr. Fitzhugh Mullan, Scholar-in-Residence, Institute of Medicine, transcript of 19th meeting of the President's Commission, Atlanta, Ga. (April 3, 1982) at 54.

82 See pp. 119-28 *infra* for a discussion of the subsidization of medical education in the United States.

83 Public Health Service, Health Resources Administration, THIRD REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL IN THE UNITED STATES, U.S. Dept. of Health and Human Services, Washington (1982) at 11-18, 11-23; Public Health Service, Health Resources Administration, SUPPLY AND CHARACTERISTICS OF SELECTED HEALTH PERSONNEL, U.S. Dept. of Health and Human Services, Washington (1981) at 59 (1980 figures are estimated).

84 Office of Graduate Medical Education, 1 SUMMARY REPORT OF THE GRADUATE MEDICAL EDUCATION NATIONAL ADVISORY COMMITTEE TO THE SECRETARY, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1980).

Table 6:**Population-to-Physician Ratio by SMSA and County Size,
1970-1978**

Source: Mary A. Fruen and James R. Cantwell, *Geographic Distribution of Physicians: Past Trends and Future Influences*, 19 *INQUIRY* 44 (1982).

	Number of People Per Physician		Drop Form 1970-1978
	1970	1978	
Total U.S.	728	578	150
SMSA*			
Over 5 million	458	380	78
1 million to 5 million	585	454	131
500,000 to 1 million	708	531	177
50,000 to 500,000	835	636	199
Non-SMSA*			
Over 50,000	850	656	194
25,000 to 50,000	1470	1210	260
10,000 to 25,000	1962	1763	199
Less than 10,000	2352	2260	92

* Standard Metropolitan Statistical Area.

The fact that some communities benefited more than others from the growth in the total physician pool is reflected in physician-to-population ratios within rural areas. Although the number of physicians moving into these areas increased significantly between 1970 and 1977, most of the practitioners settled in medium-sized rural towns, not in sparsely populated rural areas that had relatively fewer health care resources. Similarly, few physicians moved to poor or economically depressed rural areas. Thus many rural communities facing the greatest problems in attracting and retaining health care professionals have benefited less than other, more attractive rural areas from the substantial diffusion of physicians into nonmetropolitan areas.⁸⁵

This uneven distribution of physicians was highlighted in testimony before the Commission. One witness noted that 51 of Mississippi's 82 counties have no obstetricians and 50 have no pediatricians. In addition, 105 of the 170 obstetricians in the

⁸⁵ Karen Davis, Deputy Assistant Secretary for Planning and Evaluation/Health, *Statement before the Subcomm. on Health and the Environment, Comm. on Interstate and Foreign Commerce, U.S. House of Representatives* (March 25, 1980).

state and 92 of the 159 pediatricians practice in just five counties.⁸⁶ Although family physicians are more evenly distributed across the state, a disproportionate share of the pregnant women and children at highest risk, who could benefit from the specialized care that obstetricians and pediatricians provide, live in rural areas.

Although data on physicians practicing in the inner city versus suburban communities are very limited, what is available suggests that wide disparities exist. An extensive study in Chicago, for example, revealed a decline from one doctor per every 1000 people in 1950 to one doctor for every 4000 people in 1970.⁸⁷ This was accompanied by a corresponding increase in physicians practicing in the ten most affluent suburbs surrounding Chicago. In New York City, there is one physician per 1319 persons in the borough of Queens compared with one physician for every 6013 people in the South Jamaica section of the borough.⁸⁸

Decisions by physicians to locate in a particular area are governed by many considerations. Potential income, the site of the physician's medical training, the geographic background of the physician and spouse, social and cultural opportunities in the area, the presence of other physicians, and the opportunities for continuing education all contribute to the decision about where to practice medicine. Physicians, like everyone else, are concerned about the quality of life available to themselves and their families.

Underserved or "Shortage" Areas. Although population-to-physician ratios are useful in assessing differences in the availability of health professionals, they do not indicate whether the existing supply is adequate to meet the needs of particular areas. The available supply of health resources should be matched to the needs of the community to determine whether it is sufficient to allow everyone to receive an adequate level of care without undue hardship. Yet most currently used standards for identifying underserved areas and population groups focus on deficiencies in personnel, facilities, and services in relation to those available to an average area or population. As a result, they direct attention away from whether resources are being used inappropriately or wastefully. This stems in part from methodological problems and the lack of data and in part from different underlying philosophies about goals and standards.⁸⁹

86 Jeanne Lockett, Chairperson, Mississippi Coalition for Mothers and Babies, Commission Testimony, *supra* note 70, at 180-81.

87 Davis, *supra* note 85.

88 *Id.*

89 Eugenia S. Carpenter, *Concepts of Medical Underservice: A Review and Critique* (1982), Appendix T, in Volume Three of this Report.

Most attempts to relate the available supply of health professionals to the needs of a community are tied to an arbitrary norm intended to reflect a “favorable” supply or “appropriate” use of services.⁹⁰ Different assumptions about practice norms and the organization of health care providers lead, however, to differences in what is considered “adequate.” And these approaches are based on varying perceptions of how to solve the problem of geographic maldistribution, the most obvious difference being whether the standard of adequacy should be tied to a “floor” or minimum level of available health professionals or to a lessening of remaining disparities between areas.

The most widely used standards for designating geographic areas or populations as underserved are the Index of Medical Underservice and the Health Manpower Shortage Area criteria.⁹¹ Both are used by the Federal government as the basis for allocating resources under 24 public programs. In addition, the Robert Wood Johnson Foundation has identified a category of individuals as “structurally underserved.”⁹² Although these three standards all, in varying degrees, consider the availability of health professionals, they also incorporate other factors that may indicate a lack of access to health care. The Index of Medical Underservice, for example, is a weighted measure that includes information on primary care physician-to-population ratios as well as infant mortality rates and the proportion of aged and poor in the county, minor civil division, or census tract.

An estimated 20 million Americans live in areas classified by the Index of Medical Underservice as “high priority.”⁹³ These are generally rural or inner-city communities where there is less than one primary care physician per 2000 people and at least 20% of the population is poor. Many have high rates of infant mortality and of low birth weight babies, a high

⁹⁰ *Id.*

⁹¹ The Index of Medical Underservice was developed in response to the Health Maintenance Organization Act of 1973 (Pub. L. No. 93-222). General guidelines for identifying Health Manpower Shortage Areas were established by Congress in Section 322 of the Public Health Services Act, as provided in the Health Professions Educational Assistance Act of 1976 (Pub. L. No. 94-484).

⁹² The structurally underserved are those Americans who “because of geographic, cultural, and other barriers have trouble getting mainstream personal medical care.” Robert J. Blendon, *Statement before Subcomm. on Health and the Environment, Comm. on Interstate and Foreign Commerce, U.S. House of Representatives* (March 4, 1981) at 2.

⁹³ Unpublished data from Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health, Education, and Welfare, Washington (1979).

prevalence of activity-limiting chronic conditions, substandard housing, and inadequate water and sanitation systems.⁹⁴ These multiproblem communities are often considered less desirable places to live, which, coupled with the lack of a strong financial base to support a physician's practice, suggests that such areas will continue to be unattractive places for physicians to settle in.

Currently, there are 2033 parts of the country designated as Health Manpower Shortage Areas.⁹⁵ Although the designation is based chiefly on a deficit of primary care providers within an area, other factors, such as the presence of primary care physicians in surrounding counties in the service area, are also considered. A refinement of the data, taking into account the number of people in these areas who are already being served by physicians, yields a figure of 16 million Americans who are underserved.⁹⁶

The measure of the accessibility of health care used by the Robert Wood Johnson Foundation estimates that from 12-15 million Americans are "structurally underserved." To reach this figure the Foundation identifies populations with particular demographic characteristics associated with a lack of access to medical care, including race, ethnicity, poverty, age, and residence (inner-city as well as rural). The structurally underserved are viewed as having serious problems in obtaining care either because they live in areas with few health providers and have to travel long distances to secure services, because they face special cultural barriers such as speaking a different language, or because they fail to have an identifiable source of care they can turn to when services are needed.⁹⁷

The length of time and mode of transportation required to get medical care also give some indication of the accessibility of medical services in a community. Travel patterns—whether people must leave their own inner-city community or, in the case of rural residents, go to a metropolitan area for care—are telling signs of the distribution of health professionals and other resources.

Most Americans spend less than 30 minutes traveling to their regular source of health care.⁹⁸ Those most likely to have

94 Bonnie Lefkowitz and Dennis Andrulis, *The Organization of Primary Health and Health-Related Preventive, Psychosocial, and Support Services for Children and Pregnant Women*, in 4 BETTER HEALTH FOR OUR CHILDREN, *supra* note 27, at 441.

95 Selected statistics on Health Manpower Shortage Areas (as of Dec. 31, 1981) from the Division of Health Professions Analysis, Bureau of Health Professions, Health Resources Administration, U.S. Dept. of Health and Human Services, Washington, mimeo. (April 1982).

96 *Id.*

97 Carpenter, *supra* note 89.

98 Aday, Anderson, and Fleming, *supra* note 36, at 58-59.

longer travel times are the elderly, blacks and Hispanics, Medicare beneficiaries, those with low incomes, and those with poorer overall health.⁹⁹ People who live in metropolitan areas have the shortest travel times and, as might be expected, those in rural areas travel the longest distance to reach medical care providers.¹⁰⁰

Reaching the site of care can be a problem for low-income inner-city and rural residents, especially those without insurance. Of people without insurance, 25% travel 30 minutes or more to obtain care, compared with 18% of individuals with insurance.¹⁰¹ Data from the National Health Interview Survey show that the uninsured also wait longer at the site of care to see a practitioner.¹⁰² As one witness who lacked insurance coverage told the Commission:

We didn't have a car, and we had to take a city bus...We would take the child with a very high fever,...and we had to wrap her in a blanket, go wait for the bus, go all the way downtown, change buses, go to the hospital and wait for two-and-a-half hours or longer....With a really sick child, after a long bus ride to and from, that's an awfully long visit.¹⁰³

In rural areas, health services may be available but not easily accessible; public transportation is not routinely available. In families with a car, it is usually needed by the breadwinner to travel to and from work. Families without cars typically rely on neighbors, who may be willing to drive them to the physician, though often at some cost.¹⁰⁴

“Inaccessible” Health Care Providers. A sufficient supply of health personnel and facilities does not ensure that health care resources are available to all members of a community. Some physicians elect not to serve publicly insured Medicaid patients; some hospitals discourage the entry of uninsured or medically indigent individuals.¹⁰⁵ The refusal of some providers to serve all citizens may rest on financial considerations,

99 Judith A. Kasper and Gerald Barrish, *Usual Sources of Medical Care and Their Characteristics, Data Preview 12*, National Health Care Expenditures Study, National Center for Health Services Research, U.S. Dept. of Health and Human Services, Hyattsville, Md. (1982) at 12.

100 Aday, Anderson, and Fleming, *supra* note 36, at 56-58.

101 Karen Davis and Diane Rowland, *Uninsured and Underserved: Inequities in Health Care in the U.S.* (1982), Appendix O, in Volume Three of this Report.

102 *Id.*

103 Commission Testimony, *supra* note 70, at 13.

104 Ernestine Player, Director, Office of Social Work, Dept. of Health and Environmental Control, State of South Carolina, Commission Testimony, *supra* note 70, at 171.

105 Davis and Rowland, *supra* note 101.

philosophical objections to government involvement in the financing of health care, class distinctions, racial or ethnic discrimination, or other factors.

Neither Medicare nor Medicaid, the major government programs financing care for the elderly and the poor, created additional health care resources (professionals or facilities); beneficiaries were expected to receive services from existing physicians and hospitals, with Medicare and Medicaid footing the bill. The intent was to draw the elderly and the poor into mainstream medicine by allowing them the freedom to choose their providers and treatment settings. The success of those good intentions depends in large part on the cooperation and participation of the private sector.

Although most physicians treat Medicaid patients, a sizable proportion (22.6%) do not (see Table 7). Furthermore, 14% of primary care physicians (general practice, family medicine, internal medicine, pediatrics, and obstetrics/gynecology) serve half of all Medicaid patients.¹⁰⁶ The fact that a small proportion of physicians in the primary care specialties treat such a large share of the program's beneficiaries has led to concerns about "Medicaid mills" and the quality of care available to these patients.¹⁰⁷ About 32% of physicians in the medical specialties, 15% in the surgical specialties, and 40% of psychiatrists do not treat any Medicaid patients.

These patterns have significant implications for the access of publicly covered patients to health care. One Commission witness commented:

Many doctors will not take Medicaid...you have to ask up front, when a doctor gives you a referral, "Do you accept Medicaid?" and if they say "No" then you don't have any place to go. You go back to the original doctor and say "Can you give me another referral?" Sometimes the doctor will go ahead and take you because of the referral if the referral was persistent enough.¹⁰⁸

Other testimony revealed that Medicaid-eligible women in rural areas also encounter problems in identifying physicians willing to accept them as patients: 14 counties in Georgia have

¹⁰⁶ Janet B. Mitchell and Jerry Cromwell, *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare* (1982), Appendix Q, in Volume Three of this Report.

¹⁰⁷ Janet B. Mitchell, Jerry Cromwell, and Rachel Schurman, PHYSICIAN PARTICIPATION IN PUBLIC PROGRAMS: FINAL REPORT, Center for Economic Research, Chestnut Hill, Mass. (1981). This report shows that among the five categories of primary care physicians, 22.5% serve no Medicaid patients, 14.6% serve 50.2% of the Medicaid population, and the remaining 62.9% of these physicians serve 49.8% of the Medicaid patients seen.

¹⁰⁸ Commission Testimony, *supra* note 70, at 42.

Table 7:
Lack of Participation in Medicaid, by Medical Specialty

Source: Janet B. Mitchell and Jerry Cromwell, *Medicaid Mills: Fact or Fiction, 1 HEALTH CARE FINANCING REV. 37 (Summer 1980)*.

	Proportion Who Treat No Medicaid Patients
All Specialties	23%
Primary Care	22%
General Practice	24%
General Surgery	8%
Internal Medicine	18%
Obstetrics / Gynecology	37%
Pediatrics	24%
Medical Specialties	32%
Allergy	40%
Cardiology	39%
Dermatology	26%
Gastroenterology	15%
Surgical Specialties	15%
Neurosurgery	18%
Ophthalmology	12%
Orthopaedic Surgery	20%
Otolaryngology	13%
Urology	14%
Psychiatry	40%

no physicians who provide obstetrical care to Medicaid beneficiaries.¹⁰⁹ A rural Georgian obstetrician who does serve Medicaid-eligible women told the Commission:

Basically my feeling is simply that not only do I not have a choice but they have nobody else available. It does mess up a private practice to have a number of people that you are being underpaid to care for but it is not only my choice—my patients really have no choice either. They have nobody else to take care of them.¹¹⁰

The availability of physicians is also reduced for the low-income elderly who are unable to pay for the portion of their medical bills not reimbursed under Medicare.¹¹¹ One out of every two Medicare claims is taken by physicians on assignment, which means the patient is responsible for paying the

¹⁰⁹ Lucile Dismukes, Executive Director, Council on Infant and Maternal Health, State of Georgia, Commission Testimony, *supra* note 70, at 165.

¹¹⁰ Dr. Charles Richardson, Commission Testimony, *supra* note 70, at 127.

¹¹¹ Mitchell and Cromwell, *supra* note 106.

nonreimbursed portion of the bill in addition to the normal coinsurance and deductible.

Economics play an important role in decisions by physicians to treat or not treat publicly insured patients. The cost of medical education and of maintaining a practice means that physicians cannot ignore insurance coverage and reimbursement schedules. Demand for physician services is high enough to allow them to be selective in accepting patients and, as a result, the patients less likely to generate as much income—most often the poor and the less well insured—may find themselves relegated to the back of the queue.¹¹²

Medicaid beneficiaries and, to a lesser extent, Medicare enrollees are considered less well insured by physicians because of lower reimbursement levels.¹¹³ In addition, program limits on covered services, cumbersome forms, long payment delays, and arbitrary procedures and requirements all serve to limit the physicians' sense of autonomy and affect their propensity to treat publicly insured patients.¹¹⁴ The result, however, is that limited participation by physicians creates more competition among the elderly and poor for scarce physician time.

As with physicians, the presence of a hospital does not ensure that all residents of the community have access to hospital care. According to a 1981 survey conducted by the Department of Health and Human Services, some hospitals are much more likely than others to admit patients who lack insurance.¹¹⁵ Uninsured patients are not uniformly distributed across all hospitals; they rely extensively upon large public hospitals.¹¹⁶ There is some concern that the availability of hospital care may be further reduced for these patients.

The recent purchase of some formerly public hospitals by proprietary companies is one source of this concern. In 1960,

¹¹² *Id.*

¹¹³ *Id.*

¹¹⁴ Steven Davidson, *Physician Participation in Medicaid: Background and Issues*, 6 J. HEALTH POLITICS, POLICY AND LAW 703 (1982).

¹¹⁵ *Preliminary Results of the 1981 Civil Rights Survey*, *supra* note 71.

¹¹⁶ Davis and Rowland, *supra* note 101. In the 164 public hospitals with high uninsured patient loads, 37% of all patients are uninsured, 36% are covered by public programs such as Medicare and Medicaid, and 24% have some private insurance. By contrast, 6% of all patients admitted to nonprofit private hospitals are uninsured, 39% are covered by public programs, and 51% are privately insured. For-profit hospitals admit almost exclusively insured patients, with 4% of their patients uninsured, 42% covered by public programs, and 49% covered by private insurance.

about 6% of all acute hospital beds were owned or managed by proprietary companies; in 1980, the proportion exceeded 12%.¹¹⁷ Much of this change has occurred in the South, where local public county hospitals are often the residents' only local source of hospital care. One possible effect of these purchases is that for-profit hospitals, rather than relying just on greater management efficiencies to improve revenues, will change policies in a way that will discourage or prevent noninsured or low-income patients from using the facilities. For example, hospitals constructed with Hill-Burton funds are required to provide a certain amount of free care over the period of the loan.¹¹⁸ This obligation is typically canceled when investor-owned chains purchase a Hill-Burton hospital in cases where they repay the balance of the loan. Although there is no large-scale, systematic evidence of reduced access in these facilities, concerns about the effects of the rapid expansion of proprietary hospitals continue to be heard.

Some services offered by state-supported county health departments (particularly in the South) are available only on a periodic basis. It may be that demand for the service is low or that available staff are insufficient. This situation can, however, impede access to very basic care. In health department prenatal clinics, for instance, care may be available once every two to four weeks. If a clinic session is "filled," the pregnant woman must wait an additional two weeks or a month for care. Since the woman's condition can change and major complications can appear, especially toward the end of pregnancy, a biweekly or monthly visit may not ensure proper care. Thus poor and minority women, who rely extensively on these clinics and who are often at higher risk of complications, may have only sporadic access to prenatal care even if they are enrolled in a health department clinic.¹¹⁹

Access to care may be restricted for racial and ethnic minorities because of discriminatory practices. In a recent attempt to assess the extent and causes of racial and ethnic disparities in health care, the Institute of Medicine (IOM) found that "there is considerable evidence that racial and ethnic factors are associated with disparities in patterns of health care (and) clearly support the concern of many people that minority groups are still discriminated against in this country."¹²⁰ The IOM Committee reviewed evidence showing that the average need for medical care among racial and ethnic minorities exceeds that of whites, a difference that is not

117 Federation of American Hospitals, 1982 DIRECTORY OF INVESTOR-OWNED HOSPITALS AND HOSPITAL MANAGEMENT COMPANIES, Little Rock, Ark. (1981).

118 The Hill Burton program is described in detail on pp. 121-23 *infra*.

119 Goldenberg, *supra* note 15, at 6-7.

120 HEALTH CARE IN THE CONTEXT OF CIVIL RIGHTS, *supra* note 35.

mirrored in the use of health services. Reports were heard of cases in which members of minority groups who were seriously ill or badly injured, as well as women who were in active labor, were turned away from hospitals, transferred to other (public) hospitals, or subjected to long delays before they received care. Furthermore, the Committee found that various forms of racial separation and segregation exist within the American health care system itself.

Paying for Health Care

The nature and the economic structure of the U.S. health care system require people to absorb the cost of care either directly, through personal payment, or indirectly, through some form of insurance. Although particular physicians no doubt treat some “charity” patients and hospitals cross-subsidize to support the care of nonpaying patients, the ability to pay remains a critical determinant of who receives health services.

In recent years, Americans have relied increasingly on insurance to pay their medical bills. Protection against the high cost of health care is no longer viewed as optional. It is essential. An average stay in the hospital now costs almost \$2200; the cost of an initial office visit to an internist is \$36.¹²¹ Since the need for health care and its attendant costs are unpredictable, people without insurance face substantial risk of financial ruin. Furthermore, their health is endangered because they are more likely to delay seeking care or fail to seek it entirely because of an inability to pay. Although many families can absorb routine health care expenses and their access to this care would be unaffected by the lack of insurance, those with low incomes may find it difficult to absorb even “predictable” health care costs.

Clearly, if the distribution of income were more even, differences in the amount of family income spent on health care might just be reflecting differences in preferences about the use of health care by people with similar health problems. But this is not the case; families at varying income levels do not necessarily share similar options to purchase insurance or finance health care out of their own pockets.

The vast majority of Americans have health insurance: an estimated 87-90% of the noninstitutionalized population are covered by some form of public or private insurance.¹²² Most

¹²¹ Unpublished data from the Health Insurance Association of America, Washington (1983). The cost of a hospital stay reflects the average cost to the hospital per stay; the cost of a physician visit reflects the median office-visit fee.

¹²² Public financing programs like Medicare and Medicaid are not “insurance” plans in the traditional sense. Their intent is not to protect the participant against unforeseen medical expense but rather

obtain coverage through their place of work, where their employer may pay all or some of the premium; others purchase plans on an individual basis; many are protected under publicly supported financing programs like Medicare and Medicaid.

In 1980, according to the Survey of Income and Education,¹²³ 70% of the population (161 million Americans) were insured primarily under private plans, including those sold by commercial insurance companies, by hospital and medical services plans offered by Blue Cross and Blue Shield, or by prepayment plans, such as health maintenance organizations (HMOs) (see Table 8). A further 21% of Americans were protected under public government financing programs: Medicare provides hospital and medical benefits to some 28 million elderly and disabled citizens; 21 million people receive assistance

Table 8:

Health Care Coverage by Type and Age, in Millions, 1980

Source: Survey of Income and Education, Dept. of Health and Human Services.

	Total	Private	Public				Uninsured
			Medicare	Medicaid	Medicare and Medicaid	Other Public*	
Total	231.0**	161.2	21.7	15.2	6.1	5.3	21.5
Under 65	205.2	160.9	2.0	15.2	1.0	5.2	20.9
65 Years and Older	25.8	.3	19.7	-	5.1	.1	.6

* CHAMPUS and VA programs.

** Unlike the census, the total population includes estimates of the number of institutionalized persons based on the Survey of Institutionalized Persons (projected to 1980) as well as certain citizens residing abroad and the population of U.S. possessions (Guam, Puerto Rico, etc.).

to remove financial barriers that impede access to care. For the purposes of this discussion, however, public financing programs and traditional insurance programs will be treated similarly in identifying the extent to which people are unprotected against the expense of care and therefore find access to care compromised because of their inability to pay. For a discussion of the impact of these programs on the distribution and the cost of care, see Chapter Three *infra*; see also Table 10, p. 96 *infra*.

123 Office of the Assistant Secretary for Planning and Evaluation, Survey of Income and Education, U.S. Dept. of Health and Human Services, Washington (unpublished).

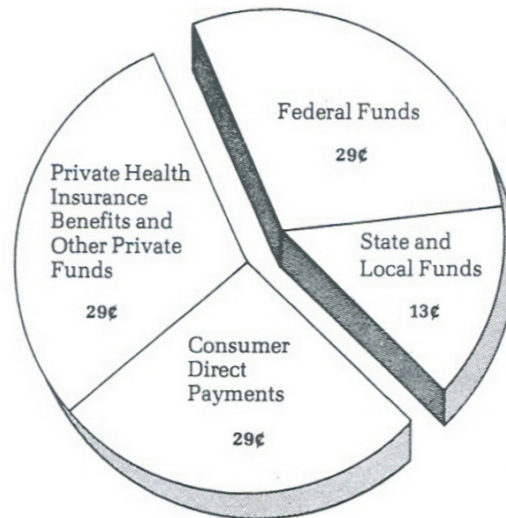
under Medicaid, the joint Federal-state program designed to reduce the financial burden of health care expenses for the poor (the total participation under both programs is 43 million, since 6.1 million are covered by both Medicare and Medicaid). Further, 5.2 million people are eligible to receive health benefits from the military under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Veteran's Administration.

This high level of insurance coverage is due in part to the recent growth of public financing programs. Prior to the enactment of Medicare and Medicaid in the mid-1960s, a substantial number of people (predominantly the elderly and the poor) had no insurance protection. The expansion of government financing programs, coupled with the continued growth in employment-related insurance benefits, is largely responsible for the dominance of third-party payment. Private insurance and public programs now account for over two thirds of every dollar spent on health care (see Figure 8). In 1966, in contrast, third-party payers covered only half of personal expenditures for health care.¹²⁴

Lack of Health Insurance. Despite the prevalence of insurance coverage, a sizable number of people—estimated

Figure 8: The Nation's Health Care Dollar, 1981

Source: Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FINANCING REV. 2 (Sept. 1982).



¹²⁴ Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FINANCING REV. 1 (Sept. 1982).

Table 9:**Persons With and Without Health Insurance Coverage**

Survey	Number of People Without Insurance (mills.)	Share of U.S. Population Without Insurance
National Medical Care Expenditure Survey (National Center for Health Services Research, 1977)	25	12.6%
National Opinion Research Center* (University of Chicago, 1976)	22	12%
National Health Interview Survey (National Center for Health Statistics, 1978)	23.5	11%

*Under 65 years of age includes 2-3 million people with one form of categorical coverage (Workman's Compensation, Medicare, etc.) available to them.

from 22 to 25 million—are uninsured. According to three recent major national surveys, 11-12.6% of the noninstitutionalized population lack insurance (see Table 9). The number of people without health insurance during a 12-month period is substantially larger than the number of uninsured at a particular time, for many people are covered only during a portion of the year. For example, factory workers covered under group plans may find they are not protected against the cost of medical care when they are laid off; low-income single parents become ineligible for Medicaid once their earnings exceed the state's income cutoff limit. Thus, there are two groups of uninsured people—the never-insured and the part-time insured. Eighteen million people lacked insurance coverage during all of 1977 and another 16 million were without coverage for part of that year; the total number of people without insurance for part or all of the year was 34 million, or 16% of the population (see Figure 9).

Though many of the part-time insured fail to show up in “snapshot” statistics, their needs while they are uninsured are as great as those who are never covered. National Medical Care Expenditure Survey data show that individuals insured for only part of the year use substantially fewer services when they are uninsured but are not any less sick during the period without coverage—and that these people do indeed forego medical care when they are sick.¹²⁵ For example, individuals covered under Medicaid part of the year who are uninsured for

125 Gail R. Wilensky and Marc L. Berk, *Health Care, the Poor, and the Role of Medicaid*, 1 HEALTH AFFAIRS 93 (Fall 1982).

the remainder of the year make one-third fewer visits to physicians' offices or hospital outpatient clinics than people insured under Medicaid for the entire year. Also, these part-time insured people receive half as many prescription drugs as those who are covered by Medicaid during all of the year who use prescription drugs.

This point was illustrated for the Commission by a single parent of two small children:

I got sick in 1976 and had to have a complete hysterectomy. During this time I had to go on Medicaid because I lost my job...We went to the eye doctor with my son and found he needed glasses. By the time I was well and back to work I didn't qualify for Medicaid anymore. I couldn't get the glasses. They were \$82. We'd put away a little here and a little there, and then someone would get sick and we'd have to use it to get medicine, or the electric bill would be higher because it would be wintertime. It was always something. I kept putting a little bit back, but I simply could not get the \$82.

Later, I had to be hospitalized again for another surgery. I had developed a tumor and it had to be removed. My son at that point got his glasses. [Because I was again eligible] Medicaid immediately covered his glasses.¹²⁶

Patterns of insurance coverage can vary within families.¹²⁷ Benefits under public programs like Medicaid and Medicare extend only to specific members of a family who qualify for assistance; private insurance is sold on either an individual or a family basis. The decision not to insure an entire family may reflect individual preferences or, in the case of insurance purchased through an employer, the fact that only individual coverage was available.

The uninsured include people of all ages, incomes, geographic settings, races, and ethnic groups. But available data show that some individuals—the very poor, the near-poor, members of racial and ethnic minorities, and rural residents—are more likely to be uninsured. Those who fall into several of these groups, such as black rural Southerners, are especially likely to lack insurance coverage.

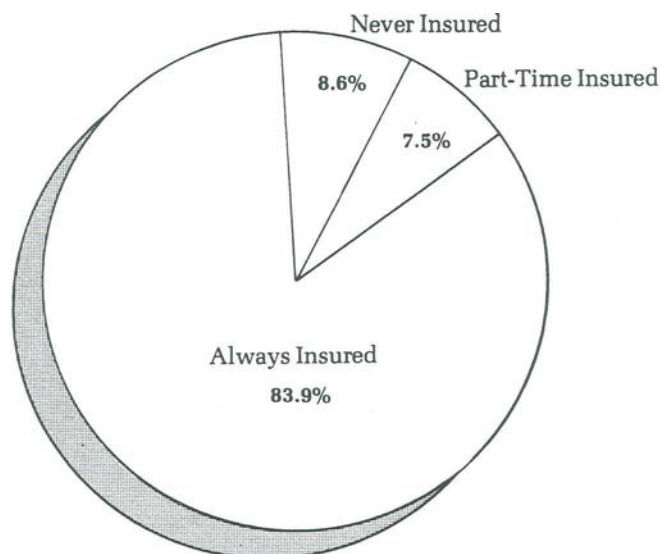
Although public programs have done much to eliminate financial barriers to health care, the likelihood of having

¹²⁶ Commission Testimony, *supra* note 70, at 15-16.

¹²⁷ Judith A. Kasper, Daniel C. Walden, and Gail R. Wilensky, *Who Are the Insured?*, *Data Preview 1*, National Health Care Expenditures Study, National Center for Health Services Research, U.S. Dept. of Health and Human Services, Hyattsville, Md. (1980) (hereinafter cited as *Data Preview 1*).

Figure 9: Health Insurance Status, 1977

Source: Selected data from the 1977 National Medical Care Expenditures Survey, National Center for Health Services Research, Dept. of Health and Human Services, Washington.



insurance is still tied to family income: as income rises, the prospect of being covered by insurance also increases. The poor are almost three times as likely to lack insurance as people with high incomes and almost twice as likely as those with middle incomes (see Table 10). In 1976, over half (55%) the uninsured people under 65 years of age were in families with incomes below \$8000.¹²⁸

The fact that many low-income families have no public coverage is rarely understood by the public. Although the view that all poor people receive public medical assistance may be generally accepted, in fact only about one-half of those classified as poor under Federal guidelines are covered by Medicaid.¹²⁹ The income eligibility limits for Medicaid, which are related to state welfare assistance standards, are generally more restrictive than national poverty guidelines. A dramatic

¹²⁸ Aday, Anderson, and Fleming, *supra* note 36, at 83.

¹²⁹ Office of Research and Demonstrations, Health Care Financing Administration, THE MEDICARE AND MEDICAID DATA BOOK, 1981, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1982) at 111.

Table 10:**Health Insurance Status by Family Income, 1977***

Source: Gail R. Wilensky and Daniel C. Walden, *Minorities, Poverty, and the Uninsured*, at 109th Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981.

	Insured	Uninsured All or Part of the Year
All Incomes	84%	16%
Poor	73%	27%
Low-Income	78%	22%
Middle-Income	86%	14%
High-Income	90%	10%

* Family income definitions for a family of four: poor, less than \$10,000; low-income, \$10,000-\$16,000; middle-income, \$16,000-\$32,000; high-income, over \$32,000.

example of a state's low eligibility level is in Texas, where a family of four with a monthly income above \$141 is ineligible for Medicaid.¹³⁰ Moreover, eligibility for Medicaid is tied to particular family composition requirements, such as being a single parent with children; a couple without children, no matter how poor, is typically ineligible for Medicaid.¹³¹ One Commission witness told how her \$53-a-week salary, the only source of support for herself and her children, was too high to allow her to qualify for public medical assistance. She became eligible only when the cost of hospitalization forced her income down:

Medicaid has been a lifesaver in my lifetime. It's terrible for me to have to be so ill for my kids to get health care, and I really don't like dealing with Medicaid [nor] dealing with the welfare system. I try to work for my living.¹³²

The Commission also learned of an Atlanta couple, with one child, who were unable to afford needed care. The husband, an automobile mechanic by trade, had been unable to find work after being laid off. They had virtually no income but were ineligible for Medicaid because they were married; Medicaid in Georgia does not cover families in which both parents are in the home.¹³³

¹³⁰ Office of Family Assistance, Social Security Administration, U.S. Dept. of Health and Human Services, Washington.

¹³¹ Gerald R. Connor, *The Medicaid Program in Transition* (1982), Appendix P, in Volume Three of this Report.

¹³² Commission Testimony, *supra* note 70, at 42.

¹³³ Personal communication from The Council on Infant and Maternal Health of the State of Georgia, Atlanta, Ga. (Feb. 1981).

