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ABSTRACT

This publication presents proceedings of a conference on barriers to health care experienced by women and minorities in the United States. Welcoming remarks were offered by Representative Charles B. Rangel. Representatives Patricia Schroeder (Congressional Caucus on Women's Issues), Louis Stokes (Congressional Black Caucus), and Robert Garcia (Congressional Hispanic Caucus) presented the viewpoints of their respective caucuses. A keynote address was delivered by Dr. Karen Davis of Johns Hopkins University. The section, "Today's Budget Cuts/Tomorrow's Priorities," is comprised of the following presentations: (1) "Reordering Our Priorities" (Dr. John L. S. Holloman, Jr.); (2) "How Health Care Cuts Affect Women, Infants, Children" (Representative Matthew G. Martinez); and (3) "Rips in the Elderly's Safety Net" (Representative Claudine Schneider). "Points of View: A Panel Discussion," moderated by Paquito Vivo, is comprised of the following presentations: (1) "The Past Still Haunts Us" (Dr. Marjorie Lightman); (2) "Is There a Role for the Private Sector in Solving the Problem of Indigent Care?" (H. Michael Schiffer); (3) "Cross-Cultural Differences in Health Insurance, Coverage, and Access to Health Care" (Fernando M. Trevino); (4) "For-Profit Hospitals: The Implications for Indigent Patients" (Marcia Jones); and (5) "Assessing the Health Care Gap for Women and Minorities and Their Families" (Dr. Irene Trowell-Harris). Concluding comments were presented by Senator Edward M. Kennedy and Representative Mickey Leland. A list of references is appended. (AF)

Who Cares?

The Health Care Gap And How to Bridge It

Proceedings of the April 30, 1986 Conference

Caucus Room, Russell Senate Office Building
Washington, D.C.

Sponsors:
Congressional Black Caucus Foundation, Inc.
Congressional Hispanic Caucus Institute, Inc.
Women's Research and Education Institute

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1987

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Introduction

In the spring of 1986, the Women's Research and Education Institute (WREI), the Congressional Black Caucus Foundation, Inc., and the Congressional Hispanic Institute, Inc. sponsored a joint conference on the barriers to health care experienced by women and minorities. Supported by a grant to WREI from the Ford Foundation, this was the first event to be held under the combined sponsorship of the three research organizations. At the conference, entitled "Who Cares: The Health Care Gap and How to Bridge It," a lay audience—including congressional staffers, media people, representatives of advocacy organizations, and interested members of the public—heard a range of expert testimony on the extent of the health care gap, the reasons why it has widened so alarmingly in recent years, and various ways in which it might be narrowed and, ideally, closed.

The Members of Congress who addressed the conference participants included: Representatives Claudine Schneider and Patricia Schroeder of the Congressional Caucus for Women's Issues; Representatives Mickey Leland, Louis Stokes, and Charles Rangel of the Congressional Black Caucus; Representatives Robert Garcia and Matthew Martinez of the Congressional Hispanic Caucus; and, Senator Edward M. Kennedy. These Members of Congress, as well as the experts who delivered papers at the conference, stressed that the door to good quality health care may be closed depending on place of employment, age, bank account, type of health insurance, and geographical location. Congressman Martinez noted that lack of access to health care "is a growing crisis for Americans who are young or old, low-paid or unemployed, male or female, minority or non-minority." Nevertheless, the problem is particularly acute among minority families, which are more likely than families overall to be headed by women with low-wage, no-benefits jobs.

A grant from the Rockefeller Foundation has enabled WREI to publish the proceedings of the conference along with additional material submitted by the American Nurses' Association.

On the whole, the problems described at the conference remain. The public may be more aware of at least some of these issues, but the political climate, chilled by alarm over the monstrous federal deficit, remains uncongenial to comprehensive solutions. Prospects seem best for relatively modest, incremental approaches. Several such measures have been introduced in the 100th (current)

Congress. These legislative proposals seek to protect the non-institutionalized spouses of nursing home patients from being impoverished by the spend-down requirements for Medicaid eligibility. Under present law, Medicaid coverage may be denied one spouse unless both spouses are virtually without means, a situation producing what is commonly termed "spousal impoverishment." The House-passed FY 87 budget includes funding for this needed change.

Congressman Henry Waxman has introduced a bill that would amend the Medicare statutes and provide limited coverage for up to three weeks of less-than-skilled home health services. Several bills have been introduced to protect patients—and their families—from financial devastation caused by hospital bills for catastrophic illness Some form of catastrophic-care legislation is expected to be adopted, although everyone involved admits that there is no chance for legislation (such as H.R. 65, introduced by Rep. Pepper) to help with what is far more likely to impoverish older Americans: a long-drawn-out, chronic illness requiring constant care and/or attendance [but not prolonged hospitalization].

Senator Edward Kennedy will introduce a bill that would deny certain tax deductions to all but the smallest employers unless they provide health insurance to their employees. Representative Pat Schroeder is introducing legislation that would provide health insurance and pension benefits to part-time workers on a *pro rata* basis.