The Medicaid program has provided benefits to many of the near-poor. In some states, people with very large medical expenses become eligible for medical assistance once their income, net of medical expenses, drops below the eligibility standard. Some states also offer medical coverage to residents with incomes slightly above the cutoff limit. In order to qualify for either type of assistance, however, beneficiaries must fit into several special categories (blind, over 65, disabled, or single parents with dependent children). A high proportion of near-poor beneficiaries are concentrated in large, populous states, such as New York, California, and Michigan. This extended Medicaid coverage is not offered to residents of 20 states.¹³⁴

Health insurance coverage also varies by race. Blacks and Hispanics are less likely to be covered during the year than whites: 14% of whites are uninsured during the year compared with 23.2% of blacks and 24.3% of Hispanics. Blacks are more likely to be without insurance for part of the year; Hispanics are more likely to be uninsured for an entire year.¹³⁵ Differences in insurance coverage between racial and ethnic minorities and others persist when income levels are considered: low-income minorities lack insurance more often than low-income whites do. Low-income blacks and Hispanics are nearly four times as likely to be uninsured as high-income whites.¹³⁶

The lack of insurance coverage is also a problem for people in rural areas. The National Health Care Expenditures Survey found that almost 18% of people in largely rural areas had no coverage, compared with 10% of the people in the nation's 16 most populous cities.¹³⁷ This may be related to the lack of opportunity for coverage in the workplace, since a higher proportion of jobs in predominantly rural areas are in low-wage, small-scale, or seasonal industries that fail to offer health insurance benefits. And 40% of rural minorities under the age of 65 are uninsured—a rate twice that of whites in that age-group in rural areas.¹³⁸

Over one-third of the uninsured are employed but receive no coverage through the workplace.¹³⁹ For example, 45% of employees in firms of 25 or fewer workers do not have

¹³⁴ Conner, *supra* note 131.

¹³⁵ Gail R. Wilensky and Daniel Walden, *Minorities, Poverty and the Uninsured*, at the 109th Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981.

¹³⁶ Davis and Rowland, *supra* note 101, at Table 3.

¹³⁷ *Data Preview 1*, *supra* note 127.

¹³⁸ Davis and Rowland, *supra* note 101.

¹³⁹ Congressional Budget Office, Congress of the United States, *PROFILE OF HEALTH INSURANCE COVERAGE: THE HAVES AND THE HAVE-NOTS, U.S.* Government Printing Office, Washington (1979).

employer health insurance, compared with less than 1% of people in firms with over 1000 employees.¹⁴⁰ Insurance status also varies by the type of employment—white-collar workers are the most likely to be insured; blue-collar and service workers fare only somewhat better than agricultural workers (one-third of whom are uninsured all or part of the year).¹⁴¹ The lack of employment-related health benefits appears to be a special problem for low-wage workers, particularly in firms with a concentration of employees earning the minimum wage or close to it.¹⁴²

Even when insurance is offered, some low-income workers choose not to purchase it. Although there are no data on the precise number of people who choose not to purchase insurance through their employer, experts estimate this number to be small.¹⁴³ One state official told the Commission:

Some [of the working poor] do not take advantage of health insurance which they may purchase through their employer. It simply takes too much out of the paycheck to pay for something they don't immediately need when food, shelter, and clothing are needed now and the check doesn't cover these sufficiently.¹⁴⁴

Workers at all income levels are vulnerable in times of high unemployment and increased layoffs. Although employment-related coverage usually protects former employees for some period of time after loss of work, lapses between jobs are longer in a slow economy. Estimates of the number of laid-off workers who lose their company-paid health insurance vary by industry and range from a high of 93% of those employed in the finance, insurance, and real estate sector to a low of 73% in manufacturing.¹⁴⁵

140 Amy K. Taylor and Walter R. Lawson, Jr., *Employer and Employee Expenditures for Private Health Insurance, Data Preview 7*, National Health Care Expenditures Study, National Center for Health Services Research, U.S. Dept. of Health and Human Services, Hyattsville, Md. (1981) (hereinafter cited as *Data Preview 7*).

141 Davis and Rowland, *supra* note 101.

142 *Data Preview 7, supra* note 140.

143 Information provided by personal communication with Gail Wilensky, Project Director, National Medical Care Expenditure Survey, National Center for Health Services Research, U.S. Dept. of Health and Human Services, Washington (1982).

144 Player, *supra* note 104, at 173.

145 Suresh Malhotra and John Wills, 1 EMPLOYER PROVIDED GROUP HEALTH PLANS AND THE UNEMPLOYED (prepared for the National Commission on Unemployment Compensation), Battelle Human Affairs Research Centers, Seattle, Wash. (1980) at 37. These estimates are for 1975 (a period of high unemployment); according to the authors, current figures are likely to be considerably higher due to increased unemployment.

For the most part, the options to secure insurance for people who are “caught in the middle” are at best circumscribed, at worst nonexistent. Such people not only lack health benefits at their workplace but often have incomes that are too modest to afford the average annual premium of an independently purchased plan (about \$2243 for a family of four).¹⁴⁶ In addition, they are usually ineligible to participate in a public financing program because they fail to meet the required income and family composition standards. Their income is usually above the state eligibility level, even though it may fall below national poverty guidelines. People in families with incomes between \$10,000 and \$16,000 are more than twice as likely to be uninsured as those at the higher end of the income scale.¹⁴⁷

The situation many of these people find themselves in is reflected in this testimony from a young father from Alabama, who is now paying off a \$3750 bill:

Insurance, as we know, is pretty high these days, and with the way my job has been rolling I couldn't afford the insurance. I checked into Blue Cross-Blue Shield and some more companies, but they were pretty high, too.

My job is a family pulpwood job.... It's a seasonal job. It depends on the weather. It's been raining and it's been a slow economy these days, and they are not taking much wood nowhere. And this time of year I average about two to three days of work. And with the business being like it is—wood, making lumber and all these kinds of things in the sawmill—nobody is buying much wood these days.

If my wife [had a normal pregnancy and delivery at] nine months, I could have really taken care of the \$250 bill. But when my wife was released and I went to the office, I picked up the bill and I asked about any kind of assistance. I had heard about the Hill-Burton Act, and I asked them whether I could fill out an application for the Hill-Burton Act. They told me they didn't have any more funds for this Act. And I asked could I get any kind of assistance, and they told me that I couldn't. So they told me I would have to work some kind of monthly payment or weekly payment to pay this bill out. So I told them I could pay \$25 a month right now with the way things were going. So I pay \$25 a month. It doesn't seem like a whole lot of money, but the way things have been going, it's really a whole lot of money to me. That means a lot

¹⁴⁶ Sampling of Blue Cross, Aetna, Metropolitan, and Mutual of Omaha Insurance premiums for a man and woman aged 40 with two children aged 12-18 as of March 1982.

¹⁴⁷ See Table 10, p. 96 *supra*.

to us, and we can't pay some of the bills sometimes, and there is less food for us to eat.¹⁴⁸

In short, health insurance coverage in the United States is to some extent a matter of "luck." Those fortunate enough to be employed by large manufacturing firms are also likely to have good health insurance coverage. Workers in smaller firms, especially in agriculture, construction, or a retail trade, are less likely to have health insurance. The death of a worker can leave a family without health insurance; spouses may lose coverage through divorce; children eventually are not covered by their parents' policies. In fact, almost one-third of those aged 19-24 are uninsured during the course of a year, reflecting high youth unemployment and the marginal jobs held by this age-group. Single-parent families are more likely to be covered under public programs than are two-parent families. Poor families in one state may be covered by Medicaid, while families with the same income in another state are not.¹⁴⁹

These statistics identify some of the characteristics common to uninsured individuals and so reflect the products of behavior; they do not, however, provide a basis for stepping back to observe the dynamic of being uninsured. For example, how many workers do not purchase insurance because it is unavailable or it costs too much? How many feel insurance is not necessary or desirable? How many families with modest incomes, unable to pay for needed care, apply for some form of public medical assistance but find that they do not qualify? And how many, for a variety of reasons, including pride, choose not to even explore this possibility? Although the various considerations taken into account by each individual cannot be pinpointed, it is reasonable to assume that most people would obtain insurance coverage for themselves and their families if the opportunity to do so was available at a price they could afford.

Use of Services and Insurance Coverage. Insurance coverage can affect the use of health services in a number of direct and indirect ways.¹⁵⁰ As indicated earlier, some hospitals

148 Commission Testimony, *supra* note 70, at 64-65.

149 Davis and Rowland, *supra* note 101.

150 The information in this section was prepared especially for the Commission by Karen Davis, Ph.D., of Johns Hopkins University. The data supplied by the National Medical Care Expenditure Survey is presented to reflect the insured population as those individuals covered throughout the year of 1977 and the uninsured as those individuals lacking insurance for the entire year. Unless otherwise specified, comparisons by insurance status are for persons under the age of 65. The uninsured reflect those persons uninsured for the entire year. Those insured for part of the year are excluded; presumably their utilization resembles that of the insured. *See* Davis and Rowland, *supra* note 101.

Table 11:
Physician Visits Per Year for People Under Age 65, by
Insurance Status, Race, Age, Region, and Residence, 1977

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio, Insured to Uninsured
Total	2.4	3.7	1.54
Race			
White	2.5	3.7	1.48
Black and Other*	1.6	3.2	2.00
Age			
Under 6	3.0	4.0	1.33
6-18	1.6	2.6	1.63
19-24	2.2	3.6	1.64
25-54	2.6	3.9	1.50
55-64	3.1	5.1	1.65
Region			
South	2.1	3.5	1.67
Non-South	2.6	3.8	1.46
Residence			
SMSA **	2.4	3.8	1.58
Non-SMSA**	2.3	3.3	1.43

*Includes Hispanics, Native Americans and other minorities.

** Standard Metropolitan Statistical Area.

refuse admission to patients without insurance unless substantial preadmission deposits are paid. Physicians also may decline to take patients who cannot pay at the time care is provided. Furthermore, many patients are reluctant to seek care because other pressing needs—food for their families, transportation to work, heating bills, rent—take precedence. Seeing a physician may be postponed until serious illness or a life-threatening event occurs.

The National Medical Care Expenditure Survey found that use of the health care system is very closely linked to insurance coverage. Insured individuals use physician services 54% more often than the uninsured do (see Table 11). Insured blacks and other minorities receive twice as much physician care as their uninsured counterparts. Uninsured minorities lag well behind uninsured whites in the average number of visits made to physicians. Differentials in the use of physician services between those with and without insurance are consistent across all age-groups as well as by region and residence.

Differences in the use of health care between the insured and uninsured also extend to hospital care. Individuals covered by insurance receive over 90% more hospital care than the

Table 12:**Hospital Days Per 100 Persons Under Age 65, by Insurance Status, Race, Age, Region, and Residence, 1977**

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio, Insured to Uninsured
Total	47	90	1.91
Race			
White	44	86	1.95
Black and Other*	60	116	1.93
Age			
Under 6	33	50	1.51
6-18	15	27	1.80
19-24	23	86	3.74
25-54	69	110	1.59
55-64	104	201	1.93
Region			
South	35	104	2.97
Non-South	56	84	1.50
Residence			
SMSA**	50	86	1.72
Non-SMSA**	42	99	2.36

*Includes Hispanics, Native Americans, and other minorities.

**Standard Metropolitan Statistical Area.

uninsured do (see Table 12). The use of hospital services by the uninsured varies considerably around the country. Among those living in the South, for example, insured people spend nearly three times as many days in the hospital annually as uninsured people do, regardless of race or ethnic origin. Differences in the use of hospital care between insured and uninsured 19-24 year olds is especially pronounced.

Some of these differences in hospitalization by those with and without insurance may be attributed to self-selection: those who expect to be hospitalized may be more likely to arrange for coverage. Also, some uninsured individuals may become eligible for Medicaid assistance when they incur large medical bills. Some of the difference may be the result of overuse of hospital services by the insured; standards for the appropriate use of hospital services are still the subject of wide debate. But these explanations cannot account entirely for such significant differences in the use of hospital care between people with and without insurance.

Table 13:**Physician Visits Per Year for People Under Age 65 in Fair or Poor Health, by Insurance Status, Race, Age, Region, and Residence, 1977**

Source: unpublished data from National Medical Care Expenditure Survey, National Center for Health Services Research, 1977.

	Uninsured	Insured	Ratio. Insured to Uninsured
Total	4.1	6.9	1.68
Race			
White	4.5	7.2	1.60
Black and Other*	2.6	5.7	2.19
Age			
Under 6	4.7	5.6	1.19
6-18	4.7	4.8	1.02
19-24	3.4	7.5	2.21
25-54	4.3	7.2	1.67
55-64	3.8	7.6	2.00
Region			
South	3.8	6.1	1.61
Non-South	4.5	7.4	1.64
Residence			
SMSA**	4.1	7.2	1.76
Non-SMSA**	4.2	6.3	1.50

*Includes Hispanics, Native Americans and other minorities.

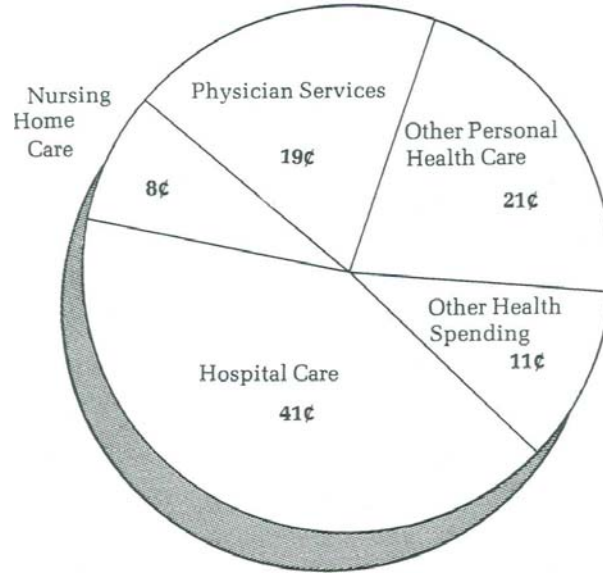
** Standard Metropolitan Statistical Area.

Lower rates of physician visits and hospitalization by the uninsured are not a reflection of a lower need for health care. In fact, the uninsured appear to be in somewhat poorer health than the insured; they are 33% more likely to rate their health as fair or poor and spend one-third more days in bed per year than the insured do. Moreover, the uninsured in fair or poor health use fewer medical services than their insured counter-parts (see Table 13). Physician visits adjusted for health status show that these individuals make one-third fewer visits to a physician than the insured in fair or poor health. Of particular note are differences by race and ethnicity. Uninsured whites in fair or poor health visit physicians over 1.5 times more often than uninsured blacks and other minorities of comparable health status.

Impact of Medical Expenses on Access to Care. In 1981, expenditures for health care reached \$287 billion, with over half the total being spent on hospital care and physician services (see Figure 10). As already noted, third-party pay-

Figure 10: Personal Health Care Spending, 1981

Source: Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures, 1981*, 4 *HEALTH CARE FINANCING REV.* 2 (Sept. 1982).



ments by private insurers, government programs, philanthropy, and industry accounted for two-thirds of all expenditures for personal health care services. The rest—\$81.7 billion—came directly out of consumers’ pockets.¹⁵¹ Generally, consumers were responsible for these payments because they were uninsured or because their insurance failed to cover the full cost of care.

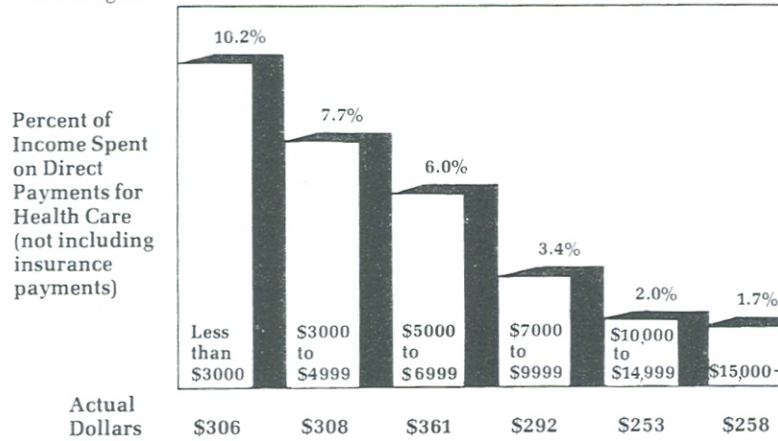
Conceivably, all but the poorest people could purchase insurance or pay for services themselves if they were willing to devote enough of their income to buying an adequate level of care. But expenditures for premiums and direct payments to physicians, pharmacies, hospitals, and others have a substantially different impact on families at different income levels. Consideration of that impact is not new; it is rooted in the legislative debate surrounding the enactment of public financing programs such as Medicare.

[The Medicare] legislation was justified on the basis of two arguments. The first derived from the fact that many persons, ages 65 and over, were unable to obtain an appropriate amount of health care because they lacked

¹⁵¹ Gibson and Waldo, *supra* note 124.

Figure 11: Average Out-of-Pocket Personal Health Expense for Persons with a Medical Expense, by Income, 1977

Source: Unpublished data from the 1978 National Health Interview Survey, National Center for Health Statistics, Dept. of Health and Human Services, Washington.



*Income is factored at categorical midpoint.

the financial resources to purchase the care. The second justification was that, even though individuals might be able to pay for care, their financial resources were so limited that the care would cut heavily into their discretionary income. Thus, the debate related both to the financial ability to pay for the care that was needed and to the impact of large and unpredictable medical expenses on the financial status of the aged.¹⁵²

The impact of comparable personal expenditures for health care is greater on families of modest incomes. The cost of premiums coupled with out-of-pocket expenses for uncovered services, deductibles, and coinsurance requirements can result in substantial outlays relative to outcome. Consumers with private insurance spent on average \$327 for health insurance premiums for each individual (not family) in 1979.¹⁵³

In 1977, the average out-of-pocket payments for people with a medical expense, excluding premium contributions, was \$276.¹⁵⁴ Direct personal payments were greatest for individuals with incomes in the \$5000-\$7000 range (see Figure 11). When

152 Rashi Fein, *On Achieving Access and Equity in Health Care*, 50 MILBANK MEMORIAL FUND Q. 157, 161 (1972) (citation omitted).

153 Marjorie Smith Carroll and Ross H. Arnett III, *Private Health Insurance in 1978 and 1979: A Review of Coverage, Enrollment and Financial Experience*, 3 HEALTH CARE FINANCING REV. 55 (Sept. 1981).

154 Unpublished data from the National Health Interview Survey, National Center for Health Statistics, U.S. Dept. of Health, Education and Welfare, Washington (1978).

these out-of-pocket payments are viewed as a reflection of the portion of family income devoted to personal health expenses, marked variations are found.

The burdens imposed by health care expenses relative to income can be expected to become more severe as the cost of medical care continues to escalate. The average cost to the patient of a semiprivate hospital room per day is \$152.¹⁵⁵ The expense of high-technology services is especially great. A recent survey shows that 27% of all Americans indicate that they are currently having difficulty in handling the expenses of even routine medical care.¹⁵⁶

The breadth and depth of insurance coverage is an important measure of the level of financial protection against health care costs. Some insurance plans offer comprehensive coverage of virtually all hospital and medical expenses; others offer only the most minimal benefits. Likewise, insurance plans differ widely in the level of copayments, coinsurance, and deductibles required. Having insurance does not therefore guarantee financial access: limited benefits and/or high cost-sharing can lead to sizable outlays on the part of the insured. These out-of-pocket expenditures may not significantly deter the use of services by more affluent individuals, but they can seriously compromise access for those at the lower end of the income scale.

Insurance plans purchased under group arrangements in the workplace or through associations tend to offer a greater degree of financial protection against high absolute medical costs than plans bought independently. Virtually all group plans cover basic hospitalization, including such charges as a semiprivate room, X-rays, laboratory fees, and other hospital based charges. Most people insured under group policies also have basic medical-surgical coverage that pays for physicians' services resulting from hospitalization and sometimes for care provided in physicians' offices. In addition, many group enrollees are protected from the cost of extraordinary unforeseen expenses through major medical insurance. Despite this significant financial protection, however, some people may still have to spend a sizable portion of their income on health care because the actual services covered and the deductibles and coinsurance provisions vary considerably among group plans.

Individual policies sold independently tend to offer less financial protection.¹⁵⁷ This is true for protection against both absolute costs and large out-of-pocket expenditures relative to

¹⁵⁵ Health Insurance Association of America, SOURCE BOOK OF HEALTH INSURANCE DATA, 1981-1982, Washington (1982) at 48; charge as of July 1981.

¹⁵⁸ *Public and Physician Attitudes on Health Care Issues*, American Medical Association, Chicago, mimeo. (1982).

¹⁵⁷ PROFILE OF HEALTH INSURANCE COVERAGE, *supra* note 139.

income. Individual plans generally have minimal coverage of ambulatory care, higher deductible and coinsurance provisions, limitations on benefits (such as the number of allowable hospital days), and exclusions of pre-existing and chronic conditions. Also, these policies are usually very costly relative to the benefits they offer. This is due in part to the higher marketing costs of selling plans on an individual rather than a group basis, and in part to the characteristics of the enrollees. Less healthy individuals, who are more concerned about having insurance, may be willing to purchase a more expensive individual plan if coverage is unavailable through their workplace. The Department of Health and Human Services estimates that approximately 19 million people—most of them with low incomes—are insured under individual plans.¹⁵⁸ According to the Congressional Budget Office, a higher proportion of people who earn less than \$10,000 have individual policies as their *only* source of coverage.¹⁵⁹

Public financing programs have successfully reduced the financial barriers to care for many of the poor and the elderly eligible for such assistance, yet people protected under these programs can also be subject to sizable out-of-pocket outlays relative to income. Under Medicare, the required deductible of \$304 for hospitalization can serve as a considerable hardship on the elderly poor with no other coverage. Medicare's exclusion of such services as eyeglasses, hearing aids, drugs, dentures, dental care, and nonskilled nursing home care can involve relatively large personal expenditures that beneficiaries may be forced to absorb.

The Commission heard testimony from several people about the impact of wide variations in insurance coverage. A married mother of three described the financial hardship her family has experienced in connection with over \$1000 in nonreimbursable medical expenses. This debt represented a sizable financial burden, as she had lost her job and her husband had been laid off periodically. She told the Commission:

We needed both incomes to pay our bills and medical expenses. Our expenses (house note, taxes, insurance, utilities, etc.) averaged \$850 per month, without groceries, clothing or extras. My husband's take-home pay,

158 Office of the Assistant Secretary for Planning and Evaluation, *Memorandum for the President on a National Health Program*, Nov. 1977, in 1 NATIONAL HEALTH INSURANCE WORKING PAPERS: BACKGROUND PAPERS, U.S. Dept. of Health and Human Services, Washington (1980) at 13, 17.

159 PROFILE OF HEALTH INSURANCE COVERAGE, *supra* note 139.

160 Medicare deductible as of Jan. 1, 1983, according to the Health Care Financing Administration, U.S. Dept. of Health and Human Services, Washington.

which had averaged \$1100/month, was now averaging \$500.... He has worked for the same company for 11 years.¹⁶¹

Although this couple would most likely have been able to absorb the additional medical expense of treatment not covered by their insurance while they were both working, this was no longer possible in their current circumstances.

The Commission also heard testimony from a Mississippi mother whose ten-month-old daughter had recently died after a series of major medical complications.¹⁶² The total cost of the infant's medical care was \$55,000, of which insurance is eventually expected to cover from \$30,000 to \$44,000. The remaining balance is the responsibility of the parents, whose former income totaled roughly \$25,000 per year. In this case, catastrophic medical expenses were incurred under a policy with an open-ended coinsurance provision. Also, a number of the medical supplies and therapies required for the baby were not reimbursable under their insurance plan.

In short, nonreimbursable expenses can result in severe financial hardship for families of both middle and modest incomes. Excessive or catastrophic costs place an onerous burden on all but the wealthiest. However, even relatively modest expenses for prescription drugs, eyeglasses, or prenatal care can create serious financial strains for people at the lower end of the income scale.

Ethical Implications of Patterns of Access

This chapter has focused on identifying disparities in people's access to care that are based on considerations other than their need for health and medical services, particularly disparities associated with income, race, and place of residence. The Commission concludes that many differences in access to care do exist that cannot be explained by differences in need or health condition. These disparities take many forms: variations in the level of financial protection against health care costs, in the financial impact of health care expenses, in the use of services, in the availability of health resources, and in the use of different settings offering varying levels of quality of care.

In evaluating the ethical implications of these patterns of access, the Commission believes it appropriate to rely on two principles: differences among groups should be considered inequitable when they preclude the receipt of an adequate level of health care or when they place an excessive burden on people who do obtain care. The absence of accepted standards of either measure complicates this evaluation and, as a result,

¹⁶¹ Commission Testimony, *supra* note 70, at 58.

¹⁶² *Id.* at 20-31.

the Commission has relied in part on relative comparisons as indicators of inequitable patterns of access to health care. Clearly, not all *differences* are *inequities*. In some cases, the Commission's conclusions about whether differences in access meet the requirements of equity are explicit; in others, the findings are less definite.

Specifically, the Commission finds that a substantial number of people—from 22 to 25 million at anyone point in time—lack insurance coverage. (A total of 34 million individuals are uninsured during some part of the year.) Another 19 million with very limited coverage are considered seriously underprotected against medical expenses. In the Commission's view, the inability to pay appears to be a critical factor affecting entry into the health care system and an important determinant of the use of services. The current pattern of insurance coverage resembles a patchwork quilt—with coverage depending in large part on where and whether a person is employed and on whether someone meets specific requirements to qualify for coverage under a public program. Lack of insurance is most pronounced among the very poor, the near poor, racial and ethnic minorities, and residents of rural areas, but it is a problem that affects the entire population. The absence of health insurance—either public or private—fails both “ethical tests”: it denies equitable access to an adequate level of care and it places the uninsured at risk of undue financial hardship.

The Commission finds that wide variations exist in the impact of medical expenses on people at various income levels. The financial burden of health care costs can fall heavily upon any family without comprehensive insurance that experiences very high medical expenses. Families of modest income, who are least able to absorb these costs without hardship, devote a greater share of their budgets to medical care than more affluent families do.

Obviously, when the proportion of personal financial resources required to obtain health care jeopardizes people's ability to acquire such essentials as food, housing, and basic utilities, the sacrifice is too great to meet the requirements of equity. At what point the financial burden of securing health care becomes inequitable when less compelling choices are at stake is less clear. Although the Commission does not presume to identify when the financial burdens of health care costs become ethically unacceptable, it does recognize that the current disparities raise questions of equity. Thus, the Commission proposes that differences in the proportion of income devoted to health care expenses be consistent with an adequate level of care being within the reach of all Americans.

Substantial improvements have occurred in the geographic distribution of health professionals and facilities. Yet people in

some rural and inner-city communities still find it difficult to secure health services because of insufficient health care resources. In the most underserved areas it is reasonable to assume that these shortages can preclude equitable access to an adequate level of care. In addition, the lack of transportation and the very long distances to travel or time required to obtain health care can create substantial barriers for some residents and may place an excessive burden on those who do secure services.

The Commission believes that the distribution of health personnel and facilities should be sufficient to ensure reasonable geographic access to an adequate level of care. Equity does not require that every community have a full complement of health providers and services, only that patients can obtain adequate care without excessive burdens. In rural areas, for example, referral systems and transportation to providers in other communities could facilitate such access, although people in these areas may still face greater burdens than those encountered in metropolitan areas.

The Commission finds that differences exist in the source of care typically used by different populations and that the reliance on some settings can result in a compromised quality of health care. Although the Commission recognizes the difficulty inherent in assessing the quality of care, it feels that some unrefined assumptions can be made about the services available in various settings, especially with regard to the continuity, comprehensiveness, and coordination of services. Equity is not achieved when people receive care that fails to meet the standards of adequacy—in either content or quality.

The Commission recognizes that disparities persist in the amounts of services used by different groups with similar health problems. Despite substantial progress in the use of health services by low-income individuals and by minorities, these groups continue to use many health services at lower rates than others with comparable health conditions. Differences also persist in the mix of services received by different groups and in when that care is initiated.

The Commission believes that greater uniformity in the use of health care by individuals with similar health conditions is a precursor to equitable access. At the same time, it recognizes the problems in evaluating differences in the amounts of care received by different groups without accepted benchmarks as to what constitutes appropriate, optimal, or adequate use. It does, however, consider rate of use as a significant indicator of equitable access and feels that progress in reducing existing disparities should not await the development of agreed-upon explicit standards.

As already noted, it is difficult to distinguish how the use of health care is influenced by someone's "motivation" or

propensity to seek care as against financial, geographic, social, or cultural considerations such as language barriers or lack of knowledge. A state official responsible for social services described the transportation problems that many pregnant rural women face in getting to the physician's office or public clinic and commented, "If one feels healthy, why go to the extreme effort to get to the maternity clinic for services that will give no immediate or obvious health benefit and cannot give gratification at least equal to the hardships encountered in arriving at the health delivery site?"¹⁶³ She also noted that financial barriers played a role in determining whether or not such women sought care. "In one of our teaching hospitals in South Carolina, the first prenatal visit cost \$68, and we know that this is a deterrent to early and regular prenatal care." Yet even if all barriers to access related to income, race, and residence were eliminated, health services would still not be used in equal amounts by people with similar health problems since individual attitudes, beliefs, and values would continue to affect decisions to seek health care. However, the Commission would expect that the existing disparities in the use of services by various groups that cannot be explained by differences in need would be reduced significantly.

The lack of access to care can have serious health, economic, and social consequences for both society as a whole and for individuals. The most obvious of these is that people affected by lack of access may go without needed services and suffer the consequences. Or they may delay in acquiring care or may defer needed treatment. Evidence suggests that people with compromised access are more likely to be hospitalized when their illness is at a more advanced stage. This point was underscored by one witness who told the Commission:

My daughter kept having numerous problems. I didn't take them [her children] to the doctor unless they were sick. I just could not afford it. I couldn't take off work to get there because I had to wait all day. It wasn't like you could take them to the pediatrician and take them back to the babysitter. It was like an all day affair when you went, to the public hospital. So you just didn't go to the hospital unless they were extremely ill.¹⁶⁴

Delays in care can have significant health consequences, as many conditions that are amenable to timely medical treatment can develop serious complications if neglected. Several witnesses told the Commission of pregnant women, unable to obtain prenatal care in their communities, who when they entered hospital were already in labor. These women and their infants were considered to be at high risk of complications at delivery.

¹⁶³ *Id.* at 172-73.

¹⁶⁴ *Id.* at 14.

Timely diagnosis and treatment can also affect the cost of health care by limiting the progression of many illnesses and reducing the need for more-intensive and costly medical interventions. For example, patients entering the hospital with conditions in advanced stages use more diagnostic tests and ancillary services than people who are hospitalized at earlier stages of a disease.¹⁶⁵

Limited financial access to care can result in substantial economic hardship. Individuals without insurance are placed at serious financial risk: they can incur considerable debt or can be forced to spend their life savings to secure medical services. The poor and near-poor devote a greater portion of their income than higher-income individuals do to paying directly for health services; thus, the direct cost of medical care falls most heavily on those least equipped to bear the burden.

Lack of access can place great emotional strain on people who are unable to secure needed services. They may know the value of health or medical attention and perceive the need for care but fail to seek it because the burdens are too great.¹⁶⁶

Similarly, differences in access also confront providers of care with difficult decisions. Hospitals must decide whether or not to admit and treat patients who are unable to contribute the full or even partial cost of services. Physicians and other

¹⁶⁵ Mohan Garg *et al.*, *Evaluating Inpatient Costs, The Staging Mechanism*, 16 MED. CARE 191 (1978).

¹⁶⁶ As noted earlier, national data show that the use of health care varies with insurance coverage and that people do fail to receive care during the periods in which they are uninsured. The implications of this problem for individuals were illustrated for the Commission by one witness who testified about a neighbor, with two daughters, who made \$62 a week but who was ineligible for Medicaid and unable to afford an individual insurance policy:

Now, this lady cannot take this child to the doctor because the only place she can take her to is General Hospital. Her job has threatened to fire her on numerous occasions because she has had to take off to pick up her daughter at school because she couldn't breathe.

During spring break I was home and she came to my door with her daughter. Her daughter was blue in color. She could barely breathe at all.... She said, "I've been told if I am not back to work within an hour I'll lose my job. If I go to the public hospital it's all day long. I don't have the medication. I've got a prescription but it's \$14 and I just don't have it. I had to pay rent this week."

This is not a neglectful mother. This is not a mother who did not care for her child or not appreciate the problems that were associated with the child's asthma. Although she may not be a highly literate mother, she knows the problems with her daughter and knew she needed the care.

Commission Testimony, *supra* note 70, at 19.

health practitioners must choose whether or not to treat people who are unable to afford their services. Health professionals must consider whether or not to practice in underserved communities that are considered less desirable locations. Health care providers must determine whether or not they are responsible for responding to such problems as language barriers or the lack of education. As the cost of health services continues to rise and as gaps in access persist and possibly widen, the pressures on the health care system will intensify, and will require even more painful financial, social, and ethical choices.

The Impact of Government Actions on Access to Health Care

3

The Government and Health Care: Premises and Purposes

The government is deeply involved in health care at the Federal, state, and local levels. This involvement has been growing over time—not in obedience to a clearly perceived sense of its proper role in health care but in response to particular problems.

Some government actions are designed to promote the access to care of the population as a whole; of special groups, such as veterans and the military; of groups whose access is considered inadequate, such as the poor, the elderly, and rural residents; and even of middle- and upper-income people. Access to care is also affected by government measures with different primary objectives, such as regulating the quality of providers and ensuring the safety of drugs and devices; promoting biomedical research; disseminating information about health, health care, and health care providers; preventing the spread of communicable diseases; and promoting the efficient use of resources. Beyond this involvement in the health care sector itself, policies that redistribute income affect people's ability to pay for care. And actions that have an impact on the distribution of ill health (for example, pollution control and highway safety policies) indirectly affect access by changing the kinds and amounts of services people need.