We hope that the information and insights contained in this document will help to further inform the public, as well as policymakers, as this country grapples with what is surely one of the most important public policy questions before it: how can we make sure that all of us, regardless of our means, have access to affordable, good quality health care?

Betty Dooley,
Executive Director
Women's Research and Education Institute

Spring 1987

Welcoming Remarks

The Honorable Charles B. Rangel, M.C.

Let me sincerely congratulate all of you who participated in planning this conference. This coalition of caucuses marks the emergence of new strength for women and minorities.

Sixteen years ago when I first came to Congress, some of the problems we had to face were making decisions on supporting the Hallman bill, the Kennedy health bill, or the Dellums national health system. At that time, no one doubted whether our nation was prepared to fulfill its obligation to the aged, the poor, and the sick to make certain that no one died as a result of quality health care being unavailable to them.

Tragically, we are now beset by an Administration that truly believes the federal government should not be responsible for domestic services to people. The Administration's *laissez-faire* attitude is evident in issues of housing, education, and health. And, long after we change the concepts and the administration, we will still be crippled by the damage this Administration has done through funding [illegible] dismantlement, and elimination [illegible] in services programs.

It is ideal to believe that as good as the American people are they will accept a tax increase to support federal intervention in this nation's health concerns. On the contrary, this country's voting booths show taxpayers are reluctant to pay more for even the most beneficial programs no matter how meritorious the cause.

Today we find ourselves with no national strategy relative to health care. We have resolved ourselves to letting people stay in hospitals at very expensive costs because we are not prepared to invest in neighborhood clinics, or provide for preventive education in medicines. We are prepared to keep people on welfare, because families outside the AFDC (Aid to Families with Dependent Children) program are at risk of being denied health care for their children. We are afraid the elderly would be victimized by reduced Medicare/Medicaid benefits.

But, keep in mind that the thrust of national priorities should be to create jobs that will provide sufficient income to remove as many as possible from welfare assistance altogether. Soon you will see that not only has your federal government crippled the AFDC and Medicare/Medicaid programs, which are in need of major

revitalization, but both the House and Senate have proved they don't have the political courage (especially on the Senate side of the Hill), to deal with the expenditures or taxes involved in implementing a national health plan.

For a President to decrease the revenue coming into the government by $750 billion, as was initiated in 1981, and then embark on a defense spending program of $2 trillion means serious repercussions and a gross lack of monies channeled to domestic programs.

When the President proposed a bill that raised revenues by $139 billion in 1983, some Members of Congress thought we would soon be addressing the void of national health coverage. However, the entire transfer of money raised in closing the loopholes and shelters was not transferred to improve services to the American people. It was transferred to offset the earlier reductions in the tax rate.

In addition to overweighted defense spending, Congress too has not dealt with the crucial issues of making good health care accessible to all. Congress must consider: "How can we use the money that is available? What priorities should we establish? Do we take care of the sick and aged first?"

"No," the Congress said, "We will not deal with national health care at all." Instead, Congress reached out to the Senate grab bag of mystery and suspense and brought to this nation Gramm-Rudman. What is Gramm-Rudman? Gramm-Rudman is a commitment to make the nation do something to reduce spending sometime in the future, while paying penance every year for five years without looking to see where the cuts are. Gramm-Rudman delegates this congressional responsibility to computers and to federal agencies so Members can return to their constituents and say, "I had nothing to do with it."

Well, I hope this Supreme Court at least transfers the responsibility of budget cuts back to the House and Senate where it belongs. Many Members are greatly concerned that to reduce the deficit, increases in taxes must occur. However, I believe our greatest concern should be setting priorities that will be of maximum benefit to meeting the crucial needs of our people, such as access to health care.

I see that you have another speaker from New York, Dr. Mike Holloman, one of the most respected doctors in the United States. We were privileged to have Dr. Holloman as long as we did on the Ways and Means subcommittee. I also want you to know the staff on Ways and Means, the health subcommittee, and my individual staff are here to help you. I will even promise technical assistance from Congressman Henry Waxman's subcommittee.

We are proud to have these combined caucuses of women and minorities dedicated to helping Congress do a better job of meeting the needs of the American people. You can be assured that your conference will be a success because, tragically, Congress has done poorly in addressing health care. We need all the help we can get.

Perspectives: Three Caucuses

The Honorable Patricia Schroeder, M.C.
Congressional Caucus On Women's Issues

The Honorable Louis Stokes, M.C.
Congressional Black Caucus

The Honorable Robert Garcia, M.C.
Congressional Hispanic Caucus

Ms. Schroeder: State Level

This is really an historic occasion. And how appropriate it is that for this first of what I hope will be many cooperative ventures of these three caucuses, the subject is health care for the millions of Americans who either lack medical insurance altogether or simply haven't enough. For surely, the constituencies of these caucuses are disproportionately represented among those who are, as the term goes, "medically indigent."

Certainly, women—especially minority women—are a major share of the working poor—and a 1984 study in my state of Colorado found that *half* of the working poor had no health insurance. And certainly women—and minority women—are an overwhelming majority of the low-income elderly who can't afford private insurance to cover the growing gaps in their Medicare coverage. Many of them aren't poor enough—or are too proud—for SSI. But how will those who have to go to the hospital next year find the nearly $600 they'll need just to cover the first day's deductible?

I've been asked to speak to you briefly about states' efforts—particularly my own state's efforts—to ensure that the medically needy get adequate health care. I know you'll hear from the range of experts here today the specifics and statistics about the crisis in health care for the medically needy and I'm sure you'll hear, too, about many initiatives around the country to try to cope with the crisis. So I'm not going to give you chapter and verse.

But I do want to say that it is unrealistic and inequitable to expect states to close the enormous and growing health care gap without more help from Uncle Sam—especially with respect to Medicaid.

Recommendations for improvements in Medicaid made by the Committee on Federalism and the National Purpose—a distinguished, bipartisan, moderate panel led by Senator Dan Evans and Governor Chuck Robb—tell you a lot about the situation across this country today. Here are the key points urged by the Commission which, I should stress, I wholeheartedly endorse:

- that the federal government establish *nationwide* benefit floors for Medicaid, and provide 90 percent of the funding for these benefits;
- that the federal government establish *uniform* eligibility standards for Medicaid, including *nationwide* application of the now-optional program making intact families with unemployed parents eligible for Medicaid and *nationwide* application of the now-optional provisions for the medically needy.

Implicit in these recommendations are the enormous difficulties you encounter when you try to generalize about what the 50 states are doing—with and without federal assistance—to care for the medically needy. A charitable adjective would be "confusing."

For example, eligibility for Medicaid is *not* uniform across the country.

In some states possessing a few modest assets, such as an old car, can automatically disqualify you for Medicaid and/or other health assistance. In many states, including Colorado, you have to be on AFDC or SSI to be eligible for Medicaid. The 34 states that do extend Medicaid eligibility beyond AFDC and SSI recipients (known as the "categorically needy") have widely varying criteria for eligibility.

In more than 20 states, the income ceiling for Medicare eligibility is less than 55 percent of the federal poverty level. In other words, it's not enough that you be poor—you must be *desperately* poor—at least, that's how I'd describe a family of three with less than $4,600 a year. Some states depend largely or entirely on counties to care for the needy who aren't eligible for Medicaid; a number of them let the counties set the eligibility criteria and determine benefits. In these states, you can lose eligibility just by stepping across a county line.

And some states that have several programs of health assistance have different eligibility standards for the different programs. So, for example, you might qualify for a free ambulance ride to the hospital but not for help with your hospital bill. And, of course, except for the basic services that states must provide if they participate in Medicaid, the services provided—and the character of the providers—are far from uniform across the country.

Unacceptable Variations

These are just some of the tremendous variations you find. And to the extent that they mean—as they do—that a lot of genuinely needy people aren't getting the health care they need, I don't think these variations should be acceptable.

All across the country—in every hamlet and town—there should be a basic level of decent care for people who cannot afford to pay for it themselves. And that level should not require the recipients to be in abject poverty to qualify.

Clearly, ensuring an acceptable, *uniform, humane* minimum of coverage throughout this land means that we here in Washington will have to take a lot more responsibility, both for setting the standards and for more of the cost.

That being said, however, I don't argue that states shouldn't have the right—and feel the responsibility—to develop and fund programs that respond to the special needs of their populations, or that there should necessarily be total uniformity in health services, or in the way they are delivered, in every state.

And, in fact, many states have been working in many ways—some of them ingenious and innovative—to improve their programs to assist the medically needy. Improving their Medicaid programs is one common approach—although it has been pointed out that a lot of the states taking that approach are states with less than average Medicaid and coverage to begin with.

The number of states with their own indigent care programs has increased, and some states have improved existing ones and/or added new components. Some states are making hospitals' licenses or Certificates of Need contingent on their agreeing to provide emergency care to people without health care coverage. Some states have set up special funds, or targeted taxing authorities, to help pay for medical care for those who can't pay.

All of these, and many other interesting approaches are part of the broad agenda of health care access concerns we address in our agenda today.

Mr. Stokes: Federal Legislation

It is indeed my pleasure to be a part of this conference on health care for minorities and the poor. The Congressional Black Caucus Foundation, for whom I speak today, is proud to join with the Hispanic Caucus and the Congressional Caucus on Women's Issues in supporting this most important event. Ms. Betty Dooley, along with her staff at the Women's Research and Education Institute, are to be commended for their efforts in developing such an exciting and worthwhile program. This conference represents an ideal setting for us to reexamine our society's commitment to providing decent health care for those on the lower end of the economic spectrum; and, judging from the events outlined in the conference brochure, I am sure that we can all look forward to a very productive dialogue.