Rather than undertaking a comprehensive evaluation of government health policy, which would be beyond its mandate, the Commission chose to examine key aspects of a small number of policies to illustrate the effects such actions have on equity of access and the difficulties that arise in attempting to design ethically acceptable health policies. To this end, the Commission looks at subsidies to increase the physical avail-

ability of care, the direct provision of care by government providers, subsidies for the purchase of care, and regulation of the behavior of public and private health care providers. This chapter is intended to provide a historical perspective on government actions that affect access, rather than to evaluate current policy initiatives. Thus the discussion generally does not cover program changes that have occurred or that have been proposed since the Commission began deliberations on this subject in 1980.¹

The Commission evaluates the effects of the programs or subsidies on equitable access to health care. First, what is their impact on the distribution of health care? To what extent do they contribute to ensuring adequate care for all? Second, what is the impact of government programs on the distribution of the cost of obtaining care (broadly defined to include transportation and waiting time in addition to financial cost)? Do they help to eliminate excessive burdens on those who need care? Equally important, are the costs of reducing these burdens distributed fairly? Third, what is the impact of the program on the cost of the individual services themselves? Although controlling the costs of health care goods and services is not an ethical obligation in itself, unnecessarily high costs make it more expensive to provide adequate health care to all and divert resources from other important social purposes.

Finally, the effect each policy has on the degree of choice available to individuals is considered. What have been the effects on people's choice of provider, treatment, or insurance and on providers' choice of specialty, location, patient, mode of treatment, or fee structure? To what extent has the government's reluctance to interfere in such individual choices constrained efforts to bring about equitable access?

In the overview of government involvement in health care provided in this chapter, the Commission finds significant accomplishments. Although private initiatives, both individual and collective, have played a major role in securing access to care, the disparities documented in Chapter Two would be much greater were it not for government involvement. Nevertheless, problems have arisen that undermine the ability of government programs to achieve their goals.

At the root of these problems is a lack of consensus on the proper role of government in health care. Certain underlying and sometimes contradictory principles can be imperfectly distinguished. A strong societal preference exists for private solutions—for limiting the role of government in health care,

¹ In some cases, information on changes since 1980 is provided in footnotes. In contrast, Chapter Four examines several policies currently under discussion in order to illustrate how the ethical framework of this Report can provide an ethical component in future evaluations of policy.

particularly its role in the direct provision of personal health care to individuals. Thus Federal policy has emphasized temporary measures to increase the supply of services both generally and in areas of greatest need, as well as programs to provide individuals with the financial means to obtain care from the private sector. Most of these programs—the subsidies to medical education and hospital construction, for example, and medical care financing programs such as Medicaid and Medicare—have been designed to interfere as little as possible with private sector arrangements. Others—those intended to provide services more directly—such as the National Health Service Corps and community health centers—illustrate the conflicts that occur when government actions run counter to this approach.

At the same time, the very existence of a wide array of government programs is evidence of a felt obligation to ensure access to health care. The clearest indication can be found in the history of the public hospital. For many decades, locally funded hospitals have served as providers of care for people who have no other way to obtain it. Yet little progress has been made in developing methods to define and deliver the “right” level of care. Similarly, Americans clearly feel that some burdens in obtaining care are excessive, but there is uncertainty about how much individual responsibility people should be expected to take for obtaining and paying for care.

Thus, people often receive either too little or too much publicly supported care. On the one hand, care is extensively subsidized (through the Federal tax system) for people who could take more financial responsibility for their own care without an excessive burden. On the other hand, stringent limits on publicly funded services cause others to be denied adequate care, or to obtain it only at great personal cost. Public health “insurance” programs, such as Medicaid, fail to secure adequate care for many low-income people while providing care for others that is more than adequate. Often the amount of public medical assistance varies arbitrarily, based on personal characteristics irrelevant from an ethical standpoint—type of employment, for example, in the case of tax subsidies; marital status or place of residence, in the case of Medicaid.

The policies examined here also highlight the consequences of failing to address the question of the proper distribution of the cost of meeting society’s obligation. Currently, the costs of caring for those who cannot pay fall in a haphazard manner. For example, the public cost of Medicare is borne at the Federal level, but that of Medicaid is shared between the Federal government and the states. Thus the cost of care for the elderly is spread broadly, but taxpayers’ share of the cost of care for the poor covered under Medicaid depends on the number of poor in each state and the generosity

of that state's Medicaid program. Some of the costs of caring for those with low incomes fall on the providers who treat them and on people who are privately insured as well as on local taxpayers who support public hospitals.

A lack of coordination of the roles of private sector entities and of the various levels of government makes it difficult to achieve equitable access. For example, the private insurance system—on which the great majority of Americans rely for access to adequate care—is based on insurance provided through the workplace. When people become unemployed, many find that neither the private insurance market nor the government makes available a means of obtaining care that is both affordable and adequate. Moreover, when responsibilities for ensuring access are assigned to public and private entities the assignment often does not match available resources to the cost of fulfilling the responsibilities. The poorer the state, for example, the greater are its Medicaid needs, but the harder it is for it to find the necessary resources; local communities—responsible for public hospitals, the providers of last resort—face even greater difficulties. As a result, people “fall through the cracks” and the cost of meeting the societal obligation is unfairly distributed.

The control of health care costs is not an ethical obligation in the sense that achieving equitable access to health care is. Nevertheless, because collective efforts to control costs are increasingly felt to be necessary and are being undertaken, the ethical questions raised by government programs to contain health care costs deserve ethical scrutiny. Efforts to control costs raise a particularly difficult question: What is the ethical duty of the physician if a patient's interest in additional care (when he or she does not bear its full cost) conflicts with society's interest in restraining the amount of resources devoted to health care?

The Commission finds that although equity and cost control can be pursued in tandem, in the past one has often been pursued at the expense of the other. The Medicare reimbursement system, for example, lacks proper financial incentives to providers to contain costs and has thus contributed to inflation in the cost of medical care, while such cost-control measures as certificate-of-need legislation and hospital reimbursement regulation (as currently designed) do not ensure that services are distributed equitably.

Finally, this chapter shows that reluctance to interfere with the choices of providers and patients limits the ways in which the government can bring about an equitable allocation of resources. Great emphasis has been placed on particular kinds of choices without sufficient attention to the impact of the entire system on the range of choices available to patients and providers. For example, the designers of the Federal health

care financing programs gave great weight to preserving the freedom of patients to choose their providers and the freedom of providers to choose whether or not to participate in the program. Yet the unwillingness of some providers to treat program beneficiaries leaves such patients with little real choice, and those without insurance with no choice at all.

Subsidies to Increase the Physical Availability of Care

Several Federal programs have been undertaken to increase the amount of care available and to bring additional care to underserved areas or population groups. Subsidies for medical education and hospital construction have been relatively successful in increasing the general supply of care, but less successful in improving its distribution. Two programs directly targeted at the underserved—the health center program and the National Health Service Corps—have been more successful in improving the distribution of care. All these programs, however, have been seen as temporary “resource development” efforts, not as ways to subsidize the direct provision of care on a long-term basis. Therefore, they have difficulty overcoming one of the underlying barriers to access: inability to pay. As a result, a considerable share of the additional resources have been used to provide care to those already well off; institutions and practitioners who serve the poor have continually faced funding problems.

Subsidies for Medical Education and Hospital Construction

Background. Concern about the availability of physicians dates back to at least the 1930s.² It was not until the early

² Medical education is carried out in conjunction with research and clinical services in medical schools and teaching hospitals. Government may subsidize education directly, through aid to educational institutions or to students, or indirectly, through financial support of these other activities. Separating the costs of education from those of research and clinical services is an arbitrary exercise. Therefore, while the shares of an institution’s revenues that come from student tuition and from public and private funds earmarked for a particular purpose can be computed, the degree to which each share corresponds to the activity’s actual costs cannot be determined. It is impossible to be certain whether government research funds or payments for care (for example, through the allowance for educational costs in Medicare/Medicaid reimbursement or through appropriations for public teaching hospitals) actually constitute a net subsidy to medical education. In this Report, the Commission concentrates on direct subsidies for educational purposes given to increase access to care through medical education.

The discussion of subsidies for medical education in this section

1940s, however, that documented shortages of health personnel became a major national policy issue. Extensive Federal financial support for medical schools began after World War II. At first, the opposition of organized medicine precluded direct government funding of medical education. However, the government provided extensive Federal funds for biomedical research in the medical schools, intending that these funds would also contribute indirectly to the expansion of medical faculties and to increased enrollment.

Explicit and direct Federal funding began in 1963 with the Health Professions Educational Assistance Act, which sought to increase the number of health personnel by boosting enrollment and guaranteeing the financial viability of schools. As Federal support increased over the next decade, secondary objectives included improving the distribution of medical graduates by geographic region and specialty and increasing access to medical education for minorities and the poor. The latter was important not only for equal opportunity reasons but also because sociocultural factors, especially the ability of patient and doctor to communicate, affect access to care.

Federal support went to medical schools as construction grants, “capitation” grants (based on the number of students enrolled), and special project grants for primary care training, curriculum development, and programs for poor and minority students. Aid was provided to students as scholarship and loan programs, some of which included special incentives to practice in underserved areas.³

By the mid-1970s there seemed to be enough physicians; indeed, by the end of the decade there was concern over a projected surplus. Continuing problems of maldistribution—by geographic region (including inner cities) and by specialty—led Congress to tie support of schools and students in the 1976 Health Professions Educational Assistance Act more directly to the goals of increasing the number of primary care physicians, placing doctors in underserved areas, and raising the proportion of minority and poor students in medical schools.

draws on Ruth S. Hanft, *Health Manpower*, in Steven Jonas, ed., *HEALTH CARE DELIVERY IN THE UNITED STATES*, Springer Publishing Co., New York (1981) at 61; Jack Hadley, ed., *MEDICAL EDUCATION FINANCING: POLICY ANALYSIS AND OPTIONS FOR THE 1980s*, PRODIST, New York (1980); Stuart H. Altman and Harvey M. Sapolsky, eds., *FEDERAL HEALTH PROGRAMS—PROBLEMS AND PROSPECTS*, D.C. Heath and Co., Lexington, Mass. (1981); Richard Price, *Health Professions Education: Administration Budget Proposal and Health Professions Education and Nurse Training*, Congressional Research Service, Library of Congress, Washington, mimeos. (Rev. Jan. 19, 1982).

³ After 1972, scholarships were also available through the National Health Service Corps Scholarship Program, in exchange for commitments to serve in a shortage area. See pp. 133-38 *infra* for a discussion of the Corps.

To receive capitation support, for example, medical schools had to have a specified percentage of first-year residency positions in primary care. Money for scholarships was cut, and student aid programs were changed to concentrate funds on first-year students in exceptional financial need. Government loan programs were made more restrictive; the Health Education Assistance Loan was introduced to provide Federally insured loans in the private sector at higher interest rates.⁴

The states also provide direct support for medical education, primarily through their support of public medical schools, although they give some financial support to private medical schools as well. The amount of support has varied widely. For example, in fiscal year 1976 it ranged from \$9.9 million in Texas (to five public medical schools and one private one) to \$75,000 in New Hampshire (to one private school).⁵

In addition, most states (and some localities) fund educational subsidy programs designed to affect physicians' decisions about where to locate. Loan forgiveness and scholarship programs are the most common; other activities include the subsidization of "preceptorships" (apprenticeships in underserved areas designed to encourage eventual practice there) and special medical school courses.

Concern about the availability and distribution of physicians has been matched by worries about the availability and location of hospitals.⁶ At the end of World War II it was generally believed that there was a national shortage of hospital beds. Moreover, the existing beds were disproportionately concentrated in the richer states and in urban areas. In an

4 In addition to this Federal aid, the Veterans Administration provides extensive financial support to medical education as a result of affiliation agreements with medical schools. The agreements were developed to ensure the quality of care in VA hospitals. Steven Jonas and David Banta, *Government in the Health Care Delivery System*, in Jonas, *supra* note 2, at 313, 331. The Department of Defense trains physicians in the Uniformed Service University of the Health Sciences. They serve in the armed forces upon completion of their education but will eventually add to the general stock of physicians when they leave the military. *Id.* at 333.

5 Hadley, *supra* note 2, at 178.

6 The discussion in this section draws on Judith R. Lave and Lester B. Lave, *THE HOSPITAL CONSTRUCTION ACT: AN EVALUATION OF THE HILL-BURTON PROGRAM 1948-1973*, American Enterprise Institute, Washington (1974); Michael Enright and Steven Jonas, *Hospitals*, in Jonas, *supra* note 2, at 169. The focus is on the Hill-Burton Act as by far the most important program subsidizing hospital construction. Other ways the government subsidizes hospital construction include the tax-exempt status of bonds issued to finance hospital capital projects. See Congressional Budget Office, U.S. Congress, *TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES*, U.S. Government Printing Office, Washington (1980).

attempt to deal with this problem, in 1946 Congress enacted the Hospital Survey and Construction Act, commonly known as the Hill-Burton program. This was intended to increase the supply of hospital beds, to improve the distribution of medical services, to upgrade facilities and standards, and to rationalize the planning of facilities.

Hill-Burton was a partnership that involved Federal and state funds. Federal funds were allocated to the states according to a formula based on relative population and per capita income, so that poorer states got a larger share.⁷ States were expected to incorporate minimum standards into their licensing laws and to designate an administrative body to survey hospital needs and prepare a yearly state plan that, following approval, would draw on Federal funds for construction. Rural areas were to receive special priority in state plans. The shortage of beds tended to be greatest there, and it was believed that the presence of a hospital would help rural areas attract physicians. Funds could go to public or to private voluntary (that is, nonprofit) hospitals.

Initially, the standard was set for each state by the Surgeon General of the United States using simply a ratio of total beds to total population; by statute, it could not exceed 4.5 beds per 1000 people, except in very sparsely populated states. In 1965, a more complex approach to standard-setting was introduced, to allow for factors other than current population size that affected the need for hospital care. The new formula included a five-year population projection, current usage rates, and an occupancy factor.

The Hill-Burton Act was amended over time, gradually enlarging in scope from hospital beds to other types of facilities, and from new construction to modernization.⁸ In 1970, the grant program was supplemented with Federal loan guarantees and interest rate subsidies. The program ended as a separate entity in 1974, with passage of the National Health Planning and Resources Development Act.⁹ Over its lifetime, Hill-Burton provided about 15% of hospital investment and

⁷ The state per capita income also influenced the share of the project's total cost that could be covered by Federal funds. In general, the share ranged from one-third to two-thirds; amendments in 1970 allowed it to rise to 90% for facilities serving people in a poverty area or for projects with a great potential for reducing costs.

⁸ For example, in 1954 grants were added for the construction of outpatient facilities, hospitals for the chronically ill (and, later, long-term care facilities), and rehabilitation centers. In 1964, funds for modernization were added.

⁹ For further discussion of this Act, see pp. 169-75 *infra*.

funded approximately 496,000 inpatient hospital beds and 3450 outpatient units.¹⁰

As with the supply of physicians, concern about a shortage of hospital facilities had by the mid-1970s changed to worry about a surplus. The 1974 Act provided some support for construction but emphasized that it should be targeted carefully to improve the distribution of beds and to modernize existing hospitals. After 1978, no new loans or guarantees were issued even for these more limited purposes.

Effects on the distribution of care. It is widely accepted that government subsidies played a major role in the expansion in the number of doctors and hospital beds during the postwar period.¹¹ As discussed in Chapter Two, the effects on the distribution of those resources were more mixed. The large increase in the total supply of physicians as a result of government subsidies was a major factor in the diffusion of physicians into certain smaller communities.¹² With the exception of the National Health Service Corps, the programs tying student aid to location in underserved areas have not had very much impact, according to most observers. The principal mechanism improving the geographic dispersal has been the search by new physicians for congenial surroundings and an uncrowded market for their services. For that, many doctors move to pleasant, relatively prosperous smaller towns and cities, not to inner cities or very poor rural areas in the South.¹³

The distribution of doctors by specialty has received considerable attention. So far there has been little increase in

10 National Academy of Sciences, HEALTH PLANNING IN THE UNITED STATES: ISSUES IN GUIDELINE DEVELOPMENT, Washington (1980) at 13.

11 Federal immigration policy also played a role. Another important source of additional physicians was in the substantial immigration of foreign medical graduates into the United States. Between 1966 and 1976, a period when entry was relatively easy, such graduates constituted nearly one-third of the permanent additions to physician supply. Public Health Service, Health Resources Administration, THIRD REPORT TO THE PRESIDENT & CONGRESS ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL IN THE UNITED STATES, U.S. Dept. of Health and Human Services, Washington (1982) at IV-10 (hereinafter cited as REPORT ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL).

12 See, e.g., W. B. Schwartz *et al.*, *The Changing Geographic Distribution of Board-Certified Physicians*, 303 NEW ENG. J. MED. 1032, 1038 (1982); M.A. Bruen and J.R. Cantwell, *Geographic Distribution of Physicians: Past Trends and Future Influences*, 19 INQUIRY 44 (Spring 1982).

13 Jonas, *supra* note 2, at 78-79. For example, Colorado, New Hampshire, and Vermont now have few geographic gaps in distribution. Although rural, these states are attractive to migrants because of their beauty and recreational opportunities.

the proportion of primary care specialists among physicians (38% in 1970 compared with 39% in 1979).¹⁴ However, the downward trend in that proportion has been arrested, and the percentage of first-year residents entering primary care specialties doubled in just 13 years (although some of them switch to other specialties later).¹⁵

Some progress has been made toward increasing the proportion of minorities in medical schools, which in the long run is believed to improve the access that minorities in the general population have to care. In 1968-69, 3.6% of medical school students were minorities.¹⁶ By 1979-80, the proportion of first-year medical students who were minorities had increased to 13.5%; most of the increase occurred in the early 1970s.¹⁷

Since 1946, the distribution of hospital beds has become much more equal throughout the United States, and there is no longer a strong association between a state's per capita income and its supply of hospital beds.¹⁸ Yet even though a higher portion of the construction costs of hospitals in low-income communities came from Federal funds, the share of total Hill-Burton monies such communities received was limited by the requirements for local initiatives and matching funds. Much of the money supported the construction of short-term hospitals in middle-income communities.¹⁹ The hospital construction program probably also had some impact on the distribution of physicians to rural areas through the link with hospital

14 These figures are for professionally active physicians and include those in general practice, family practice, internal medicine, and pediatrics. If obstetrics and gynecology are included, the figures rise to 44% and 45% respectively. It should be noted that there is considerable debate about the proper way to define a primary care physician; some generalists devote only a portion of their practices to primary care, while specialists deliver a substantial amount of primary care. REPORT ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL, *supra* note 11, at IV-2 to IV-9; data computed from Table IV-2 at IV-81.

15 The proportion of first-year residents in primary care specialties increased from 28.6% in 1967 to 56.1% in 1980. Altman and Sapolsky, *supra* note 2, at 9. Most of this increase occurred by 1976 and was a result of the growth in family practice. Donald M. Steinwachs *et al.*, *Changing Patterns of Graduate Medical Education: Analyzing Recent Trends and Projecting Their Impact*, 306 NEW ENG. J. MED. 10, 12 (1982).

16 National Center for Health Statistics, HEALTH UNITED STATES, 1980, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1980) at 81.

17 REPORT ON THE STATUS OF HEALTH PROFESSIONS PERSONNEL, *supra* note 11, at IV-108-09. The proportion of first-year students in schools of osteopathy who were minorities increased from 3% in 1971-72 to 6.7% in 1979-80. *Id.*

18 Lave and Lave, *supra* note 6, at 47.

19 *Id.* at 21.

location, but this effect was less substantial and has not been well documented.²⁰

The impact of these subsidy programs depended not only on the number, location, and types of additional physicians or hospital beds provided, but also on the degree to which individuals could actually make use of them. The Hill-Burton Act addressed this issue by requiring that hospitals receiving funds make their services available “to all persons residing in the territorial area...without discrimination on account of race, creed, or color” and provide “a reasonable volume of hospital services to persons unable to pay therefore.”²¹ (These requirements became known as the Hill-Burton “community service” and “uncompensated care” assurances.)

The requirements were not very stringent, however. At first, for example, individual hospitals were explicitly allowed to have racially discriminatory policies if the state plan provided for separate but equal facilities for the excluded groups. The separate-but-equal provision was declared unconstitutional in 1963 and that language was eliminated in the 1964 revision of Hill-Burton. Free care did not have to be given if “not feasible from a financial standpoint”; in general, it was left up to each hospital whether and how to meet the uncompensated care obligation.²²

During the 1970s, litigation and external pressure forced the Department of Health, Education, and Welfare to attempt to define and enforce the statutory access obligations. The 1974 Act that subsumed Hill-Burton explicitly left in place recipients’ obligations, as well as applying them to recipients of the new funds, and it required the Department to monitor and enforce compliance.²³ In 1979, the Department issued stringent and specific regulations defining the uncompensated care requirement and how it should be met. As these efforts are still a matter of controversy and legal challenges, their practical effect remains to be seen.

These requirements were not imposed on individual physicians whose education had been Federally subsidized. Physicians in National Health Service Corps sites (most of whom served in the Corps in exchange for medical school

²⁰ *Id.* at 41-43; Carol McCarthy and Steven Jonas, *Planning for Health Services*, in Jonas, *supra* note 2, at 369, 380.

²¹ Institute of Medicine, *HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS*, National Academy Press, Washington (1981) at 168 (quoting Public Health Service Act 6222 (f) as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946)).

²² *Id.* at 169.

²³ The obligation to provide service to all members of the community extends in perpetuity; the “charity care” obligation extends for 20 years after receipt of funds.

scholarship assistance) could not refuse service to any patient because of inability to pay.²⁴ However, physicians generally have been free to choose which patients they will treat (except in certain emergency situations) and to provide as much or as little free care as their own ethical principles dictate, whether or not their education was subsidized.²⁵ The tied scholarship and loan assistance programs required physicians to locate in an underserved area, but, with the exception of the NHSC, there was no provision that they provide care to those most in need. In an area that is underserved because many of its residents lack the ability to pay for care, doctors would have difficulty earning an average income.

To a significant extent, therefore, the increased supplies of doctors and hospital beds have ended up serving middle- and upper-income people, who on average already enjoy better health and better access than low-income people. The impact of subsidies to hospital construction and medical education on access to care has been greatest when geographic unavailability is the only barrier to access. When other barriers exist, especially financial ones, the impact has been much smaller.

As discussed in Chapter One, in the case of health care the forces that normally bring expenditures for goods into line with the benefits provided are weakened. (This is particularly the case for the well insured, whose numbers greatly increased during this period.) Thus a by-product of the increased availability of care seems to have been a large increase in expenditures on care of marginal or even questionable benefit. The doubts about the benefits of the care underlie some of the shift in policy that is now emerging toward limiting the number of medical school places and hospital beds, even though there are still many individuals without access to very basic health care.

Effects on the level and distribution of cost. The substantial increase in the number of physicians and hospital beds relative to the population did not reduce the relative prices of their services; in fact, relative prices increased. Of course, during this period other factors were pushing these prices upward: advances in medical technology, changes in the age distribution of the population, and a general increase in demand resulting from the proliferation of third-party payors through the spread of private health insurance and the

²⁴ For a description of the National Health Services Corps, see pp. 133-38 *infra*.

²⁵ There is a problem, for example, with low physician participation rates in the Medicaid program, which finances medical care for the poor. See pp. 85-87 *infra*; Janet B. Mitchell and Jerry Cromwell, *Access to Private Physicians for Public Patients: Participation in Medicaid and Medicare* (1982), Appendix Q, in Volume Three of this Report.

introduction of new government financing programs (such as Medicare and Medicaid). The increase in the supply of physicians and hospital beds may have slowed down what could have been even greater price increases. Any such retarding effects seem to have been small, however, since between 1950 and 1980 the price of physicians' services increased 1.6 times as much as the consumer price index, and the price of a hospital room increased 5.2 times as much.²⁶

The allotment formula in the Hill-Burton program attempted to redistribute resources to poorer states and to poor communities within states. Much of the money went to middle-income communities, however, and most low-income people still faced financial barriers to the newly created health care resources. The program did not specify how the charity care that was required was to be financed.²⁷ The nonprofit hospitals received a large amount of resources and prices did not fall. Thus, a substantial share of tax money probably ended up financing more care and more—elaborate care for the middle- and upper-income population.

The subsidies for medical education mainly redistributed money from taxpayers generally to a group that can expect to be relatively well off in the future: physicians-to-be. Studies have shown that medical education yields a very good net financial return,²⁸ not to mention the intangible prestige benefits and other nonfinancial satisfactions. Since someone not from a wealthy family has a real problem in financing the high cost of medical training because of the difficulty of borrowing from conventional sources on the basis of future earnings,²⁹ a good case can be made for government-sponsored loans at normal rates of interest. Scholarships and low-interest loans, however, seem less justified.

Subsidies to physicians willing to care for the underserved might seem more justifiable. Yet it is the service that deserves the subsidy, not the physician's education. Otherwise, once a

26 National Center for Health Statistics, HEALTH UNITED STATES, 1981, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1981) at 266 (hereinafter cited as HEALTH U.S. 1981).

27 For a discussion of the problem of financing charity care, see pp. 158-59 *infra*.

28 See, e.g., Stephen P. Dresch, *Marginal Wage Rates, Hours of Work and Returns to Physician Training and Specialization*, in Nancy Thorndike Greenspan, ed., ISSUES IN PHYSICIAN REIMBURSEMENT, Health Care Financing Conference Proceedings, Health Care Financing Administration, U.S. Dept. of Health and Human Services (Feb. 1980). For an earlier, classic treatment, see Milton Friedman and Simon Kuznets, INCOME FROM INDEPENDENT PROFESSIONAL PRACTICE, National Bureau of Economic Research, New York (1945).

29 Medical students are considered better risks than other students but all students have trouble borrowing on their future income given the risk to the lender when there is no collateral that can be repossessed.

physician's education is finished, he or she has no further financial incentive to care for the underserved and may even face financial hardship in doing so. Thus, using tied educational aid to get care to the underserved is likely to be unsuccessful unless strong constraints are placed on the subsequent freedom of action of doctors who receive the aid.

Limits on individual choice. Both the subsidies to medical education and the Hill-Burton program illustrate the reluctance of the government to place significant constraints on providers' freedom of action, even when large sums of public money are involved. Both programs relied on positive financial incentives to meet societal goals. Subsidized medical school graduates could avoid the service obligations of their loans by repaying the money they had received, sometimes on very favorable terms.³⁰ Although the Hill-Burton Act was designed to get hospital beds to the places with greatest need, it did not provide the means to force the issue. And projects that did not qualify for Hill-Burton money could still be built with private or other state and local funds.

Neighborhood Health Centers

Background. The neighborhood health center (NHC) was designed to bring comprehensive health care to people in inner-city or rural poverty areas.³¹ Its roots lay in 19th century

³⁰ Hadley notes: "In nineteen of the twenty-seven states the buy-out provision is simply repayment of the amount borrowed plus interest. In no case is the interest rate greater than 10 percent, which is considerably lower than charges made on conventional consumer loans." However, the trend is toward incorporating more stringent penalty clauses into loan agreements. Jack Hadley, *State and Local Financing Options*, in Hadley, *supra* note 2, at 177, 181, 186. Similarly, the NHSC scholarship program initially allowed recipients to "buy out" of their service obligation by repaying the full amount received within three years at a relatively favorable interest rate. In 1976, however, the terms were changed to require repayment of three times the amount of scholarship award, plus interest at the maximum prevailing rate, within one year. Jack Hadley, *The National Health Service Corps* (Appendix 2), *id.* at 260, 264, 268. See also John L. Williams, Sheila Ludwick Gibbons, and Gwynne Winsberg, *Short-Term Evaluation of State Educational Service Conditional Support Programs for Allopathic, Osteopathic, and Dental Students*, Macro Systems, Inc., Silver Spring, Md., mimeo. (Sept. 1980).

³¹ The discussion in this section draws on Karen Davis and Cathy Schoen, *HEALTH AND THE WAR ON POVERTY: A TEN-YEAR APPRAISAL*, The Brookings Institution, Washington (1978) at 161-202; Steven Jonas, with Robert Greifinger, *Ambulatory Care*, in Jonas, *supra* note 2, at 126, 151-155; F. Goldman and M. Grossman, *The Responsiveness and Impacts of Public Health Policy: The Case of Community Health Centers*, at Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981; Karen Davis, *Primary Care for the Medically Underserved: Public and Private Financing*, at American Health Planning Association and National Association of Community

“dispensaries” (ambulatory care clinics that served the urban poor), in a few early health centers that operated from 1900 to 1919, and in some prepaid group practices that provided comprehensive ambulatory care from the 1930s through the 1950s. The NHCs, however, were not only to provide health care but also “to intervene in the cycle of poverty”³² by responding creatively to the special health care needs of the poor and by promoting a healthy local environment, generating employment, increasing job skills, and serving as a focal point for community activity.

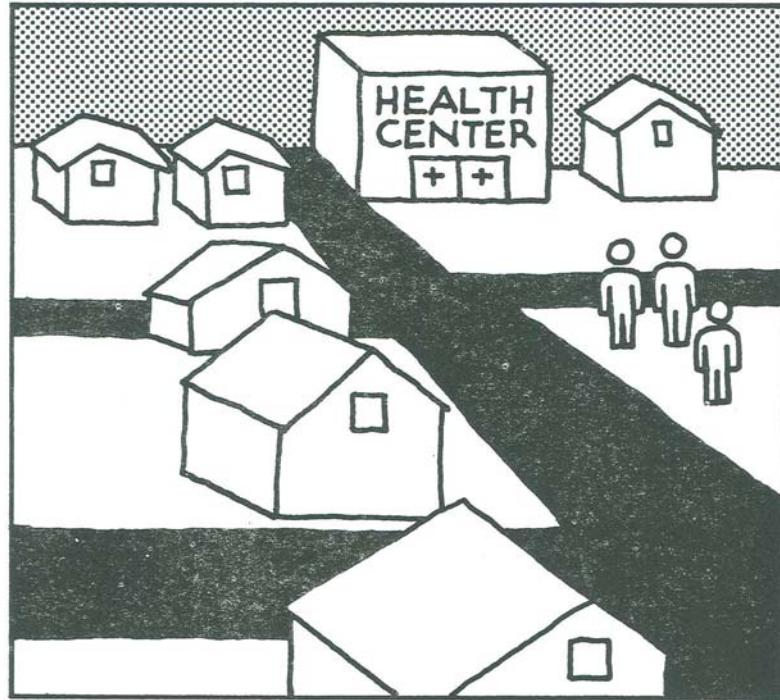
The bulk of the funding of NHCs was to come from the Federal government, either through funds specifically for their development and operation, through categorical program funds for nutrition, day care, and child development, or through Medicare or Medicaid. The Federal government was not going to own or operate the centers, however, in part because of the desire to give maximum control to local residents. But the arrangement mainly reflected a recurrent theme in American health policy: except in a few special cases, the government is not seen as having a role in providing personal health care directly to individuals. (The demise of the publicly funded dispensaries and health centers in the beginning of this century has been attributed in part to the objection that treatment of the poor opened the door to providing care to others who might be able to afford private providers.) To the extent that direct provision of services has been considered appropriate, responsibility has traditionally been assigned to local governments.

To receive funds for a health center, a poor neighborhood had to have a sponsor, which could be a medical school, a hospital, a local health department, some other existing group with similar expertise, or a new nonprofit corporation governed and administered by community residents. Federal support began in 1965 with eight centers funded by the Office of Economic Opportunity. In 1967, a detailed plan proposed the establishment of 1000 health centers to serve 25 million low-income people by 1973, at a cost of \$3.35 billion.

The needed support for this never materialized, however, for several reasons. Federal grants were expected originally to be start-up money, with the centers eventually receiving a large part of their funding through Medicaid and Medicare. Although neither of these programs provided coverage for the extensive services that the centers intended to provide, and although many people the NHCs were to serve were ineligible for these programs, Medicaid and Medicare were expected to expand and become more comprehensive. But the expansion

Health Centers, Symposium on Changing Roles in Serving the Underserved: Public and Private Responsibilities and Interests, Leesburg, Va., Oct. 11-13, 1981.

³² Jonas, with Greifinger, *supra* note 31, at 153.



never occurred. Moreover, neighborhood health centers generated political opposition, perhaps a natural result of their original conception as focal points for community involvement. But they also aroused the opposition of providers in the private sector who objected to the competition. In response to the medical community's concerns, Congress in 1967 required centers to restrict free care to low-income patients only and (as the law was interpreted in 1969) to limit paying or partially paying participants to 20% of all registrants, instead of providing care on an open basis to everyone in a particular geographic area. Finally, since NHCs were experimenting with new ways to deliver services, there was conflict within the centers—as well as between the centers and other providers—about how to provide health care.

Federal funding continued through the 1960s but never reached the level originally envisioned; after 1970, Presidents Nixon and Ford attempted to reduce the funding and the number of centers. The Ford administration also tried to shift decisions for funding to state governors. Although these attempts were unsuccessful, funding did not manage to keep up with inflation.

Moreover, the character of the program changed. Control was relocated to the Bureau of Community Health Services in the Department of Health and Human Services, with funding

under the Public Health Service Act. The centers were renamed Community Health Centers (CHC) and their mandate was redefined to focus more narrowly on medical care delivery. In the interests of financial self-sufficiency, CHCs were encouraged to increase the percentage of patients who were not poor (rather than restricting it to 20%), to charge sliding scale fees based on income, and to collect from third-party payors whenever possible.