As a United States Congressman who has been intimately involved with and concerned about our nation's health, education, and social policies, I am troubled by the dynamics which are emerging in our nation's system of health delivery. If we look at the prospects for improved health care for the poor from the perspectives of dollars, access, and quality, we see a system that is rapidly becoming a two-tiered system. A system where most of the poor get their only health care in hospital emergency rooms: an irrational as well as an inhumane system of providing care. Indeed, if access and quality were a game, we would have to say that "you have to pay to play." It should come as no surprise, then, that poverty compromises access to care and that the poor have more than twice the chance of failing to obtain [illegible]n they need it.

Yet, an overwhelming number of Americans do not have the resources to pay for health care. Let's look for a moment at the magnitude of the problem confronting us. In August of 1985, the Census Bureau reported that nearly 34 million people in 1984 had incomes below the official poverty standard. This represented a slight decrease from the 35.5 million people in poverty in 1983. The Reagan Administration hailed this reduction as a triumph for the Reagan philosophy and Reagan economic policies. Nevertheless, in the last three years of the Reagan Administration, we have had the highest poverty rates and the greatest number of people in poverty since 1965.

The growing number of poor people in our nation, coupled with reduced health care spending by the federal government and less extensive private health insurance coverage, has combined to exacerbate inequities in access to medical care in America. For minorities and the poor, these inequities are compounded by poorer health status and a lack of health insurance.

The question of how we will provide quality and accessible health care for the poor is certainly not a new one. Our nation was once committed to the principle of decent health care for all. During the "Great War on Poverty" in the 1960s, when America saw that people were starving, that we needed doctors, we did something about it. Legislation was enacted to expand the supply of health personnel and facilities and to provide low-income Americans with the means to pay for health services. One of the most significant achievements of that decade was the enactment of the Medicare and Medic-

aid programs, and the acknowledgement that health care is a right, not a privilege. These programs constituted a governmental contract with the people, especially the disadvantaged and the elderly. Nearly all of us can agree that the creation of Medicare and Medicaid in 1965 greatly improved access to health care for the elderly and some poor individuals and families.

Today's Reality

Now, however, these concepts are being threatened as never before. More and more Americans are slipping through the cracks of the safety net. Today's reality is that a substantial number of persons have inadequate income, no private health insurance and, yet, are ineligible for Medicaid—the federal government's primary health insurance for the poor. Today, we can hardly call Medicaid a national health program for the poor. In 1982, in any given month, nearly half of those with incomes below the federal poverty standard had no public or private insurance, only 38 percent were covered by Medicaid and only 13 percent by employer-provided health insurance.

I wish I could tell you that there is a strong concern on the part of our society about the plight of the poor, the unemployed, and the homeless. Unfortunately, there seems to be a desire to provide health care for the poor, but an unwillingness to pay for it. Regrettably, cost containment and retrenchment are the current watchwords.

At the federal level, the Reagan Administration has seen its primary role as limiting government participation in underwriting health care costs. More than $350 billion will be spent on health care this year, and the President and Congress are making rigorous efforts to stem the federal government's share of increasing health care expenditures. Under the new prospective payment system for Medicare, the federal government has become a "prudent buyer" of health care services, paying no more than a fixed price per diagnosis. With the new price-consciousness on the part of the government, as well as private insurers, competition among health care providers has increased, while the motivation to provide the more costly care for the indigent has decreased.

Additionally, the growth of new alternative forms of health delivery systems such as health maintenance organizations, preferred provider organizations, individual practice associations, and the rapid growth of for-profit hospital chains have increased the pressure to cut costs further. This commercialization of our health care system has already impaired the ability of some institutions to care for those who cannot pay. It may, in the long run, hurt the quality of care which is provided as well. Few incentives exist today for hospitals to provide indigent or charity care. Today, hospitals and health providers involved in serving the poor run a considerable financial risk. As a result, fewer institutions are providing this care and we are seeing greater amounts of "patient dumping" from private institutions to public ones. Indeed, stories proliferate about hospitals which turn away patients who cannot afford care, sometimes in the middle of a medical emergency and without regard to the impact on their health. Only 9 percent of the nation's hospitals now provide 40 percent of the total care to the poor.

And, this year, with the threat of automatic spending cutbacks in excess of 25 percent looming on the horizon

under the Gramm-Rudman Deficit Reduction Act, decisions on health care spending will be even tougher.

Improving the health of our nation's poor and maintaining a financially sound health care delivery system are not incompatible objectives. In fact, providing the poor with an ability to obtain preventive and regular health care will indeed reduce our nation's health expenditures in the long run.

We can begin to achieve these public policy goals by enacting legislation to provide or mandate health insurance for all poor Americans by establishing national eligibility and benefit standards for the Medicaid program, requiring health insurance coverage in all industries, and upgrading insurance coverage in industries where coverage is low. Moreover, to effectively decrease the cost and provide quality health care there must be participation in planning and policy formulation by all parties: consumers, employers and employees; insurance companies and third party payors; the government and taxpayers. When the demand for quality is accompanied by input from all affected by the system, we can expect health care for all to be accessible and at an affordable cost.