In the early 1970s, at the peak of the original NHC program, there were about 200 centers; by 1974, there were 150. During the mid-1970s the program began to expand again, in its revised form. In addition, funds were provided in the late 1970s through the Rural and Urban Health Initiatives to increase the number of centers and to add services so that existing clinics became more comprehensive. By 1980, there were 876 centers, with the capacity to serve about six million people.³³

Effects on the distribution of care. The emphasis on comprehensive care designed to meet the special needs of the populations served, without arbitrary distinctions between covered and not-covered services, is an attractive feature of the health center concept, especially when compared with other programs serving the poor, such as Medicaid. In particular, the centers have more potential for the delivery of preventive services and the control of hospital use.³⁴ The available evidence suggests that the quality of care is at least as good as that of traditional sources of care relied on by the poor.³⁵ Although the effect of NHC/CHCs on health is difficult to measure, a number of studies have found a favorable impact on certain standard indicators of health status—declines in

³³ Davis, *supra* note 31, at 3. Subsequent reductions in 1981 and 1982 reduced the number of Federally funded CHCs to about 600.

³⁴ See, e.g., Joel J. Alpert *et al.*, *Effective Use of Comprehensive Pediatric Care: Utilization of Health Resources*, 116 AM. J. DIS. CHILD. 529 (1968); Michael Klein *et al.*, *The Impact of the Rochester Neighborhood Health Center on Hospitalization of Children, 1968 to 1970*, 51 PEDIATRICS 833 (1973); Daniel I. Zwick, *Some Accomplishments and Findings of Neighborhood Health Centers*, 50 MILBANK MEMORIAL FUND Q. 387 (Oct. 1972-Part 1); Elliot J. Sussman *et al.*, *Can Primary Care Deliver?* 2 J. AMBULATORY CARE MANAGEMENT 29 (Aug. 1979); Dan Hawkins, *The Effectiveness of Community-Based Health Care Centers*, National Association of Community Health Centers, Washington (1981); reviewed by Davis, *supra* note 31, at 14-17. See also Howard E. Freeman, K. Jill Kiecolt, and Harris M. Allen, II, *Community Health Centers: An Initiative of Enduring Quality*, 60 MILBANK MEMORIAL FUND Q./HEALTH AND SOCIETY 245 (1982); Benjamin C. Duggar, Brian Balicki, and Ann Zuvekas, *Costs and Utilization Patterns for Comprehensive Health Center Users*, at Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981.

³⁵ Davis, *supra* note 31, at 21-22.

infant mortality rates, for example, in communities served by centers.³⁶

Funds were provided to communities that could show they had a large number of poor people who would not receive care without the center. Demonstrating the value of the concept was an important early objective; thus, health centers were placed in a variety of communities, some of which were better off than those that did not receive a center. Generally, however, the people served have been the poor, not the middle class.

Effects on the level and distribution of cost. The costs of medical services in health centers appear to be comparable to the costs of other providers of ambulatory care.³⁷ Total expenditures on care may be lower than in traditional settings for comparable health outcomes because of savings on hospital care.³⁸

The program has been less successful at distributing the costs of neighborhood health centers equitably. There is a fundamental contradiction in designing a center to be a permanent structure to deliver comprehensive care to people who cannot afford to pay for it at the same time that direct federal funding is regarded as temporary and financial self-sufficiency is the goal. As noted, Medicaid (the major financing program for the poor) has failed to expand to the extent required for it to form a secure funding base. The initial restrictions on paying patients limited the degree to which charges could be raised to cover the costs of those who could not pay. Though these restrictions were eventually lifted the centers have never attracted large numbers of patients who could pay for their care (which is not surprising in light of the way the centers' locations were chosen) and thus survival has been difficult without a continuing subsidy.³⁹

Limits on individual choice. The fact that the neighborhood health centers were designed expressly to serve the poor has generated controversy. Health care that is provided through institutions that serve only the poor is suspect in the United States. It raises the specter of "two-class care" and of

³⁶ *Id.* See also pp. 54-55 and accompanying notes; Fred Goldman and Michael Grossman, *The Responsiveness and Impact of Public Health Policy: The Case of Community Health Centers*, at Annual Meeting of the American Public Health Association, Los Angeles, Nov. 1-5, 1981.

³⁷ Davis, *supra* note 31, at 12-14.

³⁸ For example, one study showed that total Medicaid expenditures for recipients who used one of three urban CHCs as their primary source of care were lower than those for recipients using other sources as their primary source of care. This was true even after Medicare reimbursements were adjusted to reflect the actual costs of services (Medicaid does not always pay the full cost of services received; see pp. 154-55 *infra*). Duggar, Balicki, and Zuvekas, *supra* note 34.

³⁹ Davis, *supra* note 31, at 5.

unacceptable limits on the choices of the disadvantaged. Health centers might better be considered as examples of “two-track care”; available evidence suggests that the care provided may have different characteristics but that it is not inferior to that offered in mainstream medicine. In fact, since an express goal of the program was to tailor the care provided to the special needs of poor populations (who may, for example, be exposed to specific health risks in their living environments), the care offered in centers may be of higher quality because it is more appropriate to need. Overall, health centers have increased people’s options, since they were placed in locations where residents’ choices had been extremely limited.

The National Health Service Corps

Background. The National Health Service Corps (NHSC) combines subsidies to increase the physical availability of care in underserved areas, primarily in the form of scholarship aid tied to service, with the direct provision of services through Federally salaried Corps personnel.⁴⁰ The main emphasis in the Corps has been on physicians, although other types of health care personnel, such as dentists, nurse practitioners, and physician assistants, have also been included.

The Corps was established by the Emergency Health Personnel Act of 1970 and was originally seen as a modest program to link physicians interested in private practice in underserved rural areas with communities in need of their services. Corps involvement was expected to be limited to the initial period required for the physician to become established.

In 1972, amendments to the Act added a scholarship program that provided financial aid to medical students in exchange for service in physician-short areas.⁴¹ The 1976 Health Professions Educational Assistance Act laid the foun-

40 The discussion in this section draws on Hadley, *The National Health Service Corps*, *supra* note 30; Stanley S. Wallack and Sandra E. Kretz, *RURAL MEDICINE: OBSTACLES AND SOLUTIONS FOR SELF-SUFFICIENCY*, D.C. Heath and Co., Lexington, Mass. (1981); Richard Price, *National Health Service Corps (NHSC) and NHSC Scholarship Program: Administration Budget Proposal*, Congressional Research Service, Library of Congress, Washington, mimeo. (rev. Jan. 19, 1982); *Headings on S. 801, The National Health Service Corps Amendments, and S. 799, The Health Professions Educational Assistance and Nurse Training Act, Before the Senate Comm. on Labor and Human Resources* (April 8, 1981) (hereinafter cited as *Hearings*).

41 The terms were tuition, fees, and a stipend for living expenses for up to four years of full-time medical school attendance. The service obligation was one year of service for each year of scholarship, with a minimum of two years of service. Service could be deferred for up to three years for internship and residency training. Hadley, *The National Health Service Corps*, *supra* note 30, at 262.

dition for a greatly expanded NHSC role in changing the distribution of health care personnel. Funds for the scholarship program were increased, and additional types of personnel were included. A revised method of designating needy communities directed more attention to underserved urban areas, as well as underserved rural areas. The program administrators decided to place a larger proportion of Corps personnel in organized delivery settings (such as neighborhood health centers) as opposed to solo or small group practices. These changes suggested recognition of a continuing need for salaried Corps personnel in very disadvantaged areas, although this was not explicitly acknowledged.

The number of NHSC sites and physicians in the field doubled between 1977 and 1979, and the number of other providers more than tripled. In mid-1979, there were 800 sites, and a field strength of 1824, of whom 54% were physicians. There were 6000 people who had received scholarships to finance their medical education but who had not yet begun their Corps service.⁴² Toward the end of the 1970s, just as many physicians who were obligated to serve in the Corps were about to complete their medical training, there was political pressure to return to a smaller Corps and to the original objective of facilitating the establishment of self-sufficient private practices wherever possible. In addition to opposing direct Federal provision of personal health services, those in favor of this policy shift believed recent increases in the number of physicians would draw providers into underserved areas through ordinary market forces.

Effects on the distribution of care. The main emphasis of the Corps is on physicians, so a discussion of its effects must consider its distribution of physicians' services. The NHSC is the chief Federal policy, instrument for placing physicians in particular places to serve the general public (as opposed to special groups such as veterans or native Americans). Thus while Corps physicians have never been more than a very small fraction of total doctors in the country (at most, one-quarter of 1%), their potential for improving the distribution of care is considerable.

⁴² Health Resources Administration, *Evaluation of the Effects of National Health Service Corps Physician Placements Upon Medical Care Delivery in Rural Areas, Executive Summary*, Dept. of Health and Human Services, Washington, mimeo. (Aug. 1982) at 3. Since 1981, scholarship funding has continued for students already in the program, but no new students have been accepted. The number of Federally salaried field placements has remained constant and the growing number of physicians ready to serve out their obligations have been encouraged to set up private practices in shortage areas or to accept employment there with salaries from non-Federal sources.

The evidence on NHSC effectiveness in pursuing this goal is somewhat mixed. Corps members have not always been assigned to the areas most in the need of their services. The methods used to designate shortage areas are not well developed and some commentators maintain the criteria have done a poor job of distinguishing between underserved and adequately served areas.

More importantly, the very structure of the program makes it difficult to avoid favoring better-off areas. Since Corps salaries are not competitive with physicians' earnings elsewhere, the main source of Corps doctors is the tied scholarship program (although there have been some direct recruits).⁴³ The service obligation is a short, fixed period. In the past, Corps members were encouraged to reenlist; now they are discouraged from doing so, given the large number of new Corps physicians who will need to be placed and the desire to save on Federal salaries. At best, the low salaries mean that reenlistment would probably be for only a limited additional period.⁴⁴

Given the temporary nature of the Corps and its objective of keeping a doctor in the area (particularly as a private practitioner) the program must emphasize sites where the population base is large enough and has enough financial resources to make a practice viable and where there is a lifestyle attractive enough to appeal to physicians. These, of course, tend to be the better-off areas. On the other hand, these are also just the type of area where the increased supply of physicians and normal market forces are most likely to solve the problem of under-service without government involvement.

The services of Corps members are not always fully used. This occurs in some salaried placement sites, particularly in rural areas and in towns without hospitals. Most often (particularly in the less attractive and most underserved areas) a Corps position is a series of short-term assignments. This makes it difficult to provide the continuity of practitioner that is important for an adequate level of health care, as well as to build a practice, particularly in sponsored solo or small group practices. In underserved areas, people who can afford to pay for care have usually made some arrangements to obtain it, perhaps by traveling a long distance to a physician. They may now be reluctant to change to a nearby provider who will probably leave the area and who may not even be replaced, given the variations in Federal policy. And a salaried, short-

43 In addition, a small number of Corps members came from tied loan programs.

44 Reliance on tied scholarship aid for recruitment has the additional disadvantage of limiting Corps flexibility in adjusting the numbers, skills, and experience of its personnel in accordance with short-term needs.

term physician has little incentive to spend the time and effort it takes to build up a practice. Moreover, if the object is not for doctors to provide subsidized care on a long-term basis but to be self-supporting, then the fees they must charge mean that financial barriers remain for those who have difficulty paying for care.

On the other hand, in many rural and urban areas, Corps personnel have had an important positive impact, particularly when there is an institutional framework to provide the continuity and stability needed for practice-building. The administrator of a CHC described the value of the corps in one large metropolitan area:

A large segment of Boston...has been labeled a "Death Zone" by the New England Journal of Medicine because of morbidity and mortality rates many times above the national average. The private sector has left the inner-city neighborhoods in scores over the past 10-15 years and continues to do so. In the Mattapan neighborhood where my Center is located, 15 years ago it was predominantly a white middle-class community with ample physicians. It is now almost entirely a young, Black, lower middle-class community with only two part-time general practitioners, both over 65, besides the Health Center, providing services to a population which has increased to almost 30,000...

In response to this void created by the absence of the private sector...programs such as the National Health Service Corps have become an invaluable source of physicians to serve needy urban populations. Boston now has 28 community health centers, which serve over half the City's population. Most of the centers are not supported by Federal funds but a majority do receive National Health Service Corps placements...the majority of these sites are experiencing significant increases in utilization rather than a decline. My own Center experienced a 40% increase in utilization in 1980...⁴⁵

Effects on the level and distribution of cost. The cost of services delivered by NHSC doctors in health centers is comparable to the cost for other providers of ambulatory care.⁴⁶ However, when NHSC doctors practice alone or in small groups, the cost is higher than it is in comparable private practices.⁴⁷ If there is low use of services, of course, the per service cost is higher because the physician's fixed salary is spread over fewer services. If this is the result of a sparse

⁴⁵ Testimony of Gregory Bulger, Executive Director, Mattapan Community Health Center, Mattapan, Mass., *Hearings, supra* note 40.

⁴⁶ See p. 132 and note 37 *supra*.

⁴⁷ Hadley, *The National Health Service Corps, supra* note 30, at 268; Wallack and Kretz, *supra* note 40, at 29-46.

population coupled with the need to remedy inequity in the distribution of the cost of seeking care (that is, excessively burdensome travel time and cost), the higher cost may be acceptable. If it is the result of a failure to penetrate the local market sufficiently, either because of a lack of effort by the providers or because of financial or other barriers facing patients, it may not be acceptable.

As in the case of health centers, it has been suggested that total expenditures on care for the patients served by NHSC physicians may be lower as a result of reduced hospitalization rates, even though the cost of services provided is not lower. The data are insufficient to confirm this. One study of a small number of rural practices, both sponsored and unsponsored, showed that, because of the structure of the reimbursement system, financial self-sufficiency required not only that physicians have a minimum number of patients but that they be able to hospitalize them.⁴⁸ Again, the data do not warrant an evaluation of the appropriateness of the hospital care provided, but the study raises the possibility that financial self-sufficiency in many rural areas can only be achieved under current conditions by the provision of services that may be of little or no benefit or that are provided in an unnecessarily expensive setting.

The shifts of emphasis between eventual self-sufficiency and salaried placement as a form of subsidized care represent an ambivalence about the proper distribution of the cost of care for the poor similar to that identified in the health center program. Many metropolitan regions, for example, have an ample supply of physicians overall. Yet in the underserved areas of the inner city, a private physician may find it almost impossible to develop a self-sufficient practice with a patient mix of Medicaid recipients and working poor who can afford to pay little or nothing for care. As noted, salaried NHSC physicians serving in health centers play a significant role in providing care to this population. When NHSC support is withdrawn, however, most centers have difficulty finding funds to continue to employ the Corps physicians.⁴⁹

Thus the strength of the Corps is that it can place a health professional directly in a position to serve the most needy. However, the temporary nature of Corps financial support and the reliance on tied scholarship aid rather than competitive salaries⁵⁰ for recruitment make it difficult to retain Corps

⁴⁸ Wallack and Kretz, *supra* note 40, at 141-55.

⁴⁹ Davis, *supra* note 31, at 5-6; Charles Brecher and Maury Forman, *Financial Viability of Community Health Centers*, 5 J. HEALTH POLITICS, POLICY AND LAW 742 (1981).

⁵⁰ In this context, "competitive salaries" would mean salaries sufficient to attract enough volunteers. Given the disadvantages of living in many underserved areas (such as professional, social, and cultural

members in the service of the most needy on a long-term basis. To some extent, the scholarship program may even end up subsidizing the increase in the supply of providers for those who are already well served, especially if it continues to emphasize self-sufficient private practice.

Limits on individual choice. Although the Corps has more control than other programs that subsidize medical education over the degree to which physicians educated at public expense actually care for the underserved, it is clearly still constrained by the physicians' preferences concerning financial rewards, type of practice, and geographical location. Whether higher salaries and an elimination of the scholarship program would be a cheaper and more effective way of getting physicians to underserved areas depends on the nature of those preferences.

Direct Provision of Services: Public General Hospitals

The public general hospital is the major exception to the rule that governments have not directly provided personal health care. Public support for these hospitals as "providers of last resort" is evidence of a societal consensus that everyone should have access to some level of care. Yet the variations in amount, content, and quality of care provided by these hospitals in different locations point up the lack of agreement about what that level of care should be. Furthermore, public hospitals illustrate the difficulties that this lack of consensus causes for the appropriate distribution of the cost of care. The assignment to local governments of fiscal responsibility for health care for the poor has been matched by neither the willingness nor the capacity to fund an adequate level of care in local communities.

Background. Although direct provision of personal health care is normally left to the private sector in the United States, government has historically provided traditional public health services (immunization against or treatment of infectious diseases and certain kinds of health education) and some care for certain special groups. The Federal government's role is limited, for the most part, to providing care to categories of people, such as American Indians, veterans, members of the uniformed services and their families, and (until recently) merchant seamen. The Federal government also operates hospitals for narcotics addicts and people who have leprosy. In some of these cases, a rationale for Federal involvement is

isolation, less sophisticated medical facilities, absence of amenities), such salaries might have to be higher than those in more attractive locations.

apparent; in others, contemporary programs can be understood only in terms of historical accident.

State governments tend to provide care to people suffering from certain categories of illness, usually those that create a threat to public health or public order: tuberculosis, for example, or mental illness. The state support for medical schools has helped teaching hospitals provide clinical services as part of their educational and research mission. State and local health departments (and school health services) provide traditional public health services and some preventive care for mothers and children.

Local governments have historically borne the responsibility for supplying general personal health care for those unable to obtain it elsewhere, particularly the poor.⁵¹ The main element in providing the poor with access to care is the public general hospital, a subcategory of community hospitals—that is, short-term general and certain special hospitals, excluding Federal, psychiatric, and tuberculosis hospitals—that are owned by state and local governments.⁵² As of 1976, public general hospitals constituted about one-third of the 5679 community hospitals and accounted for one-fourth of their beds.⁵³

Both private and public hospitals have their roots in welfare institutions designed to provide general support to the poorest segment of the population (at the expense of private charity and local government entities, respectively).⁵⁴ Gradual-

51 Jonas and Banta, *supra* note 4. In recent years, some states have begun to play a greater role in the direct provision of primary care, *see e.g.*, Testimony of James Bernstein, Chief, Office of Rural Health Services, North Carolina Department of Human Resources, transcript of the 19th meeting of the President's Commission (April 3, 1982) at 61-66, but traditionally this has not been a state function.

52 Commission on Public General Hospitals, *THE FUTURE OF THE PUBLIC GENERAL HOSPITAL*, Hospital Research and Educational Trust, Chicago (1978) at v.

53 Commission on Public General Hospitals, *READINGS ON PUBLIC GENERAL HOSPITALS*, Hospital Research and Educational Trust, Chicago (1978) at 7, 14. The hospital data used by the Commission on Public General Hospitals were derived from the American Hospital Association's 1976 Annual Survey of Hospitals. However, the Commission distinguished between public and private hospitals on the basis of ownership, whereas the AHA makes the distinction on the basis of control. Therefore, the CPGH data and AHA data are not strictly comparable. The data in this section include, under public hospitals, 197 publicly owned but privately operated hospitals that are not considered public by the AHA and, under private hospitals, 37 publicly controlled but privately owned hospitals that are considered public by the AHA. *Id.* at 11-12.

54 The discussion in the remainder of this section draws on Enright and Jonas, *supra* note 6; *THE FUTURE OF THE PUBLIC GENERAL HOSPITAL*,

ly these institutions specialized in the provision of medical care to the sick poor; the sick nonpoor were treated in their own homes. As medical technology changed, starting with the turn of the century, private hospitals became “the doctor’s workshop” for the care of the middle and upper classes, who paid for their treatment; the provision of charity care became less important. Meanwhile, the public hospitals became the “providers of last resort,” meeting the needs of those who could not find care in the private sector. Public and private hospitals, along with “dispensaries,” also played a major role in medical education. In the 19th century, they were an important location for clinical training, experience, and research. Poor patients became the subjects for research and for the teaching of clinical skills.

This history is reflected in the structure of the public hospital sector today. Education is still a significant part of their role. State university medical schools operate most of the public general hospitals owned by the states.⁵⁵ Many nonuniversity public hospitals have residency programs. In 1976, public general hospitals provided clinical training for nearly 40% of the medical and dental residents who trained in community hospitals.⁵⁶

Public hospitals have always provided inpatient and emergency care for serious illness. At first they provided nonemergency ambulatory care on a very limited basis, generally in connection with the need for clinical subjects for education or research. After World War II, hospital emergency rooms were an increasingly significant source of ambulatory care for nonurgent conditions, largely as a result of a scarcity of other sources of readily available, affordable ambulatory care.⁵⁷ This pattern of use was observed in all classes of patients, but it was especially marked among low-income individuals, whose alternative sources of care were particularly limited. All hospitals, but especially public ones, found themselves forced to provide more outpatient care to deal with this problem. (In 1976, although public hospitals had only 25% of total community hospital beds, they accounted for 45% of the

supra note 52; READINGS ON PUBLIC GENERAL HOSPITALS, *supra* note 53; E. Richard Brown, *Public Medicine in Crisis: The Past, Present and Future of Public Hospitals in California*, mimeo. (Feb. 1981).

⁵⁵ University hospitals constitute 2.4% of public general hospitals. READINGS ON PUBLIC GENERAL HOSPITALS, *supra* note 53, at 13.

⁵⁶ *Id.* at 9. Nonuniversity public general hospitals located in large cities constitute less than 2% of the total number of community hospitals; however, they train half of this 40%.

⁵⁷ Jonas, *supra* note 31, at 138.

visits to organized outpatient departments in community hospitals.⁵⁸) In some areas, they are now the only source of ambulatory care for the populations they serve.

Effects on the Distribution of Care. Public hospitals play a major part in reducing geographic barriers to access. Nearly half the rural community hospitals were publicly owned in 1976 and they constituted about 75% of public general hospitals.⁵⁹ In most cases, they serve the entire population in sparsely populated areas that would have difficulty supporting a private hospital. Without them, residents have to either go without care or travel longer distances.

Public hospitals are also the source of care for people who cannot obtain it elsewhere because of an inability to pay, a particular medical condition, or social characteristics that make them undesirable patients. Many are poor, without private insurance or inadequately covered by it, and ineligible for Medicaid or Medicare. (One important group served by public hospitals, for example, is undocumented aliens.⁶⁰) Others are eligible for Medicare or Medicaid but cannot find private-sector providers who will care for them, often because of low reimbursement rates. Some are alcoholics, drug abusers, or psychiatrically disturbed individuals.⁶¹

The fact that public hospitals provide free or reduced-price care indicates societal acceptance of collective responsibility for some health care for at least some of the poor. But the operation of these hospitals reveals an ambivalence about how much and what kinds of care. It is generally agreed that acute care for serious illness is obligatory, but there is no clear consensus on how much responsibility the public hospital should take for nonemergency ambulatory care for the poor.⁶²

58 This number excludes emergency and referral visits. Private community hospitals provide a disproportionate share of referral visits; READINGS ON PUBLIC GENERAL HOSPITALS, *supra* note 53, at 7, 29-30. “[I]n the small cities and suburban areas...private physicians often send their patients to private hospitals to obtain X rays or laboratory work in support of office-based care.” *Id.* at 30.

59 *Id.* at 14. “Rural” community hospitals are nonuniversity hospitals located outside Standard Metropolitan Statistical Areas.

60 One estimate of the size of this group is five million. Emily Friedman, *Public Hospitals: Is relevance in the eye of the beholder?*, 54 HOSPITALS 83 (May 1, 1980).

61 Public hospitals also provide certain specialized types of care to the general population that the private sector has been unable to provide; in particular, care that is very expensive and requires special coordination, such as treatment for serious burns and trauma.

62 There is an inherent conflict in the fact that the hospital’s historical mission has been to provide acute, episodic specialty-oriented care—yet many patients need care for ordinary problems, or need care for specialty-oriented problems but with some continuity and consideration for their overall medical situation. Some believe that hospitals

With respect to the inpatient care that should be available, the position that seems to be implicit in the concept of the public hospital is nicely conveyed in this quote from a British physician in the 17th century:

Another cause of defect in the art of medicine and, consequently, of its contempt, is that there have not been Hospitals for the accommodation of sick persons to resort unto them—Every sort of such Hospitals to differ only in splendor, but not at all in the Sufficiency for the means and remedy for the Patient’s health.⁵³

Everyone, in other words, should receive the same standard of care but not necessarily the same amenities.

The rhetoric, however, does not match the reality. The standard of ambulatory care that poor people receive in public hospitals varies considerably. Public university hospitals generally provide high-quality sophisticated care. Many rural and suburban public hospitals function much as private hospitals do, serving the general population in a manner not unlike private voluntary hospitals. Given the way hospitals function, poor people, once admitted to these hospitals, are probably treated much the same as other patients in those hospitals and thus receive similar care.

But in those hospitals whose major function is to serve the poor, there are often serious problems. Many, particularly the large urban public hospitals, are chronically short of funds. Consequently, they end up using fewer resources but serving people who have more complicated medical problems. As the providers of last resort, they do not have the option that private hospitals have of openly limiting the number of poor admitted or of passing undesirable patients on to other providers. That is not to say that public hospitals never try to discourage patients from seeking care, but it is more difficult to do so when there is nowhere else for the patients to go. There are periodic scandals about shortages of essential equipment and staff.⁶⁴ Thus the care received by patients in public

are unlikely to do a good job of providing routine ambulatory care. This belief was an important factor in the movement to develop community health centers.

63 William B. Ober, *Sir William Petty: Medical Education, Hospitals and Health Care*, 48 BULL. NY. ACAD. MED. 998 (1972) (quoted in James G. Haughton, *The Role of the Public General Hospital in Community Health*, 1974 Rosenhaus Lecture, 65 AM. J. PUB. HEALTH 21 (1975)).

64 See, e.g., Enright and Jonas, *supra* note 6, at 194-95; READINGS ON PUBLIC GENERAL HOSPITALS, *supra* note 53, at 38 (for a discussion of staffing levels); John C.M. Brust *et al.*, *Failure of CT Sharing in a Large Municipal Hospital*, 304 NEW ENG. J. MED. 1388, 1393 (1981); Rand Rosenblatt, *Rationing “Normal” Health Care: The Hidden Legal Issues* (1981), Appendix Z, in Volume Three of this Report, at section three.

hospitals ranges from far more than adequate to seriously inadequate.

Effects on the Level and Distribution of Cost. Rural public hospitals are smaller on average than other community hospitals and have lower average occupancy rates, which suggests that economic costs in underused capacity are being incurred to improve geographic access.⁵⁵

Public hospitals whose primary role is to improve access to care for the poor are usually under severe financial pressure from a lack of funds. This creates an incentive to keep down the cost of the care they provide. On the other hand, when the public hospital is the principal (or only) source of care for certain groups, inefficiencies may develop that tend to raise the total cost of care. For example, the lack of continuity of practitioners and of a clear mandate to provide systematic ambulatory care can mean services are provided in the emergency room and or on an inpatient basis that could be provided less expensively in another setting.

Either because public hospitals are government bureaucracies or because they may not be able to afford high-quality management, they may be more prone than private hospitals to waste and inefficiency. The belief that this is the case has recently led to the leasing of public hospitals to hospital management firms. The evidence to date, however, suggests that when these companies do improve the financial positions of public hospitals it is usually by collecting revenue more aggressively from patients and third-party payors,⁶⁶ an approach that can raise financial barriers to health care for the poor.

The main problem with public hospitals lies in the distribution of the cost of care. Public hospitals get their revenue from patients who pay for a part of their care, from Medicare and Medicaid, from other third-party payors, and from public appropriations, overwhelmingly at the local level. Yet these revenue sources are often inadequate to maintain the high standard of care intended and no one seems willing to shoulder additional financial burdens.

As discussed in Chapter Two, many Americans lack public or private health insurance coverage and the personal financial resources to obtain an adequate level of health care.

⁵⁵Rural public hospitals averaged 70 beds in 1976, compared with 98 for rural private community hospitals and 165 for all community hospitals; average occupancy rates were 65%, 69.7%, and 74.6%, respectively. READINGS ON PUBLIC GENERAL HOSPITALS, *supra* note 53, at 19.

⁶⁶Mareasa R. Isaacs *et al.*, *Contract Management of Public Hospitals*, in URBAN PUBLIC HOSPITALS: OPTIONS FOR THE 1980s, Alpha Center for Health Planning, Bethesda, Md. (Aug. 1982) at Chapter Five.

The costs of medical care for these people currently rest with local government, which is the level where fiscal resources are most limited. Local communities have had great difficulty in dealing with the explosion in medical costs. In some cases the burden has become so onerous that the authorities have decided to divest themselves of ownership by selling off hospitals to private owners or by closing them altogether.⁶⁷ There has been little serious study to date of how this affects people for whom public general hospitals are the only source of care. Are they taken on as charity patients by private hospitals? Or do they go without care, and, if so, what are the consequences for their health?

Limits on Individual Choice. Providing care to the poor in public hospitals that are chronically short of funds clearly limits the choices of some patients. Often the only choice is between substandard care and no care at all. The image of the public hospital that many Americans hold is one of an institution that provides care that is disrespectful and inadequate, provided after a lengthy waiting period under unpleasant conditions to poor people who have no alternative. Not all public hospitals treat only the poor and many public hospitals provide excellent care. But there is enough historical accuracy in this image to provide a basis for suspicion of “two-class” and “two-track” approaches to the provision of care for the poor.

⁶⁷ Although financial pressures are causing problems for all types of hospitals, there is evidence that government-operated institutions are disproportionately threatened. The 1976 closing of Philadelphia General Hospital is often cited as marking the beginning of an era of danger for urban public general hospitals.

Since then, Homer G. Phillips Hospital in St. Louis was closed except for outpatient services, and New York City Mayor Edward Koch has proposed closing four municipal institutions. Maricopa County General Hospital in Phoenix may soon be leased or sold, and Detroit General Hospital is facing sale or closure. In Chicago, Cook County Hospital—the only public-general institution in the county—has been on the financial ropes repeatedly, with payless paydays and last-minute bailouts from the state becoming regular events. The hospital may soon be managed by a private firm. [As of 1983, this is the case.]

In rural areas, public hospital closings are also commonplace; at least seven institutions have shut their doors over the past two years, and many more have been turned over to commercial management firms. In California, where virtually every county at one time owned a hospital, many have been closed, and funding cutbacks under Proposition 13 are threatening others.

Friedman, *supra* note 50, at 85.

Physicians in public hospitals nominally have the same freedom to make clinical decisions for their patients as doctors in other hospitals, that is, without taking costs in consideration. In reality, their decisions are often severely constrained by limits on the resources available. Yet the lack of a public and official consensus on what an adequate level of care should be means the limited quantities of care cannot be allocated appropriately. This situation creates serious management problems for public hospital administrators and difficult ethical dilemmas for both them and doctors.

Subsidies for the Purchase of Medical Care

Subsidies for the purchase of care enable government to lower financial barriers to access while leaving to the private sector the task of providing care. The best-known programs of this type are Medicare and Medicaid, which finance care for the aged, the disabled, and certain categories of the poor. These programs have greatly improved access for those covered. Nevertheless, in basic structure and in actual implementation they have problems that keep them from reaching their potential in promoting equitable access for all.

Not generally realized is the extent to which the Federal government also subsidizes the purchase of care by middle- and upper-income people through special provisions in the tax code. The estimated amount of Federal revenue lost as a result of these tax advantages is close to the total Federal and state expenditures on the poor under Medicaid. The tax subsidies weaken the incentives on consumers and providers to hold down costs and to forego low-benefit care. Moreover, they provide greater assistance to those with lesser need, contributing to inequities in the distribution of the cost of care.

Medicare

Background. Medicare's origins lie in the drive for national health insurance.⁶⁸ The American Association for Labor Legislation began the campaign with a proposal in 1916 for coverage for people below a certain income level. But this effort, and the series of campaigns that followed, failed. National health insurance was strongly opposed by organized medicine and by the drug and insurance industries. Moreover,

⁶⁸ The discussion in this section draws on Steven Jonas, *National Health Insurance*, in Jonas, *supra* note 2, at 438-45; Davis and Schoen, *supra* note 31, at 92-119; Jennifer O'Sullivan, *An Overview of the Medicare Program and Medicare-Medicaid*, Congressional Research Service, Library of Congress, Washington (April 1981); Mitchell and Cromwell, *supra* note 25; Stephen M. Weiner, *Paying for Hospital Services Under Medicare: Can We Control Hospital Costs?*, in Altman and Sapolsky, *supra* note 2, at 135.

the growth of private health insurance for the employed diminished the urgency of organized labor's efforts.

Considerable political support remained, however, for insuring the aged, who continued to be inadequately covered by private health insurance. In 1965, the Social Security Act was amended to create Medicare, a Federal health insurance program for those over 65. In 1972, Medicare coverage was extended to people with chronic renal disease and to the disabled under 65 who had been receiving disability benefits for two or more years.

Medicare has a uniform eligibility and benefit structure throughout the country and covers hospital bills and physician bills without regard to the income or assets of those insured.⁶⁹ Hospital coverage is automatic, and financed through a special payroll tax. Medicare enrollees can choose whether to have coverage for physicians' services (approximately 95% of them do), which is financed by premium charges to enrollees and by Federal tax revenues. In other words, although some people think of Medicare as an insurance program financed by the equivalent of "premiums," in fact it is partially supported out of general revenues.

A major goal of Medicare's designers was to interfere as little as possible in the practice of medicine and the private health care delivery system and to give patients the same choices they would have if privately insured. Reimbursement of physicians and hospitals was based on the methods of private insurance companies, especially the large nonprofit insurers, Blue Cross and Blue Shield. The formula for physicians is based on the fees charged by doctors in each geographical area (called the system of "usual, customary, and reasonable charges").⁷⁰ In most cases, hospitals are reimbursed according to a "reasonable cost" formula based on the actual costs they incur on behalf of Medicare patients.⁷¹

Like private insurance, Medicare requires recipients to share in the cost of care through copayments and deductibles, excludes certain types of services, and sets limits on the

⁶⁹ Hospital coverage includes very limited coverage for post-hospitalization home health services and skilled nursing facility services.

⁷⁰ Physicians receive whichever is lowest: their actual charge, their average charge, or the 75th percentile of charges for the same procedure by physicians in the area.

⁷¹ In the past, there have been some experiments in reimbursing hospitals on a different basis in certain states. At this time, Congress and the Department of Health and Human Services are taking steps to revise the Medicare reimbursement system to include greater incentives to control costs. See Linda E. Demkovich, *Devising New Medicare Payment Plan May Prove Much Easier Than Selling It*, 14 NAT'L. J. 1981 (1982); for a discussion of reimbursement regulation, see pp. 175-82 and note 123 *infra*.

amount of services (for example, on the number of hospital days covered). The portion of the cost that enrollees are directly responsible for is not related to their income. In addition, doctors with fees above Medicare's formula can, for each patient, either accept Medicare's allowed fee as payment-in-full (that is, "accept assignment") or bill the patient for the full usual fee, a portion of which is then repaid to the patient by the program.⁷²

From the start, Medicare expanded rapidly, both in numbers enrolled and in total expenditures. In 1967, its first full year of operation, the program enrolled 19.5 million people and the total Federal cost was about \$4.5 billion.⁷³ For calendar year 1980, total Federal expenditures amounted to \$33.6 billion for 28.5 million enrollees, of whom 90% were aged and 10% were disabled.⁷⁴ About 63% of enrollees received services; reimbursement averaged \$1864 per person. Two-thirds of this was for inpatient hospital services (see Figure 12).

Effects on the distribution of care. Measured in terms of the use of services, Medicare has significantly improved access for the elderly and the disabled. Disparities among subgroups of the elderly by income, race, and place of residence still exist, but they have narrowed considerably.⁷⁵ And for one group of disabled, those suffering from chronic renal disease, the distribution of services has changed markedly. Hemodialysis used to be a procedure obtained largely by white, middle-class, middle-aged males. Now the group that receives it contains a much higher proportion of blacks, females, and

⁷² In the first case, the physician is paid 80% of the fee directly by Medicare; the remaining 20% (the coinsurance rate for physician visits) is owed by the patient. In the second case, the physician bills the patient for the entire amount; the patient is then reimbursed by Medicare for the amount allowed under its fee schedule.

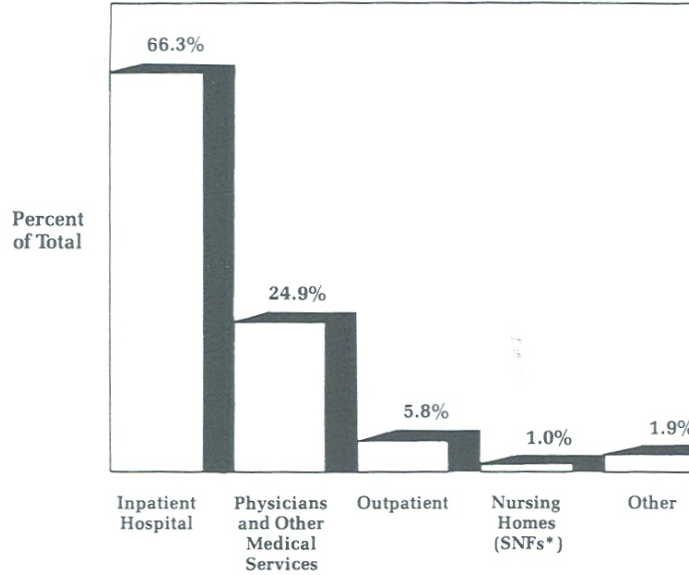
⁷³ Office of Research and Demonstrations, Health Care Financing Administration, *THE MEDICARE AND MEDICAID DATA BOOK*, 1981, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (1982) at 16, 20.

⁷⁴ Office of Research and Demonstrations, Health Care Financing Administration, *THE MEDICARE AND MEDICAID DATA BOOK*, 1982, Dept. of Health and Human Services, U.S. Government Printing Office, Washington (forthcoming).

⁷⁵ Martin Ruther and Allen Dobson, *Equal Treatment and Unequal Benefits: A Re-examination of the Use of Medicare Services by Race, 1967-1976*, 2 *HEALTH CARE FINANCING REV.* 55 (Winter 1981); Charles R. Link, Stephen H. Long, and Russell F. Settle, *Equity and the Utilization of Health Care Services by the Medicare Elderly*, 17 *J. HUM. RESOURCES* 195 (1982).

Figure 12: Medicare Reimbursements by Type of Service, 1980

Source: Office of Research and Demonstrations, Health Care Financing Administration, *THE MEDICARE AND MEDICAID DATA BOOK, 1982*, Dept. of Health and Human Services, Washington (forthcoming).



*Skilled Nursing Facilities.

older persons, which is more in line with the distribution of chronic renal disease in the population.⁷⁶

It is difficult to determine from statistical data whether or not enrollees are receiving adequate care, especially in the absence of a firm consensus on the details of adequacy. From one perspective, however, certain difficulties are clear. Medicare's structure—which is based largely on the existing payment system—makes it inevitable that some people will receive care that is more than adequate (in fact, not worth its cost) while others will fail to receive an adequate level.⁷⁷

⁷⁶ Roger W. Evans, Christopher R. Blagg, and Fred A. Bryan, Jr., *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 J.A.M.A. 487 (1981).

⁷⁷ Since Medicare's structure is based on that of private insurance, these points about structural problems are also valid for most private insurance contracts.

Medicare's reimbursement procedure preserves the existing fee structure's incentives to provide too much or the wrong kinds of care.⁷⁸ Fee-for-service physician reimbursement and cost-based hospital reimbursement give providers no financial incentive to weigh the benefits of care against the cost (although they may, of course, be sensitive to the financial burdens on the patient that result from cost-sharing provisions). The existing fee structure reimburses physicians at a higher rate for performing procedures than for talking to patients, thus encouraging the use of expensive technology and failing to encourage good patient-provider communication. Fee differentials for services provided reinforce rather than correct the imbalance between primary and specialty care, while those between geographical areas tend to perpetuate a poor geographical distribution of providers.

On the other hand, the cost-sharing provisions and coverage limits in Medicare can mean some patients receive too little or the wrong kinds of care, especially when it is a question of patient-initiated treatment. Access to an adequate level of health care need not mean full insurance for it, of course. As discussed in Chapter One, good reasons not to provide full coverage include moral hazard, government budgetary constraints, and considerations of cost distribution. Many of the elderly are able to meet some of their medical expenses themselves or to purchase private insurance policies that are explicitly designed to "fill in the gaps" in Medicare coverage. (The very poor elderly and disabled are eligible for some additional coverage through Medicaid.) The important measure here of Medicare's success is whether the government coverage combined with an individual's private resources secures access to adequate care without excessive burdens.

Medicare—like most private insurance—fails to make the distinctions discussed in Chapter One that can help set the boundaries of adequate care. It combines elements of unlimited entitlement with quantitative limits that are unrelated to the recipients' health status or to the relationship between the cost of care and the importance of a treatment to the patient's well-being. For example, the program covers almost any nonexperimental procedure ordered by a doctor in a hospital, no matter

⁷⁸ See, e.g., Thomas W. Moloney and David E. Rogers, *Medical Technology—A Different View of the Contentious Debate Over Costs*, 301 NEW ENG. J. MED. 1413 (1979); William C. Hsiao and William B. Stason, *Toward Developing a Relative Value Scale for Medical and Surgical Services*, 1 HEALTH CARE FINANCING REV. 23 (Fall 1979); S.A. Schroeder and J.A. Showstack, *Financial Incentives to Perform Medical Procedures and Laboratory Tests: Illustrative Models of Office Practice*, 16 MED. CARE 289 (1978); Frank A. Sloan, *Patient Care Reimbursement: Implications for Medical Education and Physician Distribution*, in Hadley, *supra* note 2, at 57.

how cost-ineffective it is in relation to other procedures or how small its benefits are relative to its costs, so long as it is not totally without benefit.

The legislation that established Medicare provided that procedures be covered as long as they are “reasonable and necessary,” but policymakers have moved very cautiously on the question of whether or not benefits can be weighed against costs in deciding what procedures qualify. To date, they have shied away from denying coverage on such grounds, even in the case of something as costly as heart transplants.⁷⁹ Similarly, in outpatient settings there are arbitrary restrictions on the amount of physicians’ services covered, but few restrictions on the treatments they can prescribe.

In the case of hospital care, some steps have been taken to relate reimbursement to the degree that inpatient services are appropriate to patients’ health. The Social Security Amendments of 1972 established Professional Standards Review Organizations (PSROs), in which physicians review services provided under Medicare (as well as Medicaid and Federally sponsored maternal and child health programs) to determine whether services are medically necessary, provided in accordance with professional standards, and, in the case of institutional services, rendered in the appropriate setting.⁸⁰ In prac-

79 So far, they have sidestepped the problem by continuing to call heart transplants experimental and authorizing payment on a very limited basis on those grounds. As of now, Medicare does not cover heart transplants on the grounds that they are still experimental. However, the Department of Health and Human Services is funding a national study to consider a range of issues related to Medicare coverage of heart transplants, including the role of cost in such coverage decisions. As part of this study, six centers are performing and being reimbursed for a limited number of heart transplants. 46 Federal Register 7072 (Jan. 22, 1981).

80 Some kind of utilization review is a normal feature of hospital operation and was a condition of participation in Medicare and Medicaid from the early days of the programs. However, the original regulations permitted wide latitude in how the review was done. The PSRO program introduced a new administrative structure, new sanctions, and greater uniformity across hospitals in the review process for publicly funded patients. The program—controversial among medical care providers—was implemented relatively slowly. In 1978, less than half of Medicare and Medicaid admissions were to hospitals in which PSRO review had begun; by 1980 the number had reached two-thirds. Moreover, by that time support for the PSRO program was weakening as a result of disappointment with its impact on cost. After 1978, total program funding did not keep pace with inflation, in spite of the expansion in activity. In 1981, the administration proposed phasing out PSROs entirely, a plan Congress did not accept. Instead, in 1982 Congress authorized the establishment of new entities called PROs (peer review organizations). PROs will have more flexibility in deciding how to conduct the review process and are

tice, PSROs concentrate on eliminating care that is generally considered unnecessary (which, for the most part, means excessively long hospital stays) and on ensuring that care meets quality standards. They do not tackle the more difficult task of ensuring that care is worth having relative to its costs or adequate relative to patients' health.⁸¹ Care that is of relatively small benefit but not "unnecessary" will pass PSRO review and be covered, as long as the arbitrary limit on the number of days in the hospital has not been reached. Once the number of days passes the limit, no Medicare review process considers whether further coverage is warranted, however great the benefits of additional care might be.⁸²

A special problem is raised by nursing home care. There is minimal coverage of long-term care under Medicare, although it is very expensive; most patients find it difficult either to pay for it themselves or to obtain private insurance that will cover it. The question of the nature of the social obligation to pay for this type of care, some of which is "custodial" rather than "health" care, raises different issues, however, from those presented by the obligation to ensure access to an adequate level of health care.⁸³

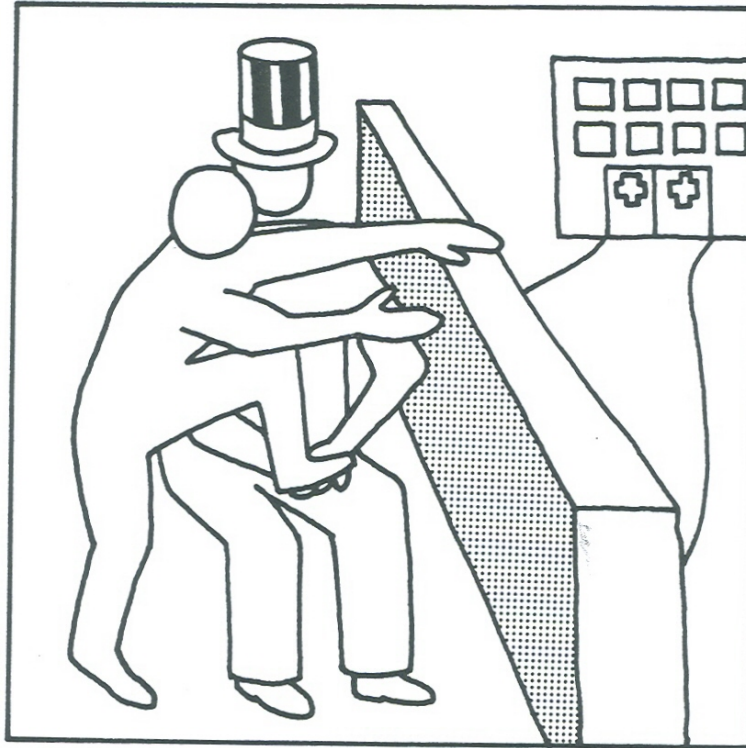
Effect on the level and distribution of cost. Since Medicare greatly increased the purchasing power of people with unmet health needs in a system that was failing to restrain the unit costs of services or the number of services received, the program contributed to the increases in those unit costs. The system of "usual, customary, and reasonable charges," for example, contains a strong inflationary bias (although this was not realized when it was adopted, since it had only recently

expected to contract with other clients as well as the Federal government. Congressional Budget Office, U.S. Congress, THE IMPACT OF PSROs ON HEALTH-CARE COSTS: UPDATE OF CBOs 1979 EVALUATION, U.S. Government Printing Office, Washington (1981) at 6, 7; *PSROs Turn PRO*, PERSPECTIVES, WASHINGTON REPORT ON MEDICINE & HEALTH, Nov. 1, 1982.

81 Clark C. Havighurst and James F. Blumstein, *Coping with Quality/Cost Tradeoffs in Medical Care: The Role of PSROs*, 70 Nw. U. L. REV. 6 (1975).

82 Some of the structural changes in Medicare now under consideration would encourage such trade-offs between benefits and costs: for example, provisions for Medicare-eligible patients to obtain their coverage through health maintenance organizations (HMOs), and hospital reimbursement on the basis of diagnosis-related groups. See note 71 *supra* and note 123 *infra*.

83 Medicaid plays a major role in paying for long-term care for the elderly and disabled. See p. 156 *infra*. For a discussion of the issues involved in government funding of long-term care, see Christine Bishop, *A Compulsory National Long-Term Care Insurance Program*, in James J. Callahan, Jr. and S. S. Wallack, eds., REFORMING THE LONG-TERM CARE SYSTEM: FINANCIAL AND ORGANIZATIONAL OPTIONS, D.C. Heath and Co., Lexington, Mass. (1981) at 61.



been introduced in the private insurance context). Cost-based hospital reimbursement exerts no pressure on hospitals to hold down costs.

Medicare has released millions of elderly and disabled Americans from the terrible fear of going bankrupt when they become ill. But the structural failings of the program as far as the distribution of the cost is concerned raise some questions of fairness. Since the cost-sharing provisions do not distinguish between adequate and more-than-adequate care, but rely instead on arbitrary limits on amounts of services, the appropriateness of the distribution of the cost of care with respect to health status can be questioned. The costs of some very essential care fall directly on recipients while the costs of some marginally important care are spread over everyone. Moreover, premiums for coverage of physician bills and cost-sharing provisions do not take account of individual income, and people must meet stringent eligibility requirements to receive assistance under other programs in paying them. People above these income limits may still have very limited financial resources, and those with serious health problems must absorb out-of-pocket costs that would be considered excessive by many observers. Even when they are not burdensome, such

costs are a deterrent on the use of care by lower-income people.

The distribution of the public cost of Medicare (through taxes and premiums) has been estimated to be slightly progressive across income classes (that is, higher-income people pay a greater fraction of their income).⁸⁴ The payroll tax that finances Medicare hospital coverage is proportional (that is, a constant fraction of income) up to a specified level. The burden of this tax falls most heavily on lower- and middle-income people because of the ceiling on the tax and because their incomes are mostly from wages. However, three-fourths of the amount paid to physicians comes out of general Federal revenues; the impact of the Federal tax structure on individuals is considered to be progressive. The remaining one-fourth comes from the premiums paid by enrollees.

From another standpoint, Medicare redistributes funds from current taxpayers to the elderly and disabled. Since most taxpayers will eventually become old, distributionally the program can be regarded as a "prepayment" system, in which contributions today will payoff in eligibility for care after age 65. Of course, those currently receiving benefits contributed a relatively small share to the scheme, since the program is relatively new.

Limits on individual choice. Minimizing limits on consumers' and providers' choices was a major goal of the designers of the program. Medicare has allowed patients a considerable degree of choice, although the reimbursement structure limits the choice of nontraditional providers or delivery modes⁸⁵ and, as discussed, the cost-sharing provisions mean that financial constraints on choice can still be significant.

The most important restriction on provider choice has been PSRO review. Many doctors consider the system to be state intervention in the practice of medicine and hence an unacceptable restriction of professional autonomy.⁸⁶ However, PSRO review is only required for public programs and only

84 Taxation is regressive when lower-income people pay a greater fraction of their income than higher-income people do. For estimates of the distribution of the cost of Medicare, see Janet L. Johnson and Stephen H. Long, *General Revenue Financing of Medicare: Who Will Bear the Burden?*, 3 HEALTH CARE FINANCING REV. 16 (March 1982). Ranking all U.S. families into quintiles by family income, Johnson and Long estimate that in fiscal year 1982, the share of family income paid to support Medicare, from the lowest quintile to the highest, was 2.2%, 2.3%, 2.6%, 2.7%, and 2.7% respectively. (This does not include out-of-pocket costs or the cost of supplementary private insurance.) *Id.* at 17.

85 For example, limited coverage for hospice care has only recently been added to Medicare.

86 Steven Jonas, *Measurement and Control of the Quality of Health Care*, in Jonas, *supra* note 2, at 398, 424-26.

considers whether care is unnecessary or of inadequate quality, not whether it is worth the cost.

Medicaid

Background. Like Medicare, Medicaid had its origins in the campaign for national health insurance, which focused special attention on the poor's access to health care.⁸⁷ Equally important antecedents were the programs in which the Federal government made "vendor payments" for the care of members of certain needy groups. In the 1930s, the states received grants for health care for the unemployed through the Federal Emergency Relief Administration (FERA). These grants marked a significant shift away from the responsibility for health care for the needy that had historically rested with local government. The FERA program was followed by the Social Security Act of 1935, which, in partnership with the states, provided Federal cash assistance to certain categories of the needy (the aged, blind, or disabled, and families with dependent children). The unpredictable and individual nature of medical care costs made it unsatisfactory to budget these expenses as a routine part of the cash grants. In 1950, the Social Security Act was amended to allow the states to purchase medical care for recipients directly from providers; by 1960, 40 states had such programs. At that time, the vendor payment programs were expanded with the establishment of the Kerr-Mills Medical Assistance for the Aged (MAA) programs, designed to cover "medically needy" aged people—those not poor enough for cash assistance but too poor to pay for medical care. By 1962, 28 states had MAA programs.

The 1965 amendment to the Social Security Act that established Medicare also created Medicaid, basically as a consolidation and expansion of Federally financed state vendor programs for the categorically needy, including the elderly who could not afford Medicare deductible and coinsurance payments or the cost of uncovered services such as nursing home care. Instead of being one Federal program, like Medicare, it is 51 separate state programs financed jointly with state and Federal funds. The Federal government mandates coverage of certain basic medical services for certain broad "categories," namely, people eligible (according to the income levels and other criteria established by each state) for Aid to Families with Dependent Children and the Supplemental

⁸⁷ The discussion in this section draws on Congressional Budget Office, U.S. Congress, *MEDICAID: CHOICES FOR 1982 AND BEYOND*, U.S. Government Printing Office, Washington (1981); Davis and Schoen, *supra* note 31, at 49-91; Gerald R. Connor, *The Medicaid Program in Transition* (1982), Appendix P, in Volume Three of this Report; O'Sullivan, *supra* note 68; Mitchell and Cromwell, *supra* note 25. See also Rosemary A. Stevens and Robert Stevens, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID*, The Free Press, New York (1974).

Security Income program for the aged, blind, and disabled. The states then have some latitude, within broad Federal guidelines, in deciding whether to participate in the program at all,⁸⁸ whether to consider additional categories of people as “medically needy,” what limits to impose on the scope of covered services (on the number of days of hospital care, for example, or of physician visits), and what kinds of cost-sharing to require.⁸⁹

Physicians are reimbursed under Medicaid in one of two ways, depending on the state. Fee schedules assign prices to all medical procedures, preserving the relative price structure of the existing fee structure. Fee profiles use the distribution of charges for each procedure to set a maximum level (for example, at the 75th percentile); usually the state then pays the actual charge or the maximum, whichever is lower. Medicaid reimbursement is required by Federal regulation to be no higher than Medicare’s. In fact, to keep the costs of the program down, in most states it is at a significantly lower level, often because fees are not adjusted to keep up with inflation.⁹⁰ Both programs reimburse hospitals according to “reasonable cost” formulas, but again the reimbursement under Medicaid is generally lower than under Medicare.

When Medicaid was introduced, many expected that the program would be expanded and eligibility broadened to include more of the poor. But as expenditures for the program mounted the original requirement that states move toward comprehensiveness was dropped.⁹¹ The program did expand, but not to the extent expected, and the different state fiscal situations as well as levels of concern for the poor widened disparities.

In fiscal year 1968, government payments (Federal and state) totaled \$3.45 billion for 11.5 million recipients.⁹² Expenditures grew rapidly over the next decade (although not as rapidly as those under Medicare, either absolutely or in percentage terms), while the number of recipients peaked in 1977. In fiscal year 1980, total government expenditures amounted to \$23.3 billion for 21.6 million recipients of services. (The number of people eligible in 1980 is not available.) Average payment per recipient was \$1078.⁹³

88 Only Arizona chose not to participate; since 1982, that state has operated a Medicaid program on a special experimental basis.

89 For members of the mandated groups, however, the states may impose no cost-sharing for the mandatory services and only nominal payments for the optional services.

90 Medicaid, unlike Medicare, *see* note 72 *supra*, requires physicians to accept the Medicaid fee as payment in full.

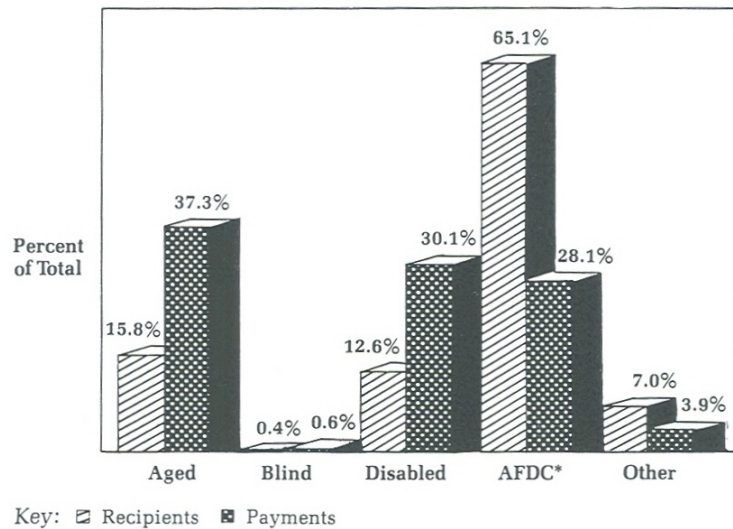
91 Davis and Schoen, *supra* note 31 at 51, 52.

92 *Id.* at 56.

93 THE MEDICARE AND MEDICAID DATA BOOK, 1982, *supra* note 74.

Figure 13: Medicaid Payments by Type of Recipient, 1980

Source: Office of Research and Demonstrations, Health Care Financing Administration, THE MEDICARE AND MEDICAID DATA BOOK, 1982, Dept. of Health and Human Services, Washington (forthcoming).



*Aid to Families with Dependent Children.

The degree to which Medicaid supplements Medicare is often not understood. In 1980, about two-thirds of Medicaid payments went to the aged and disabled—people, that is, in the general categories covered by Medicare (see Figure 13). (Definitions of disability are not the same under the two programs, however.) Medicaid pays the Medicare premiums for coverage of physician bills and the copayments for some people who are too poor to pay themselves; the program also bears the cost of long-term care for the indigent, which is why two-fifths of the Medicaid payments go to nursing homes (see Figure 14).⁹⁴

Effects on the distribution of care. As discussed in Chapter Two, disparities in the use of health services between rich and poor have narrowed since the introduction of Medicaid. Low-income people who are eligible for Medicaid use more health care than those who are not.⁹⁵ As with Medicare,

⁹⁴ Since 1980, a number of significant changes in the Medicaid program have occurred or have been seriously discussed. See Linda E. Demkovich, *States May Be Gaining in the Battle To Curb Medicaid Spending Growth*, 14 NAT'L. J. (1584) (1982). See also pp. 190-93 *infra*.

⁹⁵ See pp. 67-70 *supra*; MEDICAID: CHOICES FOR 1982 AND BEYOND, *supra* note 87, at 20.

however, certain structural features limit Medicaid's effectiveness in achieving an equitable distribution of care.

The definition of poverty varies greatly from one state to another in a manner unrelated to variations in the cost of living or the cost of medical care. Medicaid's categorical determination of eligibility (in contrast to Medicare's uniform eligibility standard) makes arbitrary distinctions among the poor on the basis of family status, place of residence, and other dimensions unrelated to health needs. As a result, one-half to two-thirds of the people below the Federal poverty line throughout the country are not covered by Medicaid, while some people above the poverty line are covered.

The program's reimbursement system also does not encourage equitable access to health care. As noted in Chapter Two, the low levels of reimbursement and the limits on covered services (as well as time-consuming paperwork, payment delay, and claim review) make many providers unwilling to treat Medicaid patients.⁹⁶

Low physician-participation rates contribute to geographical inequities in access to care, particularly in large cities and in the South, and mean that many Medicaid patients rely on emergency rooms and hospital outpatient departments. But many hospitals also discourage such patients. The limits on reimbursable amounts of services are a special constraint on hospitals. Some states, for example, have a 14- or 21-day limit on reimbursement for hospital stays, which can be too little for many serious medical conditions. If a patient is admitted and then needs to stay past the limit, the person must be covered as a charity case, moved to a public hospital—or forced to leave.⁹⁷

Formal cost-sharing in the form of deductibles and copayments is much more limited than under Medicare, which is to be expected since Medicaid covers individuals with few private resources. Yet the exclusion of services and the limits on the amounts of care constitute substantial cost-sharing. In some cases these limits are more stringent than those under Medicare, even though many Medicare recipients are not poor and can more easily pay out-of-pocket costs.

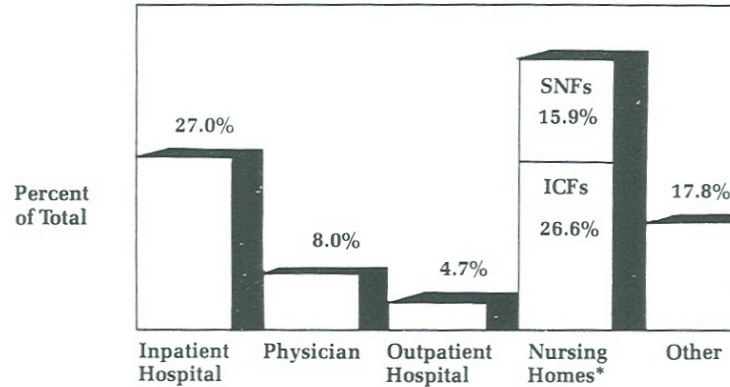
Under the existing structure of the program, reimbursement cannot be adjusted on an individual patient basis, so care of great benefit relative to its cost is covered while care of minor benefit relative to its cost is not. (Medicaid hospital care is subject to PSRO review, but the primary aim is to eliminate care of no benefit.) Thus Medicaid patients whose care is not covered must rely on private or public charity to obtain

⁹⁶ See pp. 85-87 *supra*; Mitchell and Cromwell, *supra* note 25.

⁹⁷ In recent years, some states have introduced a review procedure that permits this period to be extended under certain conditions; this allows some flexibility to respond to individual cases.

Figure 14: Medicaid Payments by Type of Service, 1980

Source: Office of Research and Demonstrations, Health Care Financing Administration, THE MEDICARE AND MEDICAID DATA BOOK, 1982, Dept. of Health and Human Services, Washington (forthcoming).



*Skilled Nursing Facilities and Intermediate Care Facilities.

additional care. Since such charity is not systematically and readily available, access to adequate care is not assured.

Effects on the level and distribution of cost. The additional demand for health care that Medicaid created has contributed to the overall increase in the unit cost of health services. The distribution of the cost of care received by Medicaid patients raises serious questions of equity. Although some people are covered by public funds for care of marginal importance to their health, others must do without essential care or bear heavy burdens in order to obtain it. These burdens—in searching for someone who will care for them, in travel and waiting time, in transport cost, and in the cost of unreimbursed care—are considered excessive by many observers.

The burden of the public cost of the program borne by ordinary taxpayers depends on where they live since the cost to taxpayers is shared between the Federal government and the states. In 1980, the Federal share averaged 54.5%, varying from 50% to 78% depending on each state's per capita income.⁹⁸ The remaining tax contribution comes from state and local taxes. Since the richer states usually have more-generous programs, they receive more Federal resources, thereby reducing the extent to which the matching formula redistributes resources from richer to poorer states. Generally, Federal taxes are considered to be progressive in their impact, while state

⁹⁸ Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures 1980*, 3 HEALTH CARE FINANCING REV. 14 (Sept. 1981).

and local taxes are considered to be regressive. Thus it is difficult to determine the distribution of the cost of Medicaid across taxpayers by income group.

In addition to the payments by government and patients for care under Medicaid, the program also imposes some costs on providers and other payors in the system. By reimbursing physicians at a below-market level, the program shifts some of the cost to those doctors who treat Medicaid patients. In addition, since eligibility is determined on a month-to-month basis, patients go on and off the program as their eligibility status changes; once a physician has formed a relationship with a patient, it may be difficult to deny that person needed services just because they are not reimbursable. The burden of unreimbursed expenses is thus not distributed evenly across physicians; it is only the doctors who treat the poor whose incomes are affected.⁹⁹

The uneven distribution of the cost of care is felt by hospitals, too. Physicians caring for hospitalized patients are responsible for patients' well-being, not for the financial solvency of the hospital; they need not consider reimbursement levels or program limits on services in deciding what treatment to recommend. Private hospitals must meet the unreimbursed costs of Medicaid patients out of the small amounts of charitable funds available to them or spread the costs over other patients. Public hospitals must cover such expenses with local tax revenues.

Since Medicaid and Medicare do not cover everyone who lacks the ability to pay for care, there is still a large group of people who depend on public and private charity when they are ill. The reimbursement policies of both programs worsen the problems that hospitals have in covering the cost of providing free care to these people.¹⁰⁰ Medicare and Medicaid (and, in some states, Blue Cross) do not allow these costs to be included in their reimbursement formulas. This places an extra burden on self-paying and commercially insured patients, who have no special responsibility for the poor.¹⁰¹ Moreover, since the cost-spreading occurs at the individual hospital level, an unfortunate spiral sets in. The more poor people the hospital treats, the more difficult its financial situation becomes. The worse its financial situation, the less attractive the hospital is likely to be to patients who can afford to pay. The fewer such

⁹⁹ Mitchell and Cromwell, *supra* note 25.

¹⁰⁰ See Stephen C. Caulfield, *Cross Subsidies in Hospital Reimbursement*, Government Research Corporation, Washington, mimeo. (June 1981).

¹⁰¹ Commercially insured patients are those who have policies with private for-profit health insurers, as opposed to those covered by nonprofit insurers such as Blue Cross or by public programs such as Medicare and Medicaid.

patients it admits, the higher a proportion of poor people it treats.

Limits on individual choice. As with Medicare, minimization of limits on participants' choices was an important goal of the Medicaid program. However, as discussed, Medicaid policies (particularly those on reimbursement) mean many recipients do not have the same choices in ambulatory or hospital care that are available to the rest of the population.

Reluctance to interfere in the choices of providers (beyond the PSRO review of services) has contributed to this. Instead of considering the standard of care that providers should make available to the poor in relation to the limited funds available and to individual patients' health needs, states have manipulated program eligibility, the definitions of the types of services covered, the quantitative limits on services, and the level of reimbursement received by providers. These have limited to some extent the choices of providers who serve the poor, but they have more sharply limited the choices of Medicaid patients, perpetuating the "two-class" system of care that the program seeks to avoid.

Moreover, restrictions on the choice of innovative forms of care delivery that are built into the structure of the reimbursement system are of particular importance to Medicaid recipients. Poor people face geographic barriers to care (since they tend to live in areas that are unattractive to physicians and that lack access to convenient transportation), sociocultural barriers, and informational barriers (since they tend to lack knowledge of the importance of health care). These difficulties, and often the nature of poor people's health problems, might greatly benefit from innovations in the delivery of health care.¹⁰²

Tax Subsidies

Background. The Commission is aware that a body of opinion holds that the failure to tax income should not be called a "subsidy" because to do so would imply that the government owns all income except that which it chooses not to tax. In using the word "subsidy," the Commission is not suggesting that the government has a prior right to income. Rather, the term is used to indicate that exemptions from the existing tax structure for income spent for particular purposes have effects similar to those that result from direct government grants.