While I recognize that the challenge to develop a comprehensive health care policy that is both responsive to the needs of the people and cost-effective has not been an easy one, it is my hope that today's conference will address many of the unique problems facing minorities and the poor in gaining access to care, and bring us one step closer to meeting the challenge of providing affordable, accessible, and quality health care to all who need and want it.

With the most resource rich and sophisticated health care system in the world, we as a nation should have no tolerance for the denial to millions of Americans of such a basic and fundamental right as health care. This issue is fundamentally a moral issue, it is not limited to the poor or to the disadvantaged. It is not just a black or minority issue. It is an American issue —an issue society as a whole must face and must solve.

Mr. Garcia: Community Programs

I understand that Congressman Rangel has been here and Congresswoman Schroeder has been here. I saw Congressman Stokes. I am glad that you have had the opportunity to meet these three giants, real champions of the causes of all Americans.

With the advent of Gramm-Rudman and the national mood of fiscal restraint there is no doubt that minority communities, especially the Hispanic community, are feeling the painful loss of essential health services. This is a direct result of the budget reduc-

Before I speak about the loss of health services, let me take a few minutes to outline the state of more than 2 million Hispanic Americans, particularly those I represent in the city of New York. Although I am here on behalf of the Congressional Hispanic Caucus, I want to speak specifically about that segment of the Hispanic community that I know so well, the South Bronx, the area where I was born and raised, the area that I live in today.

According to recent findings in a report that was commissioned by Governor Mario Cuomo, Hispanic resi-

dents of New York State are poorer, less educated, and more prone to serious health and social problems than any other segment of the population. Puerto Ricans have a higher rate of mental illness than any other ethnic group or people at large. This is due in large part to what the Governor's commission referred to as the stress, the strain, and the pain of living in poverty. Hispanics now account for more admissions to drug treatment programs for heroin than any other group. Twice as many Hispanic elderly are living at or below the poverty level as compared to the elderly population as a whole. As a result of cultural and language barriers, Hispanic New Yorkers are far less able than any other low-income people to make adequate use of the existing public health service system.

Funding Losses

The largest segment of New York Hispanics reside in my congressional district, the South Bronx. It is the poorest congressional district in the United States, with a median income of about $3,563 per year; a fact confirmed by a Bureau of the Census study of every congressional district in the United States. In addition, according to the Bronx Committee for Community Health, a consortium of 10 public health service centers, 7 out of 10 centers service more than 65 percent persons of Hispanic origins, with 3 serving over 90 percent Hispanics. Yet even though the Bronx has been designated as medically underserved, the Bronx Committee consortium lost more than $2.2 million in public health services funding this year. They anticipate there will be further cuts in 1987.

As most of you know, it was quite an [illegible] realize the passage of H.R. [illegible]gislation to reauthorize the public health centers program. This struggle took place despite the fact that the funding level contained in the bill represented an absolute freeze at current funding levels, after losing more than $54 million from past authorization levels.

One problem has been the Administration's emphasis on our already bloated defense establishment. I don't want anybody to misinterpret this statement. I believe that our nation's defense should be second to none. Nonetheless, I am appalled by the persistent reports of defense procurement abuses costing billions of dollars each year. Those wasted billions could be better used to improve the quality of life for our citizens who desperately need quality health care. Since the poor are not able to depend on adequate funding for quality health care from federal sources, we in the South Bronx have to rely on the generosity of the private sector as well as the old-fashioned fundraiser to make up the difference. If we didn't have that, communities such as ours would find themselves in even greater despair.

A Helping Hand—Not a Handout

The Bronx and many other poor communities are struggling to make do. We are going to continue to work hard to help ourselves. We are not asking for a handout. All we are really asking for in the Bronx is a helping hand—not a handout.

Just let me add one point. It concerns my work as the Chairman of the Census Subcommittee. Last year the Bureau of the Census decided that they were going to call in experts from throughout the country to hold two days of meetings in a small town outside of the District of Columbia. The purpose of the meetings was to examine new ways of defining poverty.

What does redefining poverty mean? It means many things, but the one thing I believe they hoped to accomplish was to include in-kind benefits such as food stamps, Medicaid, Medicare, all the other similar programs as a determination of additional income for those people who were already in poverty. So essentially it would have statistically reduced the number of people at the poverty level, by changing the formula for defining poverty. The important point here is that not one extra dollar would have gone into people's pockets to improve their quality of life.

Let me give you one instance. In 1979, my mother died. For most senior citizens the last years of their lives can be the most expensive in terms of medical bills. My mother was terminal, so she spent about 20 to 45 days at Mt. Sinai Hospital. The bill came to about $30,000. My mother's case is not so unusual. If the $30,000, which Medicare paid, was included as an in-kind benefit under this definition of poverty, my mother would have appeared much more well off then she was. That is one potential danger in this idea of redefining poverty.