¹⁰² Beginning in 1981, as part of efforts to contain Medicaid costs, Congress allowed states to obtain waivers to the formal "freedom of choice" requirements. A number of states are seeking to establish capitation, case management, or contracting systems that would limit the choice of providers but encourage cost-effective care. See pp. 190-93 *infra*.

In this latter sense, the Federal income tax system subsidizes personal expenditures on medical care through two provisions, the employer exclusion and the medical expense deduction.¹⁰³ The first of these exempts from employees' taxable income all employer contributions to health and accident insurance plans. These contributions first became important during World War II, when employers began to increase the fraction of wages paid in the form of fringe benefits as a way of circumventing wartime wage controls. The exemption from taxable income of these noncash fringe benefits was made explicit in 1943 for employer contributions to group health insurance policies; in 1954 the tax code was changed to equalize the tax treatment of group and individual policies. The effect is to give employees a discount in the purchase of health insurance; the income tax savings make it cheaper to obtain a given level of coverage as a fringe benefit than to buy it directly. For people with incomes below the social security tax ceiling, there is also a savings in payroll taxes.

The medical expense deduction became part of the tax code in 1942. Taxpayers were at first allowed to deduct from taxable income all medical expenses over 5% of net income; the maximum deduction was \$1250 for single tax returns and \$2500 for joint returns. Since the Social Security Amendments of 1965, taxpayers who itemize their deductions have been allowed to deduct half of their health insurance premiums (up to a maximum of \$150) as well as any "extraordinary medical expenses," defined as those that total more than 3% of adjusted gross income. Remaining health insurance premiums and drug expenditures that exceed 1% of adjusted gross income may be counted toward this total, as can a broad range of other medical services, including cosmetic surgery, rest cures, and elaborate medical equipment in the home.

The cost to the Treasury of these two provisions in terms of tax revenue foregone has been substantial. In 1980, the employer exclusion was worth an estimated \$16.6 billion (\$12.4 billion in income taxes foregone and \$4.2 billion in payroll taxes). The medical expense deduction amounted to another \$3.6 billion, for a total of \$20.2 billion.¹⁰⁴ In addition, individual

¹⁰³ The discussion in this section draws on TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES, *supra* note 6; Gail R. Wilensky, *Government and the Financing of Health Care*, 72 AM. ECON. REV. 202 (May 1982); Congressional Budget Office, U.S. Congress, CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES, U.S. Government Printing Office, Washington (1982); Paul B. Ginsburg, *Altering the Tax Treatment of Employment-Based Health Plans*, 59 MILBANK MEMORIAL FUND Q./HEALTH AND SOCIETY 224 (1981).

¹⁰⁴ Unpublished data provided by personal communication with Thomas Buchberger, Analyst, Congressional Budget Office, Washington (Jan. 25, 1983).

states that impose income and payroll taxes have their returns lowered by these exemptions. The medical expense deduction has remained relatively stable (in real dollars) over time, while the employer exclusion has been growing rapidly.¹⁰⁵

Effects on the distribution of care and its cost. Because the effects of tax subsidies are not uniform across taxpayers, they have considerable effect on the distribution of health care and its cost. These effects arise from the impact of the subsidies on the pattern of health insurance coverage (which, as discussed in Chapter Two, affects people's access to care itself), on the after-tax cost of coverage to individuals, and, to a lesser extent, on the ability to pay for care directly.

Most Americans who have private health insurance obtain it through the workplace.¹⁰⁶ Offering health insurance contracts on a group basis to employers has certain attractions for an insurance company. Administrative and selling costs are lower than they would be if each policy were handled individually. And the "risk pool" of individuals covered consists of people who are healthy enough to work (at least in the case of the primary policyholder). The insurance market's natural tendency to offer employment-based group insurance is greatly intensified by the tax treatment of premiums for such insurance (the employer exclusion) because the Federal government is in effect paying a share of the premium when the policy is obtained as a fringe benefit. If an employer pays an extra \$100 per month in wages to someone whose marginal tax rate is 20%, the employee is left with \$80 after taxes to purchase health insurance. If the employer instead spends that money directly on health insurance, the employee obtains a full \$100 worth of insurance and the government loses the \$20 the employee would have paid in taxes.

The value of this tax subsidy varies greatly depending on people's employment status. Obviously it favors those with jobs since the unemployed are not eligible for employment-based insurance. Some group plans continue coverage during temporary layoffs and for a short period after termination, but this tends to help only the better-paid workers and those who are out of work for short periods. For most people who lose their jobs, income falls and they are less able to pay medical bills directly, but the cost of maintaining their insurance

¹⁰⁵ Effective in 1983, the separate \$150 deduction for half of health insurance premiums is eliminated, the floor for deductible medical expenses is increased to 5% of taxable income, and the 1% floor on drug expenditures is eliminated. A number of proposals for modification of the employer exclusion are now under discussion. See pp. 194-96 *infra*.

¹⁰⁶ Pamela J. Farley and Gail R. Wilensky, *Options, Incentives, and Employment-Related Health Insurance Coverage*, at Annual Meeting of the Eastern Economic Association, Washington, May 1, 1982.

coverage goes up significantly. The employer exclusion is a significant factor in the low rate of insurance among the unemployed.

The employer exclusion has different effects on workers, depending on their occupation and type of employer. Group insurance contracts are more difficult to arrange for the self-employed or for those working in small businesses or in agriculture or construction. Many of these people have either no insurance or an individual policy obtained without the assistance that the government makes available to others (and at considerably higher premiums than would be charged for the same coverage under a group policy).

The fact that most health insurance is purchased through the workplace has spread the cost of care for workers and their families more evenly across differences in health status than it would otherwise tend to be. (A private insurance market will tend to sort insureds into groups by risk class so that those at higher risk pay higher premiums). But an employment-based system does not spread broadly the costs of care for the unemployed, the elderly, people outside the labor market not covered by an employed family member's policy, and others lacking health insurance, such as wage earners whose firms do not provide them with insurance.

The effects of the employer exclusion vary greatly across income groups. Because marginal tax rates increase with income, the government subsidy provided for a given health insurance fringe benefit also increases with income. For example, people in the 40% tax bracket (rather than the 20% bracket) save \$40 (not \$20) in taxes when they receive \$100 worth of health insurance in lieu of cash. To this must be added the fact that although health insurance is very important, it is less important than food or shelter. Lower-income workers may prefer to have more cash to pay for food and housing even if it means taking a chance on being inadequately protected against the expense of an illness. Thus, the employer exclusion provision gives a larger subsidy to those with a smaller need for financial protection (see Table 14), and exacerbates the tendency of lower-income people to be less well insured than those with higher incomes.¹⁰⁷

¹⁰⁷ Table 14 shows estimates for 1983. The Congressional Budget Office, in *TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES*, *supra* note 6, at 8, gives estimates for 1977 that show a similar qualitative picture. However, these do not include payroll tax savings and are based on less reliable methodology so the 1983 estimate is presented here. Gail R. Wilensky and Amy K. Taylor have estimated the distribution of tax savings, including the employer share of social security taxes and state income taxes, by income within the group of subscribers to employment-related insurance who receive employer contributions. For 1977 data, see *Tax Expenditures*

Table 14:

Estimated Employer Contributions to Health Benefit Plans and Employee Tax Benefits, By Household, 1983

Source: Congressional Budget Office, U.S. Congress, CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES, U.S. Government Printing Office, Washington (1982) at 27. CBO simulations based on the National Medical Care Expenditure Survey.

Annual Household Income *	All Households			Households That Receive Employer Contribution		
	Share of Households in Income Category	Average Employer Contribution	Tax Benefit** Per Household	Share Receiving Contribution	Average Contribution	Average Tax Benefit
\$0-10,000	19%	\$ 86	\$ 17	13%	\$ 636	\$129
\$10,001-15,000	10%	\$ 301	\$ 83	31%	\$ 972	\$269
\$15,001-20,000	10%	\$ 482	\$143	47%	\$1029	\$307
\$20,001-30,000	19%	\$ 817	\$273	59%	\$1375	\$460
\$30,001-50,000	25%	\$1319	\$501	73%	\$1798	\$683
\$50,001-100,000	14%	\$1471	\$622	73%	\$2025	\$857
\$Over 100,000	4%	\$1092	\$550	62%	\$1761	\$886
All Households	100%	\$ 823	\$309	52%	\$1578	\$594

Note: Columns may not add to total due to rounding.

* Household income before taxes but including cash transfer payments, such as Social Security benefits, projected to calendar year 1983.

** Tax benefits include both Federal income tax reductions and the employer's and employee's share of Federal payroll taxes. About three-quarters of the tax benefits are income tax reductions. State and local income tax reductions are excluded. The estimates assume that taxable excess contributions are made ineligible for the medical expense deduction.

The medical expense deduction, which gives a tax advantage to people whose medical bills are very high in relation to income, can help prevent individual medical costs from constituting an excessive burden. Like the employer exclusion, however, it favors people with higher incomes. It is available only to those who itemize deductions (a practice that is generally advantageous only to those with higher incomes), and the percentage subsidy is the taxpayer's marginal tax rate (see Table 15).

These two tax subsidies aggravate inequities in the distribution of care as well as making the distribution of costs less equitable. Better-off consumers—who tend to be healthier than others—have an incentive to buy more comprehensive coverage. Since their out-of-pocket costs for health care are therefore low (and are tax-deductible), they have little incentive to forego care even if it is wasteful or at best of marginal benefit. At the same time people with no (or less comprehensive) coverage may have to forego care that is important to their health. Furthermore, a special problem is posed by the tax code's inclusion of items eligible for deduction, such as cosmetic surgery, that society would probably not wish to help finance if a direct subsidy were at issue.

Effects on the level of cost. By subsidizing comprehensive insurance coverage, tax subsidies make the already weak cost-control incentives in the medical care market even weaker. Aggregate expenditures are inflated by expenditures on wasteful care. Patients are less sensitive to differences in prices among providers; both patients and providers have less incentive to choose cost-effective methods of treatment. Consumers and employers are less sensitive to differences in the cost of insurance plans; thus insurers, who could play a role in keeping down health care costs, have little incentive to do so. Many analysts believe these effects of tax subsidies are an important reason why the cost of care is higher than it would otherwise be. To the extent that this is true, the burden in out-of-pocket cost it imposes on people less comprehensively insured, and particularly on the uninsured, is magnified.

Limits on individual choice. Historically, most workers have had little or no choice in health insurance coverage because their employers offered only one plan and the alternative of buying individual insurance has been prohibitively expensive. Presumably, employee preferences influence the type of plan offered at each workplace, but preferences

and Health Insurance: Limiting Employer-Paid Premiums 97 PUB. HEALTH REP. 443 (1982); for 1983 data, see *Tax Expenditures and the Demand for Private Health Insurance*, in Jack Meyer, ed., MARKET-ORIENTED REFORMS IN FEDERAL HEALTH POLICY, American Enterprise Institute, Washington (forthcoming).

Table 15:**Distribution by Income Level of Tax Savings from the Medical Expense Deduction, 1979**

Source: Congressional Budget Office, U.S. Congress, TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES, U.S. Government Printing Office, Washington (1980) at 28, 29. Treasury Department tax model.

Annual Taxpayer Income*	Share of All Tax Returns Filed	Share of Returns Claiming Medical Deduction**	Share of Tax Savings Received Under Present Rules	Average Tax Increase per Claimant if Deduction Repealed***
Less than \$5000	26.2%	1.4%	0.4%	\$ 64
\$5000-\$10,000	21.7%	8.8%	6.4%	\$103
\$10,000-\$15,000	16.0%	21.5%	13.8%	\$117
\$15,000-\$20,000	13.1%	29.5%	16.3%	\$122
\$20,000-\$30,000	14.6%	41.9%	26.9%	\$127
\$30,000-\$50,000	6.5%	58.5%	21.2%	\$162
\$50,000-\$100,000	1.5%	60.5%	9.9%	\$310
\$100,000-\$200,000	0.3%	61.2%	4.1%	\$748
\$200,000 and over	0.1%	65.1%	1.1%	\$829
All Returns	100.0%	20.4%	100.0%	\$143

* Taxpayer income is computed as adjusted gross income, plus the untaxed part of capital gains, percentage cost depletion, and other tax preferences subject to the minimum tax. Also, the deduction of investment interest is limited to the amount of investment income.

** This includes all those claiming the deduction for half of health insurance premiums (up to \$150), the deduction for "extraordinary medical expenses" (that is, expenses totaling more than 3% of adjusted gross income), or both.

*** Calculated as the increase in taxes resulting from repeal of the deduction under 1979 law at 1978 income levels; estimate for calendar year 1979 at 1978 income levels.

must be averaged over the entire group. In 1977, of the 62 million people with employment-related group health insurance only 18% were offered more than one plan.¹⁰⁸ And even

¹⁰⁸ Farley and Wilensky, *supra* note 106, at 7.

The Health Maintenance Organization Act of 1973 requires employers with 25 or more employees who offer any group health insurance to offer a qualified HMO if one is available.

they still did not have the range of choice they could expect on the open market. Yet if workers were free to choose an insurance plan under the group coverage, those who considered themselves at lower risk would select cheaper, less comprehensive plans, which would negate the advantage of spreading the costs of insuring those at higher risk over a large group.

Comparison of Medicare, Medicaid, and Tax Subsidies. In 1980, the Federal government spent \$12.7 billion on the Medicaid program; revenues foregone that year through the employer exclusion and the medical expense deduction amounted to \$20.2 billion. Thus the Federal tax subsidy to health insurance and medical care exceeded the expenditure on Medicaid. In fact, it was almost as much as the total Federal and state expenditure on Medicaid, which reached \$23.3 billion. (If foregone state revenues could be estimated and included, the total tax subsidy would be closer to Medicaid.)

Using 1977 data from the National Medical Care Expenditure Survey, the Federal expenditures under Medicare, Medicaid, and the income tax subsidies by income group can be compared (see Table 16).¹⁰⁹ Medicare spends a fairly similar amount on each income group. Medicaid spends more on the poor, while the income tax subsidies mainly benefit the better off. The group that receives the least assistance from all three programs combined is the “other low-income group.” On a per capita basis, expenditures under Medicaid decrease as income increases; payments under Medicare also decrease but less sharply; and the income tax subsidies increase sharply with income. Overall, middle-income people receive the least assistance on a per capita basis under all three programs combined.

This pattern of expenditure is difficult to justify from an ethical standpoint. There seems to be little reason for such extensive government assistance to middle- and upper-income individuals, most of whom could take financial responsibility for their own care (through direct payment and through the purchase of insurance) without undue hardship. Despite government programs and private charity, many poor and near-poor people can obtain adequate care only at great personal

Our estimates show that subscribers who were offered an HMO option account for 7 of the 11 million subscribers offered any choice of coverage. This is perhaps evidence that choices would be even less common, were it not for this legislation which already requires some employers to offer more than one plan.

Id.

¹⁰⁹ The income tax savings include those from the employer exclusion and medical expense deduction; they do not include savings in payroll taxes.

Wilensky, *supra* note 103.

Table 16:

Distribution of Major Federal Government Expenditures on Health, 1977

Source: Gail R. Wilensky, Government and the Financing of Health Care, 72 AM. ECON. REV. 202, 205 (1982).

Income Group*	Proportion of Population in Income Group	Income Tax Savings		Medicare**		Medicaid***		Total Federal Expenditures	
		Total (bills.)	Per Capita	Total (bills.)	Per Capita	Total (bills.)	Per Capita	Total (bills.)	Per Capita
Poor and Near-Poor	14%	\$ 0.1	\$ 2	\$ 4.3	\$141	\$5.6	\$184	\$10.0	\$327
Other Low-Income	15%	\$ 0.5	\$16	\$ 3.1	\$ 99	\$2.0	\$ 63	\$ 5.6	\$178
Middle-Income	39%	\$ 3.5	\$43	\$ 4.7	\$ 57	\$1.3	\$ 16	\$ 9.5	\$116
High-Income	32%	\$ 6.2	\$90	\$ 3.3	\$ 48	\$0.2	\$ 4	\$ 9.7	\$142
Total Expenditures	100%	\$10.3		\$15.4		\$9.1		\$34.8	

* Family income definitions (adjusted for family size): poor, less than 1977 poverty level through 125% of that level; other low-income, 125-200% of poverty level; middle-income, 201-400% of poverty level; high-income, above 400% of poverty level (for example, middle-income in 1977 represented a family of four that earned between \$16,000 and \$32,000).

** Less premiums for physician bill coverage.

*** Excludes expenditures from veterans programs and small Federal programs.

cost. It would be more in accord with ethical principles to devote scarce public funds to their assistance.

Regulation

If private economic decisions fail to produce a socially desirable outcome—which is likely in the case of health care, given its special features and special importance—direct regulation of those decisions may be attempted. However, these same features also make government regulation of health care difficult and controversial.

Certificate-of-need (CON) laws mandate government approval of major expenditures by providers for new buildings and equipment; approval is denied if planners decide that the investment is not “necessary.” The effectiveness of these laws is limited by a lack of consensus on what is “necessary”; equally important, the planning process of which they are a part has no way to ensure that available services reach those who would benefit most. Thus the laws could actually worsen the outcome; as implemented, however, their effects, both positive and negative, have been very small.

Hospital reimbursement regulation attempts to put economic pressure on hospital administrators to produce services efficiently and to provide only services whose benefits justify the costs. Unlike CON, mandatory reimbursement regulation has slowed the rate of increase in hospital expenditures. But like CON, it limits resources without having a mechanism to ensure their fair allocation. Administrators control the way services are produced, but physicians determine the amounts and kinds of services used. Physicians and patients are generally reluctant to forego care that is of benefit, however small, especially when the patient is well insured. (In fact, many doctors believe it would be unethical not to do all that can be done for a patient.) Since there is no societal consensus on the proper role of cost in clinical decisions, economic pressure on hospitals can, if not properly structured, result in conflict and increased inequity in the distribution of both care and its cost.

Certificate-of-Need Legislation

Background. In 1932, the Committee on the Costs of Medical Care argued that regional and comprehensive health planning were needed to control health care costs and to achieve an equitable distribution of health care.¹¹⁰ Some local

¹¹⁰ The discussion in this section draws on Paul L. Joskow, *CONTROLLING HOSPITAL COSTS: THE ROLE OF GOVERNMENT REGULATIONS*, MIT Press, Cambridge, Mass. (1981); William J. Curran, *A National Survey and Analysis of State Certificate-of-Need Laws for Health Facilities*, in Clark C. Havighurst, *REGULATING HEALTH FACILITIES CONSTRUCTION*, American Enterprise Institute, Washington (1974) at

attempts at regional planning followed. Beginning in the mid-1940s, regional planning across the country was advocated by the American Hospital Association. These efforts influenced the structure of the Hill-Burton Act, which marked the Federal government's entry into health planning. However, the planning was voluntary and restricted in scope, emphasizing the construction of facilities to meet "needs" narrowly defined in terms of hospital beds.

The next major Federal initiatives were the 1965 Regional Medical Programs (RMP) Act and the Comprehensive Health Planning (CHP) Act, adopted in 1966 and modified in 1967. The 56 RMPs were to facilitate the better planning of health care delivery—"functional planning"—not merely the construction of facilities. They were originally categorical in nature, oriented toward making available the newest medical advances in treatment for cancer, heart disease, and stroke. The CHP program, which was designed to move planning away from this categorical approach, created a two-tier planning system. Local and regional agencies submitted area-wide plans to a state-level agency, where a state plan was developed. Both the RMP and the CHP legislation forbade interference in private practice, and planning was still essentially voluntary. The policy tools the planning agencies had were persuasion and the review and comment process under various Federal funding programs (though the agencies did not have the authority to disapprove funding). They had to secure local matching funds for 25-50% of their planning activities.

State governments were more concerned at this time about controlling costs than about improving access. One important factor was the rapid rise in Blue Cross premiums, which in most states were subject to state review and approval. Their concern translated into certificate-of-need legislation. New York was the first, with the Metcalf-McClosky Act in 1964 and the Folsom Act in 1965. In 1968, a nationwide drive to get CON laws passed by other states was started. Interest was fueled by the rising cost to the states of the Medicaid program. By the end of 1971, 15 states had enacted CON laws.

85; David S. Salkever and Thomas W. Bice, HOSPITAL CERTIFICATE-OF-NEED CONTROLS: IMPACT ON INVESTMENT, COSTS AND USE, American Enterprise Institute, Washington (1979); Kay Reiss, *Health Planning Program*, Congressional Research Service, Library of Congress, Washington, mimeo. (rev. Dec. 23, 1981); Congressional Budget Office, U.S. Congress, HEALTH PLANNING: ISSUES FOR REAUTHORIZATION, U.S. Government Printing Office, Washington (1982); Bruce Steinwald and Frank A. Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence*, in Mancur Olson, ed., A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE, American Enterprise Institute, Washington (1981) at 274.

Meanwhile, the Federal government was also concerned about rising costs. The 1972 Social Security Act amendments included a provision (Section 1122) for review of capital expenditures over \$100,000 by a state-designated planning agency. Failure to obtain approval meant denial of reimbursement for capital costs (depreciation, interest, and, for profit-making institutions, return on equity) under the Medicare, Medicaid, and Maternal and Child Health Programs. States could decide whether to hold these "Section 1122 reviews," and most chose to do so.

By the early 1970s, there was an extensive planning apparatus but it was dispersed among the Hill-Burton, RMP, and CHP agencies. The National Health Planning and Resources Development Act of 1974 pulled these fragments together. It created an elaborate nationwide network of state and local planning agencies whose duties are to collect and analyze data related to health planning, establish state and local plans, allocate federal funds for health purposes, and administer state CON programs. The Secretary of Health, Education and Welfare was directed to formulate quantitative goals for the characteristics, types, and standards of health care services and for health outcomes. (Previous planning legislation had exhorted rational planning but had not specified goals except in the broadest sense.)

With the 1974 Act, Federal planning legislation shifted from an emphasis on increasing health care capacity in order to promote access to an emphasis on preventing excess capacity. It also incorporated the first significant sanction on private actions; until then, positive incentives had been relied on. To qualify for certain Federal funds, each state has to have a CON program. The designated state agency is required to review both capital expenditures for facilities or major medical equipment costing more than \$150,000 (or less, if the state so chooses) and proposals for new or revised institutional health services that either involve an annual operating cost of \$75,000 or more, are associated with a capital expenditure, or require termination of an existing health service (regardless of the money involved). Hospitals, skilled nursing facilities, intermediate care facilities, kidney disease treatment centers, rehabilitation facilities, and ambulatory surgical facilities are generally subject to review. The agency is required to impose sanctions, such as civil or criminal penalties or the denial or revocation of a license, to prevent unneeded projects from proceeding. Amendments in 1979 made two changes: health maintenance organizations are generally exempted (on the grounds that they are already subject to appropriate investment incentives) and major medical equipment that serves hospital inpatients is included regardless of location (equipment in a physician's office had previously been exempt).

By 1980, all but one state (Louisiana) had CON legislation (although not all states were in full compliance with all Federal requirements).¹¹¹ About 90% of new construction, 25% of equipment purchases, and 60% of building modernization expenditures were subject to CON review in 1979.¹¹² The state programs are similar in their general nature but different in their actual operation. Some are oriented mainly toward planning and certification, whereas others are more concerned with actually constraining supply. Some have highly developed review criteria and devote considerable resources to the process.

The 1974 Act incorporated the state CON apparatus into the Federal planning process. The Hospital Cost Containment Bill, proposed unsuccessfully in 1977 and (in modified form) in 1979, would have involved the Federal government further through a capital expenditure budget that was to be allocated to each state and administered through the certificate-of-need process.¹¹³

Effects on the cost and distribution of care. In looking at the effects of CON (and, more broadly, health planning legislation) two issues must be considered: what have been the effects? And to what extent is the legislation structured to produce desirable effects? Looking first at the structural aspect, the major criticism of the health planning process has been that it lacks both clear objectives and the tools to pursue them. Planning goals are stated in vague terms; to the extent they are developed into specific policies, planning agencies have had no way to enforce their decisions.

As one Administration official with major responsibilities in the planning area remarked about the 1974 National Health Planning and Resource Development Act:

[Congress] designed a system in which local citizen boards, of which 51 to 60 percent of the members were consumers, would negotiate health plans in isolation from the process of resource allocation and without final legal authority. Their mandated but unrealistic objectives were to control costs and to promote health. The objectives were unrealistic because the mechanism for achieving them was persuasion alone instead of budget

¹¹¹ HEALTH PLANNING: ISSUES FOR REAUTHORIZATION, *supra* note 110, at 14.

¹¹² *Id.* at 13 (citing ICF, Inc., AN ANALYSIS OF PROGRAMS TO LIMIT CAPITAL EXPENDITURES, Final Report, Washington (June 20, 1980) at 26).

¹¹³ Current administration policy is to eliminate any Federal role in health planning and certificate-of-need review and emphasize other approaches to cost containment. Funding levels have been cut, the thresholds for CON review have been raised, and debate continues in Congress over the future role of health planning.

ary control of the purchase of health-care services and resources,¹¹⁴

For a long time, the only enforcement tools planning agencies had were positive incentives in the form of government grants and negative sanctions applicable only to participants in government programs. The certificate-of-need provision gave agencies the first sanctions that applied to all sectors, although it is limited in that it focuses only on new investment capital and does not give the agencies the power to make an institution reduce its size or shut down.

Although the lack of effective sanctions in the planning process is a problem, its impact may be overstated. An attempt to plan an ordinary industry without any sanctions on the firms probably would have very limited effects. As a general rule, firms would already be taking those actions that would increase profits (such as producing efficiently) and would resist taking actions that would lower profits. Although the number of profit-oriented hospitals is growing, most hospitals are still nonprofit. As such, they do not necessarily behave as profit-making businesses would, and they may be willing to be guided by planners for the sake of the common good.

The importance of sanctions depends to some extent on how the objectives of controlling cost and promoting health are understood. One interpretation of the role of planning is to ensure that the physical facilities needed to serve paying patients are available and that the health care demanded is supplied as efficiently as possible—that is, appropriately located for ease and economy of patients without unnecessary duplication of facilities, and so forth. Although this might fail to happen in the health care sector without government involvement, it is not clear whether voluntary planning can make it happen and the degree to which access would be improved and costs contained as a result. In part, this is a question of magnitude: how much inefficiency in production exists, and how much lack of access occurs because of inadequate supply?

More basically, the willingness of nonprofit providers to cooperate to supply care more efficiently is at issue. Providers who have objectives that are at odds with planning goals (for example, to make their own facilities bigger and more elaborate) may not want to cooperate. Or they may try to use the planning process to keep out competitors, which can actually raise costs and make access worse than it would otherwise be. Properly designed sanctions may be useful in controlling these tendencies, although experience in other regulated industries

¹¹⁴ Henry A. Foley, *Health Planning-Demise or Reformation?*, 304 NEW ENG. J. MED. 969 (1981). Economist Paul Joskow called the Comprehensive Health Planning Act “a triumph of organizational complexity over substance.” Joskow, *supra* note 110, at 78.

suggests a need for realism about the ease with which sanctions can be designed that have the desired effects.

Planning might be expected to go beyond ensuring that all the care someone is willing to purchase is physically available to address the general problem of overuse of health care by some and underuse by others. But it is not clear how planning—with or without effective sanctions—can do anything to solve this problem, which is at heart one of financing. Making more services physically available does not deliver health care to those without it if they have no way to pay for it. On the other hand, making fewer services available merely creates excess demand among people who can pay unless there is a change in patients' incentives to use services or in the way physicians make their clinical decisions. Consequently, to avoid undesirable increases in the cost of care the limited supply would have to be allocated by nonprice allocation methods. Since there is no societal consensus that this is necessary and desirable, it seems unlikely that voluntary cooperation will be effective in attacking this problem. On the other hand, mandatory controls that would constrain supply to the necessary extent and would allocate resources equitably are unlikely to be politically acceptable.

CON legislation illustrates these points. Denials of certificates of need have often been controversial. In a number of states there has been intense legal and political maneuvering for resources, and the potential effects on access of restrictions on the supply of beds and equipment, such as CAT scanners, have frequently been decried.¹¹⁵

In investigating the impact of the legislation, however, researchers have been able to find very little effect on hospital investment, including investment in CT scanners.¹¹⁶ There is

115 Anne R. Somers and Herman M. Somers, *HEALTH AND HEALTH CARE: POLICIES IN PERSPECTIVE*, Aspen Systems Corp., Germantown, Md. (1977) at 260-75, 455; Alan E. Reider, John R. Mason, and Leonard H. Glantz, *Certificate of Need: The Massachusetts Experience*, 1 *AMER. J. LAW & MED.* 13 (1975); Stanton J. Price, *Health Systems Agencies and Peer Review Organizations: Experiments in Regulating the Delivery of Health Care*, in Ruth Roemer and George McKay, eds., *LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS*, Greenwood Press, Westport, Conn. (1980) at 359, 372-77.

116 *See* Steinwald and Sloan, *supra* note 110 at 285-87, 296; Joskow, *supra* note 110, at 138-68; *HEALTH PLANNING: ISSUES FOR REAUTHORIZATION*, *supra* note 110, at 19-30, 57-64. *But cf.* Bonnie Lefkowitz, *HEALTH PLANNING: LESSONS FOR THE FUTURE*, Aspen Systems Corp., Rockville, Md. (1982). As the Congressional Budget Office notes, the results of studies of the effects of CON must be used with caution. Since the programs are relatively new and have been changing over time, the initial decisions on many investment projects included in the studies may have been taken before CON became effective. The programs vary from one state to another in ways that

some evidence of a slight restraining effect on the supply of general hospital beds, but no indication of a similar impact on ancillary services or total expenditures.¹¹⁷ Thus, as currently implemented, certificate-of-need laws have fulfilled neither the promise nor the threat associated with them in terms of changing the cost or the distribution of health care.

Limits on individual choice. Certificate-of-need legislation intervenes in the actions of private providers and consumers for the common good. Regulation in other industries is accepted when the private market outcome appears unsatisfactory. The “specialness” of health care does not make regulation per se more or less appropriate from an ethical standpoint. Rather, what matters is the effect of regulation on the allocation of health care resources, and, in particular, on the degree to which it helps ensure that all individuals receive an adequate level of health care. The major difficulty with certificate-of-need legislation in these terms is that if it does succeed in limiting the supply of facilities it provides no mechanism to guarantee that the limited supply goes to those who would most benefit from the services.

Regulation of Hospital Reimbursement. Because hospital care takes such a large share of health care expenditures, control of expenditures in that sector has been a matter of particular urgency. Almost 90% of hospital expenditures are covered by third-party payors.¹¹⁸ Some of these (commercial insurance companies and a number of Blue Cross companies) pay whatever the hospital charges; the rest (including Medicare and Medicaid) have traditionally paid according to formulas based on the costs incurred for their patients’

are difficult to measure; thus, effects have had to be averaged over all states, which may obscure successes in individual states. And like all economic studies, they have technical limitations resulting from measurement and data availability problems. HEALTH PLANNING: ISSUES FOR REAUTHORIZATION, *supra* note 110, at 20, 21.

¹¹⁷ Given the absence of an effect on overall investment, there has been little interest in looking at the distribution of investment, by type or by geographic location within states.

The conclusion that CON review has led to increased hospital investment for other equipment can also probably be discounted, although it has a strong analytical basis. One study [Salkever and Bice, *supra* note 110] concluded that CON review led to substitution of investment in other assets instead of hospital beds, but its result is questionable because it used data only for the early years of CON review.

HEALTH PLANNING: ISSUES FOR REAUTHORIZATION, *supra* note 110, at 25. “The little available analysis of the effects of CON review on the distribution of hospital beds is weak.” *Id.* at 28.

¹¹⁸ Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures: 1981*, 4 HEALTH CARE FINANCING REV. 2, 27 (Sept. 1982).

treatment. Neither system gives much incentive for restraining expenditures. Regulation of hospital reimbursement is therefore a promising instrument for cost containment.

Background. Like certificate-of-need, reimbursement regulation began at the state level; support for it arose out of the states' responsibility for regulating the health insurance industry and the burden of the rising costs of Medicaid.¹¹⁹ In 1969, New York became the first state to regulate hospital reimbursement, just as it had been the first to have a CON law. By the end of 1980 there were mandatory programs in effect in eight states.¹²⁰ General regulation of hospital reimbursement by the Federal government has been limited to date. The Economic Stabilization Program in the early 1970s imposed controls on hospital charges (as part of a general anti-inflationary program that affected many industries) but these were temporary. The Hospital Cost Containment Bill proposed unsuccessfully in 1977 and 1979 included mandatory revenue ceilings on all acute care hospitals.

Under the state programs, instead of being reimbursed retrospectively for charges or costs incurred, hospitals are reimbursed prospectively in one of two ways. Either they are paid at a certain rate per service, per hospital stay, or per case of a certain type treated,¹²¹ regardless of the actual costs. Or a general budget constraint is imposed: hospitals are paid a

119 The discussion in this section draws on Joskow, *supra* note 110; Brian Biles, Carl J. Schramm, and J. Graham Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980); Congressional Budget Office, U.S. Congress, *CONTROLLING RISING HOSPITAL COSTS*, U.S. Government Printing Office, Washington (1979); William B. Schwartz, *The Regulation Strategy for Controlling Hospital Costs*, 305 NEW ENG. J. MED. 1249 (1981); Sloan and Steinwald, *supra* note 110; Craig Coelen and Daniel Sullivan, *An Analysis of the Effects of Prospective Reimbursement Programs On Hospital Expenditures*, 2 HEALTH CARE FINANCING REV. 1 (Winter 1981).

120 Connecticut, Maryland, Massachusetts, New Jersey, New York, Rhode Island, Washington, Wisconsin, Rhode Island's program is not mandated by statute; it is a cooperative program between the state government, Blue Cross, and the hospital association. However, since hospitals must participate to get Blue Cross and Medicaid reimbursement, and since all hospitals do participate, the Department of Health and Human Services normally lists it with the mandatory programs (the American Hospital Association, on the other hand, lists it as voluntary). Colorado introduced a mandatory program in 1977 but terminated it in 1980. Four states have rate review agencies whose powers are advisory. In 12 states there are voluntary private rate review programs, generally implemented by Blue Cross plans. Joskow, *supra* note 110, at 113, 115.

121 For example, since 1980 New Jersey has reimbursed on the basis of diagnostic related grouping (DRGs), a coding system that identifies classes of patients requiring similar services. A flat rate, based on average costs in all hospitals in the system, is assigned to each DRG;

certain amount per time period, based on previous expenditures but without direct relation to the number of service units provided or to the cost of providing them during the period. Both methods give hospitals a financial incentive to control costs.¹²²

The eight state programs are complex and differ considerably in the details. But their evolution seems to follow a common pattern. First, the regulators collect information in a way that enables them to prepare baseline cost estimates for individual hospitals. They use these, along with simple estimates of inflation and expected changes in volume and service intensity, to establish a prospective budget. Yet retrospective adjustments are often made for any differences between projected and actual values, which dilutes the pressure exerted on the hospitals.

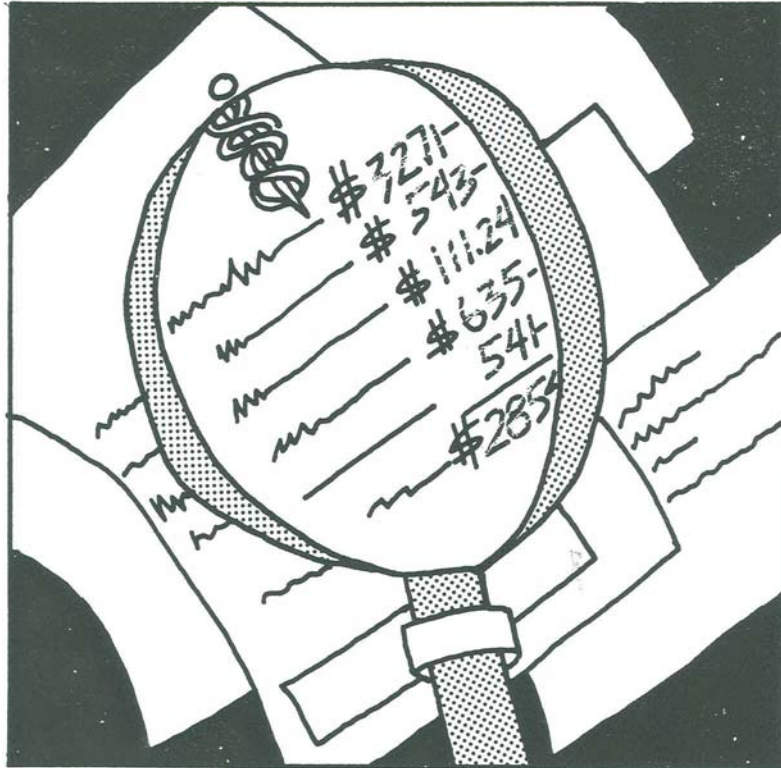
The regulators next try to refine the base level of cost by determining whether or not it is “reasonable”; for this, they often turn to systematic comparisons of hospitals. The data from individual hospitals is grouped according to characteristics considered appropriately relevant to cost differences (such as size, patient mix, or type of services offered). Within the groups, an attempt is made to distinguish efficient from inefficient hospitals, and to reimburse all of the hospitals according to a norm based on the efficient ones. In practice, this is usually done by setting reimbursement at the average for the group (though some states use the median and others the 80th percentile). Hospitals with above-average costs therefore do not get fully reimbursed. Furthermore, the regulators often pressure hospitals by limiting the way inflation is incorporated in any retrospective adjustments.

One disadvantage of the comparable-hospital approach is that it bases reimbursement on what is already being done; it does not introduce any independent criteria of what should be done. If all hospitals are overspending, this type of regulation is of little help. Moreover, there is a tendency to consider more and more characteristics relevant to cost differences, which progressively weakens the constraints.

Eventually, the states must decide whether to incorporate specific normative criteria into their reimbursement regulations. Minimum occupancy rates for a hospital as a whole or for specific services can be set, for example. Then unit costs

the hospital receives that amount for any patient in that DRG, regardless of the costs actually incurred on his or her behalf. Demkovich, *supra* note 71.

122 Contrary to the impression sometimes given in the cost control literature, it is not the fact that reimbursement is prospective rather than retrospective that makes the difference. It is the fact that limits are imposed on reimbursable costs in a systematic and predictable manner.



can be computed as they would be if the norm were satisfied, and the result used as the basis for the reimbursement formula. The difficulty lies in determining the appropriate norms.

Ideally, reimbursement is regulated in the same way for all third-party payors. Otherwise the financial pressure is lessened. Moreover, hospitals may avoid the patients of regulated payors and attempt to shift unreimbursed costs to the payors who are not regulated. None of the eight states was able to include all payors in its regulatory system at the start, although the tendency has been to move in that direction.¹²³

New York has gone furthest in reimbursement regulation. It uses a combination of comparable-hospital and specific criterion methods and also imposes an implicit general budget

¹²³ One problem was the difficulty of obtaining a waiver from Medicare. However, Medicare itself did impose some restraints on cost and on cost-shifting. See Weiner, *supra* note 68. Moreover, in December 1982, at the request of Congress, the Secretary for Health and Human Services submitted a legislative proposal for a prospective reimbursement system for Medicare based on DRGs (see note 121 *supra*). Office of the Secretary, *Report to Congress on Hospital Prospective Payment for Medicare*, Dept. of Health and Human Services, Washington, mimeo. (Dec. 1982).

constraint by allowing formula adjustment to lag behind inflation. In other states, informal general budget reviews are gradually being supplemented by normative criteria based primarily on analyses of groups of comparable hospitals within the state. The outcome in these cases depends more on negotiations between the hospitals, the regulatory agency, and Blue Cross than on any rigid formula.

Effects on the cost and distribution of care. Hospital reimbursement regulation, unlike certificate-of-need, does seem to have an effect on expenditures on hospital care. Although the impact has been greatest in New York, which has the most restrictive program, it has been substantial elsewhere as well.¹²⁴

To understand the significance of this for equity of access, the effects on the cost of providing services must be distinguished from the impact on the number of services provided. Reimbursement regulation gives hospital administrators the incentive to provide laboratory tests at the lowest possible cost, to avoid purchasing equipment that will be underused, to buy hospital supplies from the cheapest source, and so on. Of course, its success requires that administrators respond to financial incentives, which in nonprofit organizations may not happen. In the current economic climate, however, financial solvency is undoubtedly a central objective of all administrators.

Yet the real problem may be the provision of excessive quantities of services. Some are actually wasteful or harmful to the patient's health: unnecessary surgery, days in the hospital when the patient would do as well (or better) at home, or tests that contribute no useful information about the patient's condition, for example. Some services provided are of very minor benefit, especially when considered against their cost. The amount of hospital care that is of this type is a matter of dispute. Some commentators believe it is very large.¹²⁵

Ideally, financial constraints would encourage hospitals to reduce the number of treatments of little or no benefit. In practice, because treating serious illness is such a complex activity, it is a difficult technical task to design such constraints. Even a carefully designed reimbursement system may inadvertently reward the provision of inappropriate care in some cases. (For example, setting minimum occupancy rates can encourage unnecessarily long stays; setting minimum usage rates for equipment can encourage its excessive use.)

124 Joskow, *supra* note 110, at 138-68; Biles, Schramm, and Atkinson, *supra* note 119, at 665; CONTROLLING RISING HOSPITAL COSTS, *supra* note 119, at 60, 92-96; Coelen and Sullivan, *supra* note 119, at 18.

125 Anthony L. Komaroff, *The Doctor, the Hospital, and the Definition of Proper Medical Practice* (1981), Appendix U, in Volume Three of this Report.

But more importantly, the services provided to patients are not controlled by hospital administrators; they are determined by the clinical decisions of physicians. Yet reimbursement regulation has no direct impact on physicians since they have no direct financial stake in hospitals. They are usually not even employees of the institution.

Of course, administrators have some indirect control. They can keep resources in short supply in an attempt to force physicians to ration their use. Meetings, educational campaigns, and administrative rules can be used to persuade physicians to change their style of practice. But doctors typically believe they should do whatever they can for their patients, as a matter of professional ethics, especially when hospital bills will not be an undue burden to patients because they are well insured. At best, doctors may cooperate in eliminating wasteful or harmful care, but since there is often great disagreement about what that is even this may be difficult.

Some analysts argue that institutional arrangements have evolved in response to financial incentives.¹²⁶ Because retrospective third-party reimbursement insulated physicians, patients, and administrators from cost concerns, an organizational split in hospitals developed. If financial pressure were imposed on hospitals, starting slowly and increasing over time, a new institutional structure would develop. One key to this strategy would be the inclusion of the majority of hospitals and all (or nearly all) payors in a given area in the reimbursement system. This would prevent physicians and patients from playing one hospital against another by threatening to go elsewhere, and it would prevent hospitals and physicians from simply avoiding the patients of payors that restricted reimbursement. Furthermore, a statewide system might mean physicians took more note of the financial impact of their decisions since all hospitals—which physicians need—would be under the same pressure.

The belief that financial incentives have created the current institutional structure may, however, have the causality reversed.¹²⁷ Physicians often make treatment decisions when patients have difficulty deciding for themselves (because they are not health care experts and because illness may interfere with their decisionmaking capabilities); such decisions may be of profound importance to well-being. Given this, the public is suspicious of systems in which doctors are under financial pressure to stint on care. Third-party payment for hospital care arose and took the form it did partly as a result of a desire to

¹²⁶ See e.g., Joskow, *supra* note 110, at 20-55, especially at 31-35.

¹²⁷ Jeffrey E. Harris, *The Internal Organization of Hospitals: Some Economic Implications*, 8 BELL J. ECON. 467, 482 (Autumn 1977).

keep financial considerations out of the physician-patient relationship, as a doctor and economist notes:

The doctor-patient relation creates a much stronger expectation of fidelity than is present in other agent-client arrangements. The doctor is saddled with a moral burden of ultimate responsibility for the outcome of the case....

There is a special negative externality in an arrangement in which one makes repeated marginal decisions about life and death. This externality is so important that the physician's participation in the "market" for angiograms and code calls is explicitly foreclosed. Whether or not it is justified, this notion has an important influence on the way the hospital is organized.¹²⁸

The evolution of a new institutional structure requires a reevaluation of the way that financial considerations should enter into health care decisions, so that patients do not get care that is worth less than it costs. Without such a reevaluation, imposing financial constraints on hospitals is likely to result only in social discord and serious inequities in the distribution of care. Since physicians and patients have no direct incentives to cooperate in restraining use, people with political and economic power may not be forced to give up wasteful care, yet the poor and the powerless may be deprived of essential care. In New York, for example, there has been tremendous opposition by providers and members of the community to cost-containment efforts, as well as charges that the effects of the constraints are falling most heavily on the disadvantaged.¹²⁹

Effects on the distribution of cost. Reimbursement regulation's greatest impact on the distribution of cost stems from the way it handles the cost of the care of the uninsured or inadequately insured who cannot pay anything themselves. The amount of unreimbursed care varies greatly from one hospital to another, depending upon location and the type of population served. As described earlier, hospitals now spread such costs over other patients on an ad hoc basis. A reimbursement regulation system that does not make express provision for this—that is, by financing it out of tax revenues or by spreading the cost broadly over all hospitals—will cause major problems. By putting additional financial pressure on hospitals, it will make it even more difficult for them to deliver

¹²⁸ *Id.* at 473.

¹²⁹ Schwartz, *supra* note 119, at 1254; Ronald Sullivan, *Care at Many Hospitals Hit Sharply by Cutbacks*, N.Y. TIMES, May 13, 1980, at B-1; *Court Extends an Order To Keep Hospital Open*, N.Y. TIMES, May 31, 1980, at 27.

unreimbursed care, and they will be more inclined to exclude patients who cannot pay.

Limits on individual choice. If financial constraints are stringent enough to affect the quantities of services provided, they will restrict individual choice as well. This will be more acceptable for wasteful or harmful care than for care that is on average of only small benefit.

One solution advocated by some commentators is to change the financial incentives for physicians and patients, as well as for hospitals, in order to encourage them to forego inappropriate care voluntarily. In the case of patients, this means cost-sharing, which is particularly complex for hospital care. The decisions that would have to be made differently are not so much the major ones (whether or not to resuscitate, whether to have radiation or surgery for cancer) as the more minor ones about which tests to order, which medications to prescribe, and so on. Cost-sharing will affect these decisions only insofar as patients can control the services ordered by their physicians. And cost-sharing dilutes the financial protection against large hospital bills that is provided by insurance. Changing the financial incentives for physicians would affect those with the most control over these decisions, but it would require making fundamental institutional changes, and, more important, inducing physicians to behave in ways they now find ethically questionable. Thus it is unlikely to be effective without prior clarification of the ethical duties of physicians.

Another approach is through an expanded role for utilization review, which could provide a formal process for the formation of a medical consensus on what constitutes appropriate care by developing standards of practice that take cost into account. Ideally, such a system would steer a middle ground between two extremes: crude “rationing rules” that make no allowance for individual circumstances and that are devised by people with little knowledge of medicine, and social cost-benefit decisionmaking at the bedside by physicians who lack clear guidance from society about how to reconcile any conflicting interests of the patient, the physician, and society. Such a review could also incorporate mechanisms to change the behavior of physicians who are significantly out of line with their peers, so that restrictions on choice were not more severe for some patients than for others.

Developing acceptable and equitable methods to restrain the use of care is a major challenge to the health care system. If regulation of hospital reimbursement is to have a significant effect on expenditures, it is likely to have adverse effects on the distribution of care unless its implementation is carefully devised to ensure equity.

Ethical Issues in an Era of Constraints

4

The preceding two chapters set forth the Commission's findings about the extent to which all Americans have equitable access to health care and the effects of government policies on the availability of health services. The Commission has found that ethically significant disparities related to income, race, and place of residence still exist both in the adequacy of care received and in the burdens of obtaining it. Although local, state, and Federal efforts have done much to improve access, they have not yet succeeded in making equitable access to health care a reality for all Americans.

Further movement toward that goal is now in doubt because of mounting concern with the growing share of national resources, and particularly of public funds, being spent on health care. Americans are asking—with good reason—whether increased expenditures are matched by increased benefits. Though not itself an ethical issue, the appropriate and efficient use of resources in health care is a matter of concern to the Commission for several reasons. First, until effective steps are taken to control the escalation in health care costs, policymakers are likely to remain reluctant to focus their attention on improving access. Second, wasteful practices siphon off precious resources that could be used to provide adequate care for all and to promote the vigorous research efforts on which future triumphs over illness depend.

The issue for the Commission is thus not whether to contain rising health expenditures, but how to do so in an ethical fashion if the nation decides to spend less on health care. In the final chapter of this Report, the Commission examines the bases for concern about health care costs and then looks briefly at the ethical implications of its conclusions for three current cost-containment efforts: reductions in funds for the Medicaid program, recent changes in the Social Security

disability program, and proposals to reduce the Federal tax subsidies of health insurance. The approaches discussed illustrate broad strategies rather than surveying the range of proposals under consideration. The Commission does not intend this discussion to serve as a report card on specific proposals but as a beacon shedding light on the terrain of health policy. Improvements in the accessibility of health care can be made within the context of finite resources but achieving this goal will involve trade-offs, some of which are ethically more acceptable than others.

Concerns About Health Care Costs

The Rise in Health Care Expenditures. The dramatic rise in health care costs during the past 15 years has recently received a great deal of attention. Concerns have been voiced about the higher total expenditures for health care generally and about the increasing share of government resources devoted to health care. In 1965, Americans spent \$42 billion on health care; by 1981 total outlays amounted to \$287 billion.¹ The share of the Gross National Product (GNP) devoted to health care rose from 6.0% to 9.8% during this period. Not only has the price of health care goods and services risen at a faster rate than other consumer prices, but the growing share of national wealth devoted to health care has led to understandable concern about the limitations being placed on alternative uses of these resources.

The rise of total spending has been accompanied by a marked shift in the source of financing: government expenditures at the local, state, and Federal levels have accounted for an increasing share of total health care outlays. In 1965, 26% of all national health care expenditures were from public funds; by 1981, that figure reached almost 43%—that is, \$123 billion of the \$287 billion in total health expenditures that year. As noted in Chapter Three, these outlays take several forms, including programs that finance and deliver care for the underserved and the expansion of health care for the total population through the training of health professionals, the construction of hospitals, and research. In addition, the government provides an indirect subsidy for the purchase of employment-related health insurance (although this subsidy is not included in the \$123 billion figure).

¹ The information on health care costs in this chapter is derived from data supplied by the Health Care Financing Administration, U.S. Dept. of Health and Human Services. The major source of this data is Robert M. Gibson and Daniel R. Waldo, *National Health Expenditures, 1981*, 4 HEALTH CARE FINANCING REV. 2 (Sept. 1982).

There is no magical share of the nation's resources that is obviously "correct" for health care.² The important question is whether the level of spending reflects the priorities of the American people. Americans have traditionally placed great value on the ready availability of high-quality care. Most would not want to face sharp restrictions in the care available when they or their loved ones are ill. Nevertheless, there seem to be new doubts that the public is receiving sufficient benefits to justify the increased spending. The current preoccupation with rising expenditures may really reflect these doubts rather than dissatisfaction with the level of spending itself.

Eliminating Wasteful Practices. A growing body of expert opinion provides some foundation for this concern about whether Americans are getting their money's worth. Clearly, the availability of medical care has made and will continue to make a tremendous difference to health, for the population as a whole and for individuals with special health problems. Nevertheless, there is evidence that in some cases services could be produced and delivered more inexpensively, and that in other cases fewer services could be provided with little or no effect on a patient's well-being. Indeed, there may be instances when patients would actually be better off with less care.³ If inefficiencies could be reduced and inappropriate care discouraged, the total savings could be considerable. These savings could be used to improve the distribution of care, so that more people could enjoy the benefits of American medicine without diverting resources from other important social purposes.

² To put the rising share of GNP devoted to health care into perspective, it should be noted that other service industries have also been growing at a rapid rate. Moreover, in recent years, the percentage of GNP spent on health care by other countries has also increased; the U.S. percentage is not very different from that in most advanced industrial democracies.

Statistics from 1975, the latest year for which adjusted figures are available for 11 Western industrialized countries, indicate that six of these nations devoted between 8-10% of their GNP to health care (Federal Republic of West Germany, Norway, France, the Netherlands, Sweden, and the United States). Australia, Canada, and Finland spent over 7% of their GNP on health care that year. The percentage devoted to health care today is thought to be slightly higher in each country and most of these 11 countries now spend between 8-10% of their GNP on health care, according to the Division of Comparative International Studies, the Social Security Administration, and the U. S. Dept. of Health and Human Services.

³ See, e.g., Anthony L. Komaroff, *The Doctor, The Hospital, and the Definition of Proper Medical Practice* (1981), Appendix U, in Volume Three of this Report.

Although there is general agreement that savings can be made, there is debate about how large the savings might be and exactly where they might be found. Information about the magnitude of inefficient and inappropriate care is scarce but the Commission is pleased that physicians and other health professionals, health care institutions, insurers, researchers, and others are now paying increasing attention to this subject and urges that further studies be done.

In addition to questions about the extent of savings, it is often not clear at what point proposed changes will go beyond the elimination of inefficiency in the production and delivery of services and begin also to have unacceptable effects on the quality of care. For example, when surgery is performed on an outpatient rather than an inpatient basis, there may be no change in the risk of complications, or there may be a slightly greater risk that is offset by increased patient convenience as well as lower costs. Thus, the identification of potential savings frequently requires evaluation of the relative importance of the different dimensions of health care.

Even without full consensus on the valuation of costs and benefits, however, there is already sufficient agreement to give credence to the view that the potential savings are substantial. For example, about half the patients treated in hospital emergency rooms are not urgently in need of care; many could receive better care at lower cost in a setting expressly designed for routine ambulatory care.⁴ Estimates of the percentage of hospital days that are inappropriate have ranged as high as 20%.⁵ Surveys in hospitals have indicated that 50-65% of the antibiotics that are ordered are not indicated at all or are being given incorrectly; one systematic study of ambulatory patients showed that 25-40% of antibiotic injections were unnecessary.⁶

Laboratory tests and X-rays merit particular scrutiny, since the increase in their use has been especially dramatic.⁷ Although the automation of laboratory analyses has lowered the cost of individual tests, in some cases reimbursement methods have encouraged hospitals to increase the number of tests done rather than to reduce patients' hospital bills. "Routine orders," for example, for a complete battery of tests for patients entering the hospital are often still written, although many physicians have criticized this practice as

⁴ Steven Jonas *et al.*, *HEALTH CARE DELIVERY IN THE UNITED STATES*, Springer Publishing Company, New York (2nd ed. 1981) at 138.

⁵ Komaroff, *supra* note 3, at *Hospitalization* in section four.

⁶ *Id.* at *More Is Not Always Better* in section two.

⁷ Anne A. Scitovsky, *Changes in the Use of Ancillary Services for "Common" Illness*, in Stuart H. Altman and Robert Blendon, eds., *MEDICAL TECHNOLOGY; THE CULPRIT BEHIND HEALTH CARE COSTS?*, Dept. of Health, Education, and Welfare, U.S. Government Printing Office, Washington (1979) at 39.

wasteful. Furthermore, extra tests increase the probability of “false positive” results, which then lead to further testing and clinical evaluation (and hence additional expenditures) to rule out the apparent new problem.⁸ Similarly, studies have revealed that for most adults annual physical examinations provide little more protection than those performed every three to five years.⁹ Reports of the Food and Drug Administration suggest that of the 75 million chest X-rays done in 1980, at a cost of nearly \$2 billion, nearly one-third were unnecessary because they were unlikely to either detect disease or affect its outcome.¹⁰

Cardiac pacemakers can make the difference between life and death, but recent studies suggest that their use in inappropriate cases may mean the nation is spending large sums unnecessarily.¹¹ Many patients now admitted to hospital

8 For a discussion of the relationship between rising health care expenditures and the use of laboratory tests, both in and out of hospitals, see Komaroff, *supra* note 3; Harvey V. Fineberg, *Clinical Chemistries: The High Cost of Low-Cost Diagnostic Tests*, in Altman and Blendon, *supra* note 7, at 144; Thomas W. Moloney and David E. Rogers, *Medical Technology—A Different View of the Contentious Debate Over Costs*, 301 NEW ENG. J. MED. 1413 (1979); Steven A. Schroeder and Jonathan A. Shows tack, *Financial Incentives to Perform Medical Procedures and Laboratory Tests: Illustrative Models of Office Practice*, 16 MED. CARE 289 (1978); Comptroller General of the United States, *Additional Information Certain Aspects of Independent and Hospital-Based Laboratories*, Washington, mimeo. (1973); Comptroller General of the United States, *Tighter Controls Needed Over Payments for Laboratory Services Under Medicare and Medicaid*, Washington, mimeo. (1976).

9 A number of medical organizations have come forth with recommendations regarding the periodic health examination. Principally, the American College of Physicians and the American Medical Association recommended periodic health examinations when “needed,” and that asymptomatic individuals at low medical risk need not have an annual medical examination. *Healthy Do Not Need Annual Exams, Say Internists*, MED. WORLD NEWS, Dec. 21, 1981, at 8. See also *Guidelines For the Cancer Related Checkup: Recommendations and Rationale*. 30 CANCER 194 (1980); Canadian Task Force on the Periodic Health Examination, *The Periodic Health Examination*, 121 CAN. MED. Assoc. J. 1193 (1979).

10 Jeanne Kassler, *Routine Use of Chest X-Ray is Under Attack*, N.Y. TIMES, Aug. 10, 1982, at C-1.

11 Atul B. Chokshi *et al.*, *Impact of Peer Review in Reduction of Permanent Pacemaker Implantations*, 246 J.A.M.A. 754 (1981); Arthur Selzer, M.D., *Too Many Pacemakers* (Letter) 307 NEW ENG. J. MED., 183 (1982); Howie Kurtz, *25% of Pacemakers ‘Unnecessary,’* WASH. POST, July 8, 1982, at A-6; Philip J. Hilts, *Investigation by Inspector General’s Office of the U. S. Dept. of Health and Human Services*, WASH. POST, Sept. 5, 1982, at A-1.

intensive care units (ICUs) do not require the level of services such units provide.¹² Since costs in these units are two to five times those in other parts of hospitals, a more careful selection of patients could save substantial sums¹³; one estimate is that a 10% reduction in ICU use would save \$2 billion and spare many patients the isolation and stress that such units create.¹⁴ It has been estimated that at least 25% of the “respiratory care” (treatments and tests for breathing and oxygen, often involving sophisticated machinery) now given to one in every four hospitalized patients at an annual cost of \$5 billion is unneeded.¹⁵

Reducing health care costs is not per se an ethical problem nor something for which the government is necessarily responsible. There are steps the private sector can take voluntarily to achieve this end. The medical profession can encourage its members to inform themselves about the cost of care and to support efforts to control costs in ways that do not jeopardize quality. Medical researchers can pay special attention to aspects of cost so that physicians and patients have the information they need to make appropriate trade-offs in clinical care.

Private health insurers can change the incentives to providers and patients that arise from their reimbursement policies. The use of tests and procedures, for example, is now rewarded more than clinical diagnosis and communication between practitioner and patient are; a change in financial incentives might both lower health care costs and increase patient satisfaction.¹⁶ Changes in incentives to policyholders might lead them to use care more appropriately and to seek out efficient providers. Insurers can also make a greater effort to review the use of care and to deny payment when use is inappropriate. The Medical Necessity Program introduced by the Blue Cross/Blue Shield Associations in 1977 has ended routine payment for 85 surgical and diagnostic procedures judged obsolete, outmoded, or of unproven value. Recently, these Associations announced a major campaign to educate

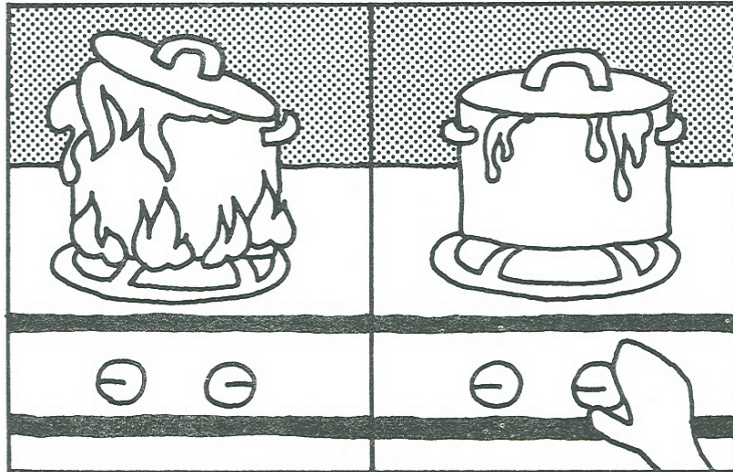
12 William A. Knaus *et al.*, *The Range of Intensive Care Services Today*, 246 I.A.M.A. 2711 (1981); Albert G. Mulley, *The Allocation of Resources for Medical Intensive Care* (1981), Appendix W, in Volume Three of this Report.

13 Mulley, *supra* note 12 (citing D.P. Wagner, *National Costs of Intensive Care*, presented at Symposium on Critical Issues in Medical Technology, Boston (1980)).

14 William A. Knaus, *Less Use of ICUs Could Mean Better Medicine*, AM. MED. NEWS, Feb. 26, 1982, at 18.

15 Victor Cohn, *Health Insurers Would Stifle Some Respiratory Outlays*, WASH. POST, Oct. 21, 1982, at A-3 (quoting Dr. Marvin Shapiro, Chairman of the Board of Blue Cross/Blue Shield).

16 *See, e.g.*, Moloney and Rogers, *supra* note 8; Schroeder and Showstack, *supra* note 8.



physicians about the use of respiratory care. If the campaign does not succeed in changing physician practice patterns, the companies plan to halt payments for that proportion of care considered wasteful.¹⁷

Employers and unions can also take measures to contain health care costs. In New York, a large union-management health insurance fund introduced a program requiring patients to obtain second opinions on the need for elective surgery. The result was an estimated savings of \$2.63 for every \$1 spent on the program.¹⁸ Sixteen Minnesota corporations have contracted with a private review organization to ensure that care received by their employees is warranted and is being provided in the most appropriate setting. Using criteria developed by physicians from accepted standards of good medical practice, the organization has been able to save an average of \$11 for every \$1 invested, while achieving good acceptance by providers and patients. Blue Cross/Blue Shield of Minnesota has now decided to offer the program to group subscribers in the Minneapolis-St. Paul area.¹⁹

These are examples of private initiatives designed to control health care cost. In the belief that others can be developed, one large private foundation is sponsoring a \$16.2 million grant program (co-sponsored by the American Hospital

¹⁷ Cohn. *supra* note 15.

¹⁸ B.S. Ruchlin, M.L. Finkel, and E.G. McCarthy, *The Efficacy of Second-Opinion Consultation Programs: A Cost-Benefit Perspective*, 20 MED. CARE 3 (1982).

¹⁹ *Blues to Offer Private Review Program*, Private Rev. Update, Foundation for Health Care Evaluation, Minneapolis, Minn., Sept. 15, 1982, at 1.

Association and the Blue Cross/Blue Shield Associations) to fund new ideas for cost-saving.²⁰

Governmental bodies can also take steps to control health care costs in response to public concern over wasteful spending and its harmful effects on public programs and, therefore, on taxpayers. The development of certificate-of-need programs and the regulation of hospital reimbursement by some states are examples of such efforts. When government does attempt to reduce health care spending, however, it is essential that it do so in an equitable manner. The burden of cost containment should not be borne mainly by those least able to afford it, who have had to rely most heavily on public funds to secure health care services.

Containing Costs in an Ethical Way

Medicaid. Traditionally, proposals to trim the increase in Medicaid expenditures have sought to limit government outlays under a particular program rather than attempting to control health care costs through improvements in the functioning of the health care system. Chapter Three recounted the dramatic growth in public expenditures under this program: combined Federal and state outlays for Medicaid amounted to \$30 billion in 1981, with the Federal government responsible for 55% of all program costs.²¹ The states have relied on limiting eligibility, placing limits on the types and amount of services available, and offering low reimbursements to providers in their attempts to contain Medicaid costs. Over half the states limited Medicaid benefits and/or eligibility in 1981.²²

Considered within the ethical framework discussed in Chapter One, these cost-control measures are seen to worsen rather than improve Medicaid's ability to promote equitable access to care. First, as discussed in Chapters Two and Three, many people fall through the cracks of the existing system of mixed public and private insurance coverage. Medicaid eligibility requirements already exclude about half of all poor people, who therefore lack even the limited guarantees provided by that program. Restricting Medicaid coverage further will increase their numbers. As pointed out by several foundation executives, who are leading commentators on health policy:

It follows that significant numbers of poor Americans, the elderly and minority citizens may be subtly disen-

²⁰ *Foundation to Fund Health Costs Study*, WASH. POST, Feb. 4, 1982, at A-16.

²¹ See note 1 *supra*.

²² *Recent and Proposed Changes in State Medicaid Programs: A Fifty State Survey*, Intergovernmental Health Policy Project, George Washington University, and State Medicaid Information Center, National Governors' Association, Washington (1982).

franchized without us really recognizing that this is occurring by the simple expedient of freezing or dropping Medicaid eligibility requirements. Thus these groups may once again find it difficult to obtain the medical care they need.²³

Beyond the question of eligibility for services, a second ethical issue concerns the adequacy of care. Arbitrary limits on the scope and amount of Medicaid services already mean that its beneficiaries do not secure adequate care for some health conditions. In some states, for example, the maximum stay in a hospital per year that will be covered is as little as 14 days.²⁴ This discourages hospitals from admitting Medicaid patients with conditions that may require extended hospitalization. Low reimbursement rates, which are considered inadequate by many providers, lessen their willingness to care for Medicaid patients, making it more difficult for such patients to receive mainstream medical care.

Similarly, the effects of “cost-sharing” on the ethical objective of adequate care deserve attention. Requiring patients to pay a portion of costs out-of-pocket is intended to limit wasteful use. For Medicaid recipients, it is more likely to discourage the use of valuable care (particularly in leading these patients to put off seeking care in a timely fashion). In the past, the requirement of copayment by Medicaid beneficiaries has been accompanied by a notable decline in the use of such services as prenatal care and immunizations—services that are generally regarded as essential for adequate care and as effective in avoiding costlier medical interventions.²⁵ Moreover, when care is received, even a small out-of-pocket charge can constitute a substantial burden for some Medicaid participants. Thus, these broad-brush devices not only appear undesirable from an ethical standpoint but stand in sharp contrast to cost-containment measures that attempt to distinguish between care that is important to an individual’s health and care that offers little benefit (and is thus less critical to the preservation of well-being and the advancement of opportunity).

Third, a reduction in Federal funding of Medicaid would worsen existing inequities in the distribution of the cost of care. Since some of the care will still be provided, payment will

23 David E. Rogers, Linda H. Aiken, and Robert J. Blendon, *Personal Medical Care: Its Adaptation to the 1980s*, Institute of Medicine, Washington, mimeo. (1980) at 3.

24 Personal communication, Intergovernmental Health Policy Project, George Washington University, Washington (Dec. 1982).