The Census Bureau's conference troubled me greatly because the people originally scheduled to participate were very conservative, many of whom don't care about the poor. I told the Director of the Census Bureau that I would be damned if he was going to have that conference, as long as I was Chairman, without some sort of balance among the participants. I am happy to report that the Census Bureau did comply and that there were many people that you know—some in this room—who participated in that conference. So at least there was some balance.

I want to ask each and every one of you here who are concerned about the monitoring of health care in our nation to watch very carefully. Keep your eyes open as to some of the "possibilities" that may come out of either the Bureau of the Census or the Office of Management and Budget. Look particularly at formula changes which will not mean a thing to our nation's poor, but which give the impression that under this Administration millions of people have moved off the poverty rolls.

The Challenge: Care for the Sick, Poor and Uninsured

Karen Davis, Ph.D., *Chair*
Department of Hygiene and Public Health
The Johns Hopkins University

One test of a just and humane society is the way it treats the sick, the old, and the poor—including the efforts made to see that those who need medical attention receive it. Modern health care is in fact so central to human survival and to life with dignity, most nations intervene (even in market-oriented health systems) to assure access to health care for those who need it.

In the United States, most of those who work receive some private health insurance coverage through their employment, under plans which usually include benefits for spouses and dependent children.[1] In 1965 the federal government enacted Medicare and Medicaid to provide coverage under public programs for many of those without access to employer health benefits—the aged and certain groups of poor.[2] Other federal programs enacted in the mid-1960s and early 1970s expanded the availability of health resources in rural and high poverty inner city areas. State and local governments have traditionally sponsored public community hospitals and clinics to provide services as a last resort to those unable to pay.

Commitment to assuring that all who need health care receive it has never been complete in the United States. Even with the advances of the past 20 years, large numbers of demonstrably poor persons still are not covered by Medicaid because of its restrictions on eligibility.[3] Some employers, especially smaller firms and nonunionized firms, do not provide health insurance to workers.[4] Some communities have public hospitals, while others do not.

This mixed and essentially spotty public-private approach to providing access to care leads to great unfairness. Whether someone has health insurance coverage or not in the United States is in part simply a matter of luck. It depends upon where one lives, what type of job one has, and on the state of one's health at the time insurance coverage is sought. Those low-income persons unfortunate enough to have serious health problems, who cannot work, and who live in states with extremely limited Medicaid coverage and few public hospitals are simply out of luck when it comes to seeking medical care.

Changing Concerns

Public concern with assuring access to care has altered over time. The period from the mid-1960s to 1980 was one of expanding coverage for health care, primarily through federal health care entitlement programs. By the late 1970s, rapid increases in health care costs and in outlays for governmental health programs shifted the focus toward cost and away from expanded access. The Reagan Administration has now shifted the emphasis entirely toward retrenchment, proposing major reductions in Medicare and Medicaid spending.[5]

It is an important time of reassessment for national health policy. An increasingly competitive health market is reducing the willingness of private hospitals and other health care providers to treat those unable to pay.[6] Local public hospitals are refusing to care for those residing outside their tax districts. Employers are seeking to cut the cost of their employee health insurance, and increasingly are unwilling to subsidize care for the uninsured. High unemployment, cuts in federal health entitlement programs, and tight fiscal pressures on state and local governments have contributed to an increase in the number of poor and uninsured over the past few years.[7] Either a basic societal commitment

will be made to assure access for those unable to pay, or pressures to exclude them from needed health services are likely to intensify.

Opinions differ, obviously, about society's obligation to provide health care. Even relatively conservative groups, however, have argued that a minimum level of health care should be provided to all.[8] This would include such basic benefits as hospital and physician services appropriate to the general treatment or prevention of acute illness or chronic health conditions. Individuals could be asked to contribute some portion of the cost of these services, so long as such financial contributions did not work a financial hardship on the individual or deter the individual from seeking necessary care. Others would argue that a much more comprehensive range of benefits, including prescription drugs and long-term care for the disabled, should be provided to all free of charge without regard to ability to pay. The cost implications of such a policy, however, are so extensive that this type of complete commitment to access to care does not appear to be an economically or politically feasible course for public policy.

The period from 1965 to 1980 was characterized by a greatly expanded federal government commitment to health care. Medicaid and Medicare were enacted in 1965 to provide health insurance coverage for the aged and many of the poor. In addition, the Office of Economic Opportunity established comprehensive health centers in high-poverty, medically underserved areas to help assure the more even geographic distribution of quality health care.

Medicare finances health care for the aged and some disabled, providing [illegible] coverage throughout the United States. As part of the Social Security system, it is entirely federally funded. Medicare is the largest federal health program. In 1984 expenditures are expected to be $66 billion, providing coverage to 30 million aged and disabled beneficiaries.[9]

Medicare Availability

Medicare is available to all those age 65 and over who receive Social Security benefits. Ninety-five percent of all aged are covered. Since 1972, Medicare also has covered those who have been determined permanently disabled for two years or more and those with end-stage renal disease. Addition of these beneficiaries reflected Congressional concern with the high medical costs these individuals face, and the lack of private insurance coverage for such conditions.

Medicare participation and expenditures both have risen rapidly throughout the 20-year history of the program. The number of enrollees increased from 19.5 million in 1967 to 30 million in 1985.[10] Reimbursement for services under Medicare will have increased from $4.5 billion in 1967, to an expected $75 billion in 1985.[11]

Growth in Medicare expenditures is caused by the same factors affecting growth of spending in the health care system generally: inflation in prices throughout the economy, expanding use of advanced technology, increased demand for care, and a reimbursement system for hospitals and physicians that encourages spending rather than restraint. Medicare payments per enrollee have increased more markedly than health care expenditures per capita, however. This reflects the fact that the elderly consume much more hospital care than other age groups, and that hospital care has experienced

the most rapid increase in expenditures. About 70 percent of Medicare expenditures go for hospital care, 20 percent for physicians' services, 1 percent for nursing home care, and 3 percent for administrative expenses. Miscellaneous benefits account for the remainder.[12]

Varying Care Needs

Medicare enrollees are not a homogeneous group. Many are healthy and rarely use health care services. Others have multiple chronic health conditions requiring extensive care and treatment. *Nine percent of the aged account for 70 percent of all Medicare expenditures of health care for the aged.* At the other extreme, *40 percent receive no Medicare-reimbursed services in a given year, and another 37 percent account for only 5 percent of payments.*[13] It is clear that most spending is concentrated on a minority of the aged, those with life-threatening illnesses and/or serious chronic conditions.

It was in fact the burden that extremely heavy medical expenses placed on a significant minority of the aged that created the impetus for enactment of Medicare. Prior to the existence of this program, half of the aged had no private health insurance.[14] Individuals lost employer-group insurance for themselves and their spouses on retirement. Insurance companies feared excessive risks and were reluctant to write individual comprehensive health insurance policies for the aged. Available policies limited coverage, exempted preexisting conditions, and offered limited financial protection against large medical bills. Medicare was created to remedy the private sector's limitations in providing adequate health insurance by creating a s[illegible] comprehensive coverage for virtually all aged. It has clearly been successful in meeting this objective, although in recent years the resulting growth in public expenditures has been accompanied by a decline in the comprehensiveness of coverage.

Medicare has also improved access to health care. Hospital utilization, particularly by those who prior to Medicare had difficulty obtaining needed care—low-income individuals living alone, minorities, residents of the South and nonmetropolitan areas— has increased significantly.[15]

Dramatic increases in certain types of surgery among the elderly have occurred since enactment of Medicare. Cataract operations doubled between 1965 and 1975, and hip replacement surgery nearly tripled, leading some analysts to conclude that the quality of life for the aged improved as a result of Medicare.[16]

Mortality Declines

Sharp declines in mortality rates of the aged also have occurred over this period—decreases considerably more rapid than prior to Medicare and also more rapid than declines in death rates in Canada and Europe during the same period.[17] While it is difficult to sort out the multiple factors contributing to such significant improvement, it appears that Medicare has had a role in extending the lives as well as in improving the health of the aged.

Systematic information on benefits of Medicare to the disabled and those with end-stage renal disease is harder to find. However, it is obvious that their medical bills would work enormous financial hardships without Medicare coverage. It is also clear that Medicare has enabled many victims of end-stage renal disease to live longer, more productive lives.

The major program which finances health care for the poor is Medicaid. Medicaid is a joint federal-state program. The federal government pays slightly more than half of the program costs. One of every ten Americans receives assistance with health care bills from Medicaid each year.[18] The cost of care for the program's 23 million recipients will be $50 billion in 1984.[19] *Seventy percent of these expenditures go for care of the aged and disabled.* Despite the magnitude of this investment, *over 60 percent of the nation's poor remain ineligible for Medicaid.*[20]

Within broad Federal requirements, each state has authority to set eligibility, benefit, and reimbursement policies for Medicaid. As a result, the program is not uniform, and benefits and eligibility vary widely from state to state.

For the low-income aged, Medicaid is an important supplement to Medicare. Medicaid pays Medicare's premiums, deductibles, and co-insurance for 4 million low-income aged. Medicaid also supplements Medicare's limited benefit package, covering services such as prescription drugs, hearing aids, and preventive services that the poor cannot afford to purchase directly. Most importantly, Medicaid covers long-term care services excluded by Medicare, and rarely covered by private insurance plans. *Fifty percent of all nursing home expenditures are paid by Medicaid. Over 75 percent of Medicaid expenditures for the aged are for nursing home services.*[21] Because nursing home care is so expensive, many middle-income aged are reduced to poverty, and, therefore, to medicaid eligibility if they are in a nursing home for more than a short period. Thus, Medicaid is potentially an important program for a large majority of the aged, not just the poor.