25 For a review of studies on the barriers to needed care as a result of cost-sharing see Geraldine Dallek and Michael Parks, *Cost-Sharing Revised: Limiting Medical Care to the Poor*, CLEARINGHOUSE REVIEW 1149 (March 1981).

simply be shifted to another source. State-supported teaching hospitals and local public hospitals will most likely treat a large share of the former Medicaid beneficiaries; they will pass these added costs on to other patients (and their insurers) or to taxpayers or they will be forced to use funds intended for other purposes, such as teaching and research, to care for these patients. The Health Insurance Association of America estimates that during 1982 hospitals providing a great deal of care to the poor will shift on to patients with commercial insurance \$4.8 billion of the costs incurred because of reductions in Medicaid and Medicare.²⁶ Physicians who do not turn away those low-income patients who are no longer eligible for Medicaid or whose coverage of benefits has been restricted will be forced to absorb the cost of these “charity” patients. Cutbacks in Medicaid thus are likely to transfer a greater share of the burden of caring for these individuals from the Federal level (where it is distributed more evenly) to state and local taxpayers, health care professionals, and privately insured patients.

Paradoxically, some of these cost-control measures may lower Federal outlays in the short run but may actually increase total costs. For example, people who are no longer eligible for Medicaid are likely to seek care in public hospital emergency rooms and outpatient departments rather than in physicians’ offices and clinics. Yet hospitals are more expensive settings for routine care and are less likely to provide the information, preventive measures, and follow-up services that could control the need for costly acute care.²⁷

Unfortunately, it is easier to cut spending for public programs than it is to make changes in the management and financing of health care. Many states, however, are beginning to take advantage of provisions in a 1981 law that grants them greater leeway in administering and paying for services provided to Medicaid beneficiaries.²⁸ States are now likely to find it easier to obtain waivers from the government to implement innovative cost-containment strategies. These include experiments to pay for home and community-based services for the elderly and mentally retarded as alternatives to nursing home care; arrangements with individual physicians who agree to be responsible for the “case-management” of Medicaid beneficiaries in order to discourage the use of costly

²⁶ Thomas W. Moloney, WHAT’S BEING DONE ABOUT MEDICAID?, The Commonwealth Fund, New York (1982) at 10.

²⁷ Diana Dutton, *Explaining The Low Use of Health Services by the Poor: Costs, Attitudes, or Delivery Systems?*, 43 AM. SOC. REV. 348 (1978); Ruth Roemer, PLANNING URBAN HEALTH SERVICES: FROM JUNGLE To SYSTEM, Springer Publishing Company, New York (1975).

²⁸ Linda E. Demkovich, *States May Be Gaining in the Battle To Curb Medicaid Spending Growth*, 14 NAT’L J. 1584 (1982).

hospital emergency rooms and outpatient departments; and changes in the way hospitals are paid, which have typically been based on the providers' costs being reimbursed retrospectively, an arrangement that offers no incentives to hospitals to operate efficiently. Many believe these types of cost-containment approaches will be more effective in addressing the forces behind rising health care costs. Though they are not without flaws and their design will require careful attention, overall they hold greater promise of acceptability from an ethical standpoint than restricting eligibility does.

Social Security Disability. In 1980 Congress enacted legislation to improve accountability in the Social Security Disability Program by encouraging the review of new applicants.²⁹ Under this prospective review, those who failed to demonstrate disability would be denied Social Security payments as well as the Medicare benefits they are entitled to after two years in the disability program. Concern has been expressed, however, that program administrators have gone beyond the intent of the 1980 statute in order to reduce expenditures in the Social Security and Medicare programs by reviewing not only new applicants but also many current beneficiaries, by accelerating the pace of the review process, and by establishing an expectation of a significant rate of denials. In short, the process of "weeding out" ineligible enrollees appears to have become one of terminating a substantial number of beneficiaries for the purpose of budgetary savings. Over half the recent disability reviews have resulted in denial or termination of benefits, yet two-thirds of those decisions have been reversed on appeal.³⁰

This process has significant implications for the health of those undergoing review: people removed from the disability program have few, if any, alternatives for health insurance because they are considered unattractive risks by commercial insurers. Any insurance that is offered, often at very high rates, is usually of little value because many policies exclude coverage of "preexisting conditions." Furthermore, terminated beneficiaries will find it hard to afford insurance since their disabled condition usually precludes gainful employment.³¹ In the absence of other public programs, the denial or revocation

²⁹ The Disability Insurance Amendments of 1980 specified new eligibility requirements for those applying for Social Security Disability Insurance and included a provision for continuing disability investigation of all beneficiaries whose disabilities were not determined as permanent, beginning in 1982; *Impact of the Accelerated Review Process on Cessations and Denials in the Social Security Disability Insurance Program*, Select Comm. on Aging, U.S. House of Representatives (May 21, 1982) (report by the Chairman).

³⁰ *Id.*

³¹ To be classified as disabled, an individual may not be capable of employment paying more than \$300 per month.

of eligibility leaves disabled persons with little assurance of securing an adequate level of health care or with the prospect of a crushing financial burden if care is obtained. The ethical obligation to secure equitable access to care would be better met if the procedures ensured Medicare coverage during the many months of any appeals process and if the review process were used as intended, rather than as a temporary cost-cutting device.

Tax Subsidies. Several proposals to reduce the substantial tax subsidies for health-related expenses have recently been considered, and an initial step in this direction was taken in the 1982 Tax Equity and Fiscal Responsibility Act.³² As discussed in Chapter Three, health care expenditures now receive favorable tax treatment in a number of ways.

First, employers' payments of employees' health insurance premiums are not treated as taxable income to the employees. The Federal and state revenues lost as a result of this exclusion are estimated to be \$30.7 billion in 1983.³³ If such payments were instead given directly as wages, employees would have to compare the health insurance coverage they wanted with other things they purchase with their ordinary (after-tax) income. The favorable treatment of employer payments of insurance premiums has led employees (especially in collective-bargaining units) to opt for very comprehensive coverage requiring little, if any, out-of-pocket payments. Thus, they have little incentive to take the relative benefits and costs of care into account when seeking care. Many believe that this situation encourages greater use of services that are of only marginal benefit, which unnecessarily inflates aggregate demand for health care. Some employers, who provide extensive insurance coverage for all their employees, have responded by requiring increased cost-sharing of incurred medical expenses.

Several proposals have been made to alleviate this situation. Some have proposed that employer payments of health insurance premiums above a certain level not be tax-deductible to either employer or employee. Others would require employers to offer their employees a choice of health insurance plans and to give a rebate to those who select a lower-cost plan.

³² The Tax Equity and Fiscal Responsibility Act, Pub. L. No. 97-248 (1982).

³³ About two-thirds of this is Federal income tax losses. The rest is nearly equally divided among state income taxes and employer and employee contributions to social security. Amy K. Taylor and Gail R. Wilensky, *Tax Expenditures and the Demand for Private Health Insurance*, mimeo., in Jack Meyer, ed., MARKET-ORIENTED REFORMS IN FEDERAL HEALTH POLICY, American Enterprise Institute, Washington (forthcoming) at 21-22.

Proponents argue that these incentives would encourage workers to choose lower-cost insurance plans that offered fewer benefits and required greater cost-sharing by individual patients. As a result, employees and their families would be expected to become more sensitive not only to the cost of insurance but also to the cost of care, since fewer would probably elect to have very comprehensive, low-or-no-deductible plans.

Reducing the tax exemption would have several ethical implications. First, if properly designed, it is unlikely that such measures would compromise access to adequate health care. It is anticipated that comprehensively insured individuals would be encouraged to use less care that, according to their own priorities, is less beneficial than other uses of their own funds.

Second, this approach to cost containment would not have a disproportionate impact on the most economically vulnerable people who have the greatest difficulty in securing care. Since cuts in the government tax subsidy for employees' health benefits primarily affect middle- and upper-income families, they are likely to reduce total health expenditures by encouraging the people most able to pay for health care to be more selective in their use of services. From an ethical standpoint cost containment should not be aimed chiefly at those for whom access to care is most tenuous.

Third, reductions in the tax exemption would limit the use of public monies to support the purchase of care that is less essential to well-being and opportunity. A fair distribution of cost requires that government funds not finance the receipt of "higher-than-adequate" care for some individuals until access to adequate care for all is ensured.

The 1982 changes in the tax code address another major subsidy: the deduction of medical expenses from personal income for tax purposes. This deduction, which was intended to recognize the catastrophic effect of large medical expenses, previously came into effect when medical expenses exceeded 3% of adjusted gross income. The new tax law raises that threshold to 5%.³⁴ It is believed that this will encourage middle- and upper-income people, who are the chief beneficiaries of this subsidy, to use services more sparingly and thus reduce overall expenditures for health care. Although this revision will affect fewer people and involve smaller savings than changes in the employer-exclusion would, it too seeks to contain health care costs in an ethical fashion by making those with greater access to care more circumspect in their use of health services.

Of course, all attempts to reduce the use of health care must be examined carefully, whether they focus on higher-

³⁴ The Tax Equity and Fiscal Responsibility Act, *supra* note 32; the new provisions are effective as of 1983.

income individuals or on low-income people enrolled in government-funded programs; policymakers need to be aware of the potential of any “reform” to restrict equitable access to care or to cause patients to forego beneficial treatment. Steps must be taken, for example, to ensure that employees’ choices of alternative insurance plans would guarantee care at an adequate level. Attention must also be paid to the effect on the amount of health insurance obtained through the workplace. If employers and employees lost all tax benefits presently connected with health insurance, a sizable drop in private coverage—and an increase in pressure on government programs—would probably result. Measures that enhance personal choice about health care and that emphasize individual responsibility are ethically preferable to those that do not, provided that the basic requisite for choice—namely, access to an adequate level of care—is preserved. Likewise, public officials have a responsibility to the taxpayers to avoid wasteful and inefficient practices in providing care: public programs should be monitored for inefficiencies and for abuses by both patients and providers, and subsidies should be carefully scrutinized for the incentives they create. Economies can be achieved, in both public programs and in the health care system generally, through measured changes that encourage a more rational and efficient system without increasing gaps in access to health care.

Setting Social Priorities

Society can honor its obligation to secure equitable access to care within the context of finite resources, but in order to do this it must set priorities about how health care dollars should be spent. All health policy embodies ethical principles and values that, although not always explicit, represent very different views about the nature of societal goals and obligations. The Commission’s brief discussion of the ethical implications of several cost-containment approaches has focused on how such policies affect the goal of enhancing equitable access to care.

Although the drive to reduce spending on social programs currently holds center stage, the Commission does not accept the position that improvements in access must wait in the wings. Such a view ignores society’s moral obligation to achieve equitable access and overlooks the fact that cost-containment efforts are acceptable only if they are compatible with other moral obligations. Improving equity of access to health care need not be inimical to true cost containment—that is, actions that control rising costs through modifications of the delivery and financing of care that affect everyone in the society.

There appears to be a growing acceptance of the position that improvements can be made in the health care system. People are taking greater interest in their health and wish to be more involved in decisions about their care.³⁵ Moreover, consumers are increasingly indicating a willingness to take account of the financial impact of health care decisions; a survey conducted for the Commission found that two-thirds of the public want physicians to give them more information about the cost of various treatments.³⁶ People seem generally more willing to address issues related to the financing and organization of health care: private insurers are developing more-efficient delivery systems; coalitions of insurers, care providers, corporations, labor unions, and consumers have been formed to identify ways to reduce duplication and develop alternative delivery systems; attempts by state government to control rising hospital expenditures show a readiness to think in terms of new methods of reimbursement.

These are examples of the serious—and laudable—efforts being made to address many of the economic and political problems in the current health care system. But the ethical aspects of health policy also need analysis of the sort that the Commission has attempted to provide in this Report. Unless these concerns are given explicit attention, society risks establishing policies that take account of economic, political, and scientific factors without giving needed weight to the ethical considerations. The Commission hopes that its efforts will highlight the need for such a process and will provide a framework that is helpful in analyzing the ethical implications of various policies.

³⁵ See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, MAKING HEALTH CARE DECISIONS, U.S. Government Printing Office, Washington (1982) at 70-102.

³⁶ *Id.* at 78; Louis Harris and Associates, *Views of Informed Consent and Decisionmaking: Parallel Surveys of Physicians and the Public*, Appendix B, in President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, MAKING HEALTH CARE DECISIONS, VOLUME Two: EMPIRICAL STUDIES OF INFORMED CONSENT, U.S. Government Printing Office, Washington (1982) at 17.

Dissenting Statement by Commissioner Ballantine

December 20, 1982

Dear Chairman Abram:

On 14 December 1982 the Commission approved for publication an extensively amended document titled *Securing Access to Health Care: A Report on the Ethical Implications of Differences in the Availability of Health Services*. I was unable, as a matter of conscience, to add my name to those of the other members of the Commission who approved the Report. The purpose of this communication is to record my reasons therefore and I am grateful to you and my fellow Commissioners for the added opportunity to explain them.

It must be recalled that in creating the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Congress instructed it to study several areas of congressional concern. Among these was "the ethical and legal implications of differences in the availability of health services as determined by the income or residence of the person receiving the service." On its own initiative, however, the Commission added "race and ethnic origin" to the issues of income and residence. The fact that there is a major difference between the phrases "securing access to health care" and "differences in the availability of health services" and the addition of race and ethnic origin as issues to be studied resulted in substantially changing the Commission's original mandate. Notwithstanding this fact, Chapter One of the Report brought forth elegant considerations and conclusions which were brought together under the title "An Ethical Framework for Access to Health Care."

As a result of constructing this framework, the Commission then set forth "an ethical standard by which the delivery of health care in the United States should be judged: access for

all to an adequate level of care without the imposition of excessive burdens.” This is a laudable ethical goal toward which our society should strive and is, therefore, one which I firmly support. My reservations are, however, based on two other aspects of the Report: the manner in which it was adopted and the political implications embodied in Chapters Two, Three, and Four.

The first of these can be dealt with briefly. You will recall that the Commission had originally planned to meet on December 13, 14, and 15 but an executive decision eliminated the first day of the meeting since it was thought that the Commission could complete the Access Draft and two other important ones in a maximum of two days.

On December 14, the Commission spent about seven hours reviewing this Draft in detail. During this period there was prolonged (sometimes intense) debate and the Draft was extensively amended by additions, deletions, substitutions, and emendations. At the close of this exhausting day a motion was made to accept the Draft as amended; it was quickly seconded and without discussion hastily approved.

Some might say that the preceding seven hours of debate had taken the place of discussion but I do not. At no time did the Commissioners discuss the amended Draft as a whole and, furthermore, there was not a Commissioner who could honestly say that, after such extensive revision, he or she could be absolutely certain of its exact content.

I am sure you will remember, for example, my several statements that the evidence presented by staff did not support the oft-repeated conclusion that significant inequities in access to health care were the result of race and ethnic origin. Will my views on this issue appear in the published document? In any event, although I was distressed by the frenetic fashion in which the Report was approved I wish now to turn to my second and more important concern.

Chapter One contains the statement that equitable access to an adequate level of health care for all should first be sought through an escalating series of efforts involving the market (*e.g.* insurance), charity, and local and state governmental activities. Should this goal not be achieved through these forces, the Report states unequivocally that the ultimate responsibility for its attainment must rest with the Federal government. The question then becomes: What is the evidence that would lead to a conclusion that a dominant role for the Federal government is or is not now necessary?

Chapters Two, Three, and Four address this question but, in my opinion, in a less than objective fashion. In fact one of the invited reviewers, Dr. Stuart Altman, Dean of the Florence Heller Graduate School at Brandeis University and a former Deputy Assistant Secretary of HEW, is reported in the Minutes

of the Commission's Meeting of September 10 and 11 as having told the Commissioners that he "found the second chapter less objective than it should be and suggested that more emphasis be placed on the progress in patterns of access and gains in health status over the past decades."

Chapter Two is devoted to a consideration of patterns of access to health care utilizing anecdotes and statistics. The Report (prepared by staff) admits that the statistical data are "not sufficiently precise to paint a complete picture" and that "the data also suffer from other important shortcomings: they fail, for example, to do justice to the fact that individuals of varying race, ethnicity, religion, and social class have different orientations toward their health, medical care, and the health care system." Nevertheless, the charts, tables, graphs, and the text accompanying them are presented as accurate and verifiable statements about the inequities of health care delivery in the United States.

As an example, it is stated that "the poor now pay on average as many visits to physicians as the non-poor. Blacks, on average, visit the physician at rates comparable to whites." But, the Report continues, "Once visits are adjusted by perceived health status [*i.e.* whether the individual thinks of himself as sick or well] the poor make fewer visits to a physician each year than the non-poor and blacks visit a doctor less frequently than whites of comparable health status," *i.e.* as they themselves perceive their health status.

This "adjustment" is capable of various interpretations one of which might be that it is meaningless and another that there are fewer hypochondriacs among the poor and blacks. It certainly cannot mean that the poor and the blacks are denied equitable opportunities to visit a doctor.

All of the anecdotes are chosen to present "illustrative" individual problems in access to medical care based on income, lack of insurance, travel time, and waiting time. These isolated instances are undesirable but not surprising in a country with a population of about 226 million.

Chapter Three is concerned with the impact of government actions on access to health care. Here again negative reporting gives the impression that, for example, subsidies for medical education and hospital construction, the implementation of Medicare and Medicaid, and the increased attempts to regulate the providers (institutions as well as personnel) have failed to alleviate significantly existing inequities in access and, in some cases, may have aggravated them.

One presumed "aggravation" which apparently aggravates the Commission's staff is the favorable tax treatment given to employers and employees in the purchase of health insurance. The Report suggests that those tax exemptions (which are called "tax subsidies") favor the middle- and upper-income

classes and, if reduced or eliminated, would provide more Federal tax dollars which could then be used to increase subsidies to the poor.

No mention is made of an opposite approach to a very serious and unfair current problem. In this era of high unemployment, most working families lose health insurance coverage when the breadwinners lose their jobs. Those tragedies could be minimized by giving more favorable tax treatment to employers who provide continuing health insurance coverage for workers who are unemployed through no fault of their own.

Chapter Four, "Ethical Issues in an Era of Constraints," is much more balanced and objective than the two chapters which preceded it. Except for again presenting arguments that would lead the reader to conclude that the Commission favors reducing or eliminating the favorable tax treatment given to employment-related health insurance I find myself in agreement with the proposals for attempting to reduce health care costs and thereby reduce government expenditures.

There is, however, one significant sentence which reads "The Commission does not intend this discussion to serve as a report card on specific proposals but as a beacon shedding light on the terrain of health policy." I believe the statements in the Introduction more clearly present the thrust of the entire Report. For example, the Commission states there that the ethical standard which it has proposed is "the standard against which proposals for legislation and regulation in this field [the availability of health services] ought to be measured." And again, "what is needed now are ethical principles that offer practical guidance so that health policymakers in the Federal, state, and local governments can act responsibly in an era of fiscal belt-tightening without abandoning society's commitments to fair and adequate health care."

The Report does state further on in the Introduction, however, that "in this Report, the President's Commission does not propose any new policy initiatives, for its mandate lies in ethics not in health policy development." This last statement is not, in my opinion, consonant with the facts. By presenting such a mass of negative evidence in Chapters Two and Three, government policymakers are almost forced to bring forth policies which involve further spending and increased control of health care services by the Federal government.

In summary, had I approved the Access Report as presented and amended on December 14, 1982 I sincerely believe that I would have agreed to the following:

1. Every society has a moral obligation to ensure equitable access to an adequate level of health care for all of its members.

2. In these United States we strive to achieve this ethical goal through the operation of the market, through private charity, and through the efforts of government at the local, state, and Federal levels.

3. The Federal government has a special responsibility to ensure that equity and adequacy are attained when the other societal forces fail. The major portions of this Report are devoted to attempting to provide evidence that we Americans have failed to fulfill the ethical obligations delineated above.

4. The achievement of equitable access to an adequate level of health care for all is an obligation of sufficient moral urgency to warrant devoting the necessary resources to it immediately despite the current attempts to contain government spending.

5. The American health care delivery system is in urgent need of reorganization relative to structure, function, and reimbursement for services provided in the health care sector.

6. The content and tone of this Report and the selected evidence provided to its readers indicate unmistakably that the most suitable way to achieve the moral imperative of equitable access to adequate health care for all is to increase the activities of the Federal government by providing more funds for health care and implementing stricter controls over the manner in which the costs are incurred and paid for.

While I agree with the moral imperative stated above as well as the fact that significant disparities still exist in reference to it, I do not agree that the failures of the market, of charity, and of activities at the local and state levels have been so severe as to warrant at this time increased intrusion of the Federal government into the health care sector. Rather, I am in agreement with Dr. Altman that this Report should have placed more emphasis on the progress in improving patterns of access and gains in health status over the past two decades. I am also in agreement with Dr. Altman's other statement to the Commissioners that the Report should not discuss cost control in great depth since the mandate from Congress was to report on the ethical issues of the availability of health care. He further recommended that any discussion of cost be without reference to techniques and methods of cost control and I do not believe that this Report is in agreement with those recommendations.

Finally, I do believe that all legislation and regulation at the local, state, and Federal level should be constructed to increase the ability of non-governmental societal forces to meet the ethical challenge which was so well expressed in Chapter One of this Report. Moreover, I believe that this document which began as a series of elegant ethical statements has been politicized to an unacceptable degree.

Nevertheless, I want to make it unmistakably clear that the fact that I feel compelled to disagree with the other

members of the Commission must not be construed in any way as indicating a diminution in the affection and respect I have had and do have for you, Mr. Chairman, and my fellow Commissioners.

Sincerely yours,

H. Thomas Ballantine, Jr., M.D.

Response by Chairman Abram

Since I find myself in disagreement with several of Dr. Ballantine's statements about the Report and the Commission's process, I wish to share with the readers of this Report some points made earlier to him. Perhaps it is only the fact that he joined us in August that has left him with the impression that this Report results from a frenetic process. It is certainly true that the Commission has had a demanding work load throughout its three years and has produced a large number of reports. But readers of the present Report would be mistaken if they were led by Dr. Ballantine's description to conclude that this Report was considered in a hurried or precipitate fashion. Indeed, no other Report consumed so much Commission time and was the subject of so many drafts.

We had this subject on our agenda at 13 of our 27 meetings, sometimes for more than one day. Just in the five months since Dr. Ballantine joined the Commission, we discussed a draft of this Report for one day in September, then again a revised draft for a day in November. And it was that draft—with the specific revisions noted as a result of my review of all suggestions made by Commissioners—that we discussed again on December 14. As we went through the Report chapter by chapter then, I was confident that everyone felt themselves on very familiar ground.

As the record of that meeting reveals, each point Dr. Ballantine raised was discussed and the reasons for each passage in the Report were explained. With rare exceptions, he did not reply to those reasons; when he did and when his fellow Commissioners were convinced, changes were made. From the statements he read out during the meeting, I sensed that he was not likely to agree to the Report even if all the changes were made as, to the best of my recollection, nearly all

of his past suggestions had been incorporated in previous revisions.

While I agree with Dr. Ballantine that Chapter One does a good job of setting forth the ethical framework, I cannot agree with his statement that the subsequent chapters “politicize” the Report. A report on the ethics of differences in access to health care needs to examine the extent of such differences. That is the task of Chapter Two, which I think it accomplishes in a careful fashion—not focusing on health status alone, as he suggests, but on a variety of measures to give a rounded view of health needs and use. The chapter was revised after both the September and November 1982 meetings, and I think readers will not find the present version subject to the criticisms voiced by Dean Altman in September, with many of which I agreed at the time.

I must also differ with any suggestion that this Report somehow reflects the views of the staff rather than the Commissioners. Had we had the privilege of Dr. Ballantine’s company earlier, I think he would have seen that this Report has been molded by the Commission all along. Outlines, examples, sentences, sections, and virtually entire chapters emerged from the pens of Commissioners. Indeed, I can think of no other Report in which we have been more actively involved in writing and rewriting. The example of tax exemptions, for which Dr. Ballantine criticizes Chapters Three and Four, was suggested by the Commission, and at the September meeting several of us urged that greater attention be paid to this subject. I personally think it is a good example to consider, not only because of its important effects on the cost and use of health care but especially because “tax subsidies” are frequently discussed in Congress and in Federal budgetary and health offices.

Finally, I am disappointed that Dr. Ballantine does not perceive the Report’s objectivity. We really are not, in my view, pushing for any particular “program” to address the range of concerns that have been expressed in many quarters with various aspects of health care costs today. By talking about some of the undesirable (and often unintended) effects of existing governmental programs—at the non-Federal as well as the Federal level—Chapter Three ought to make apparent that salvation does not necessarily lie in governmental involvement. Designing appropriate responses is a job for policymakers, not this Commission. We are simply aiming to raise (to what seems to me is a new level of explicitness) some important ethical concepts that should be kept in mind by the policymakers, as we were mandated to do by Congress.

Since Dr. Ballantine is in such substantial agreement about the ethical message of the Report, I deeply regret that his reading of certain other sections precludes his concurrence.

The Commission's Process

Former Commissioners

These members served on the Commission while this study was being conducted; their terms of service, which were completed before the Report was approved, are indicated in parentheses.

Renee C. Fox (July 1979-Feb. 1982)

Mario Garcia-Palmieri (July 1979-Aug. 1982)

Frances K. Graham (May 1980-Jan. 1982)

Albert R. Jonsen (July 1979-Aug. 1982)

Patricia A. King (July 1979-May 1980)

Mathilde Krim (July 1979-Oct. 1981)

Donald N. Medearis (July 1979-Feb. 1982)

Anne A. Scitovsky (July 1979-Aug. 1982)

Carolyn A. Williams (Sept. 1980-Aug. 1982)

Commission Hearings

November 8, 1980

The Commissioners reviewed the staff draft proposal and held a general discussion of the Commission mandate relating to access to health care and the distribution of health resources.

March 13, 1981

Empirical Foundations

Lu Ann Aday, Ph.D., Senior Research Associate, Center for
Health Administration Studies, University of Chicago

Social, Historical, and Ethical Perspectives

Paul Starr, Ph.D., Assistant Professor of Sociology, Harvard University

Norman Daniels, Ph.D., Professor of Philosophy, Tufts University

Amy Gutmann, Ph.D., Assistant Professor of Politics, Princeton University

Health Status and Quality of Care Considerations

Dr. Avedis Donabedian, Professor, Department of Medical Care Organization, School of Public Health, University of Michigan

Leon Wyszewianski, Ph.D., Assistant Professor, Department of Medical Care Organization, School of Public Health, University of Michigan

Dr. James LoGerfo, M.P.H., Associate Professor of Medicine and of Health Services, University of Washington

Viewpoints on Access to Health Care

Harry Schwartz, Ph.D., Department of Surgery, College of Physicians and Surgeons, Columbia University

Dr. John Holloman, Jr., Regional Medical Officer, Region III, Food and Drug Administration, Department of Health and Human Services

Bruce Vladeck, Ph.D., Assistant Commissioner, Division of Health Planning and Resources Development, New Jersey Department of Health

March 14, 1981**Availability of Health Services: Policy Perspectives**

Karen Davis, Ph.D., Professor of Health Services Administration, Johns Hopkins University

July 9, 1981

The Commissioners discussed a revised outline of the Report on access to and distribution of health care.

October 22, 1981**The Right to Health—Why is Health Care Special?**

Norman Daniels, Ph.D., Professor of Philosophy, Tufts University

David Gauthier, Ph.D., Professor of Philosophy, University of Pittsburgh

Limits of the Right to Health Care—The Decent Minimum

Allen Buchanan, Ph.D., Associate Professor of Philosophy,
University of Minnesota

Alan Gibbard, Ph.D., Professor of Philosophy, University of
Michigan

Dr. H. David Banta, M.P.H., Office of Technology
Assessment, United States Congress

Charles Fried, J.D., Professor, Harvard University Law
School (statement submitted in lieu of an appearance)

Health Care Needs and Desert

Joel Handler, J.D., Professor, Georgetown University Law
School

George Sher, Ph.D., Professor of Philosophy, University of
Vermont

The “Deserving and Undeserving Sick”

Gerald Dworkin, Ph.D., Professor of Philosophy, University
of Illinois at Chicago Circle

Provider and Patient Liberty

Dan W. Brock, Ph.D., Professor of Philosophy, Brown
University

Dr. Robert M. Sade, Chief of Pediatric Cardiac Surgery,
Medical University of South Carolina

Public Comment

Stephanie Hall, University of Maryland, Baltimore

November 13, 1981**Allocation of Care in Hospitals and Health
Maintenance Organizations**

Dr. Anthony Komaroff, Brigham and Women's Hospital,
Boston

E. Richard Brown, Ph.D., School of Public Health,
University of California, Los Angeles

Harold S. Luft, Ph.D., Health Policy Program, University of
California, San Francisco

Allocation of Particular Types of Care

Richard A. Rettig, Ph.D., Department of Social Sciences,
Illinois Institute of Technology (on treatment of end-stage renal
disease)

Dr. Albert G. Mulley, Massachusetts General Hospital (on adult intensive care)

Dr. Barbara Starfield, School of Hygiene and Public Health, Johns Hopkins University (on neonatal intensive care)

Milton C. Weinstein, Ph.D., School of Public Health, Harvard University (on hypertension screening and treatment)

The Role of Third-Party Payors

Clifton R. Gaus, M.H.A., Sc.D., Director, Center for Health Policy Studies, Georgetown University

Dr. Ralph W. Schaffarzick, Medical Director and Senior Vice President, Blue Shield of California, San Francisco

Richard Mellman, Vice President and Actuary, Health Policy Coordination, The Prudential Insurance Company of America, Newark, N.J.

Harold S. Luft, Ph.D., Health Policy Program, University of California, San Francisco

The Role of the Legal System

James Blumstein, J.D., Vanderbilt University School of Law

Rand Rosenblatt, J.D., Rutgers University Law School

November 14, 1981

Commission deliberation of issues to be covered in Report.

April 2, 1982 (Atlanta, Ga.)

Federal Building

Experience of Consumers in Obtaining and Paying for Medical Care

Anngel Lepley, Nashville, Tenn.

Wanda Walker, Clinton, Miss.

Reverend Timothy McDonald, Assistant Pastor, Ebenezer Baptist Church, Atlanta, Ga.

Experience of Consumers in Obtaining and Paying for Prenatal and Delivery Services

Barbara England, Sprott, Ala.

Michael England, Sprott, Ala.

Patricia Lanham, Kennesaw, Ga.

Anne Sapp, Continuum: Alliance for Human Development, Atlanta, Ga.

Experience of Physicians in Providing Prenatal and Delivery Services

Dr. Nelson McGhee, Atlanta, Ga.

Dr. Schley Gatewood, Jr., Americus, Ga.

Dr. James Rash, Toccoa, Ga.

Dr. Charles Richardson, Statesboro, Ga.

View from the Public Hospital

J.W. Pinkston, Jr., Executive Director, Grady Memorial Hospital

Dr. Asa Yancy, Medical Director, Grady Memorial Hospital; Associate Dean, Emory University School of Medicine

Overview of Differences in the Availability of Prenatal and Delivery Services

Dr. Robert Goldenberg, Associate Professor, Department of Obstetrics and Gynecology, School of Medicine, University of Alabama, Birmingham

Lucile Dismukes, M.N., Executive Director, The Council on Maternal and Infant Health of the State of Georgia

Ernestine Player, M.S.W., Acting Director, Office of Social Work, South Carolina Department of Health and Environmental Control

Jeanne Luckett, Chairperson, Mississippi Coalition for Mothers and Babies, Jackson

Site Visit at a Community Health Center

Daisy Harris, Executive Director, West End Medical Center, Atlanta, Ga.

Dr. Marian Chivers, Medical Director, West End Medical Center, Atlanta, Ga.

Public Comment

Robert A. Youngerman, Executive Director, North Central Georgia Health Systems Agency

**April 3, 1982 (Atlanta, Ga.)
Morehouse College****Insurance Coverage and the Use of Health Services**

Karen Davis, Ph.D., Professor of Health Services Administration, Johns Hopkins University

Innovative Solutions to Maldistribution of Health Care Providers

Dr. Fitzhugh Mullan, Scholar in Residence, Institute of Medicine, National Academy of Sciences, Washington, D.C.

James Bernstein, Chief, Office of Rural Health Services, North Carolina Department of Human Resources

Dr. David Garr, Co-Coordinator, Rural Practice Network, Inc., Denver, Col.

Public Comment

Albert Thomas, Student, Morehouse College

May 15, 1982

Commission deliberation of draft Report.

July 9, 1982

Commission deliberation of draft Report.

September 10, 1982**Review of Draft Report by Panel**

Robert J. Blendon, Sc.D., Senior Vice President, Robert Wood Johnson Foundation, Princeton, N.J.

Stuart Altman, Ph.D., Dean, Florence Heller Graduate School, Brandeis University

Rosemary Stevens, Ph.D., Chair, Department of History and Sociology of Science, University of Pennsylvania

Commission Discussion

Commission deliberation of draft Report.

Public Comment

Dr. August Swanson, Director, Department of Academic Affairs, Association of American Medical Colleges

Sara Rosenbaum, Senior Health Specialist, Children's Defense Fund

Dr. John Ball, American College of Physicians

Dr. Mary Tierney, Children's Hospital National Medical Center

Sam Gorovitz, Ph.D., Professor of Philosophy, University of Maryland

Dr. Philip Wyler, Professor of Community Health, Davis School of Medicine, University of California, representing the American Public Health Association

Letter from Governor Scott M. Matheson, Governor of
Utah and Chairman of National Governor's Association

September 11, 1982

Commission deliberation of draft Report.

November 13, 1982

Commission deliberation of draft Report.

December 14, 1982

Commission deliberation of draft Report, which was approved
by a vote of 10 to 1; Commissioner Ballantine dissented.

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