Judging Performance

Medicaid's performance can best be judged by examining trends in use of medical care and health status of the poor after its enactment. Available evidence shows that Medicaid has been successful in improving access to physician services and, more important, the health of those it covers.

Poor people have always had more illness and accident than the non-poor. In part this reflects their more limited access to health care, but in large part it reflects the fact that they have more dangerous jobs, live in less safe neighborhoods and housing, and suffer general deprivation from poverty.

In 1964, prior to the enactment of Medicaid, the poor were seen by physicians an average of 3.9 times per year compared to 4.9 visits for the non-poor, in spite of greater likelihood of illness and injury. By 1978, this situation had altered radically. In that year physician visits for the poor averaged 5.6 times compared to 4.7 visits for the non-poor.[22] These aggregate figures are misleading, however, because they do not take into account the fact that the poor tend to be sicker than the non-poor. After adjustment for the greater health problems of the poor, use of physician services by the poor, at least those covered by Medicaid, is comparable to use by higher income persons. Evidence suggests that those poor not covered by Medicaid continue to lag well behind others in use of services.[23]

One indicator of the impact of this increased access brought by Medicaid coverage is the decline in infant mortality. In the decade before Medicaid, infant mortality hardly changed. Rates plummeted following the enactment of this program in 1965. By 1979, rates were 13 deaths per 1,000 live births—almost half the 1965 rate of 25 deaths per

1,000 live births. Medical advances and new technology contributed; Medicaid's coverage of prenatal care and primary health services has enabled the poor to share the benefits of these advances.[24]

Adult death rates for poverty-related illness also have declined significantly since Medicaid's introduction. Maternal mortality death rates dropped from 24.5 deaths per 100,000 live births in 1968 to 7.8 deaths per 100,000 live births in 1979. Death rates from those causes traditionally more frequent among the poor, such as influenza and pneumonia, gastrointestinal diseases, and diabetes, dropped markedly following introduction of Medicaid.[25]

These measures indicate significantly improved health status for the poor. As the most important source of medical care financing for this group of the population, Medicaid has increased access to care and can claim credit for much of that progress.

The poor excluded from Medicaid continue to face serious problems in obtaining medical care.[26] For those with chronic conditions, average annual physician visits by the insured are twice those of the uninsured.[27]

Community and migrant health centers have been funded to help minorities and residents of medically underserved areas obtain important health care services. Recognizing the seriousness of health problems of this population, the centers have provided a comprehensive range of services—well beyond the Medicaid benefit package—and have assured their availability through the direct provision of services.

Reduced Mortality

Studies have found that these primary care centers have contributed significantly to the reduction of infant mortality in the communities they serve.[28] Furthermore, hospitalization rates of those served by the programs have been reduced, suggesting that serious health problems have been averted and that overall care is provided more economically than in traditional settings.[29]

The mixed public-private approach to providing health insurance coverage in the United States leaves major holes in protection against the financial hardships that major illness can bring and causes some individuals to forego needed health care. In 1980, among the non-elderly population, 153 million were covered by some form of private health insurance, 19 million received Medicaid coverage, and 30 million did not have coverage from either public or private insurance plans. Approximately 29 million people were covered by Medicare, with relatively few older people not covered. These figures reflect the average coverage on any given day. Importantly, however, more individuals than indicated actually go without insurance coverage over the course of any given year because of changes in employment or income status.

Even with major governmental programs such as Medicare and Medicaid and private health insurance coverage provided through employment or individually purchased, a substantial segment of the American population has no health insurance coverage. During the severe recession of 1981–1982, the number of uninsured increased markedly, from 29 million in 1979 to 33 million in 1982, up from 14 percent of the non-elderly population in 1979 to 16 percent in 1982. Two-thirds of these had low incomes.[30]

The uninsured population almost totally consists of people under age

65, since the Medicare program provides coverage for nearly all of the elderly. Poverty and lack of insurance are, of course, strongly correlated. The poor are twice as likely to be uninsured as the middle class and three times as likely as those in upper income groups.[31] Many poor persons are ineligible for Medicaid as a result of federal and state requirements for program eligibility, and variations in state income and asset eligibility policies. Blacks, Hispanics, and other minorities are less fully insured than whites—perhaps because they are more likely to be in jobs that do not traditionally have employer health insurance. Poor blacks are the least well insured.[32]

A survey on access to health care sponsored by the Robert Wood Johnson Foundation in 1982 found that about 12 percent of all Americans—one in eight—have serious problems with access to adequate health care.[33] In 1982 one million families had at least one member refused care for financial reasons. This included 208,000 families that were uninsured. Access is a particular problem for poor blacks, Hispanics, the poorly insured, and the unemployed. The survey found that one in nine Americans had no usual source of health care.

Coverage Affects Services

Data from the National Medical Care Expenditure Survey yield important insights into how lack of health insurance coverage affects use of health care services. Survey data show that the insured under age 65 receive 54 percent more physician ambulatory care than do the uninsured.[34] For some groups, utilization is even lower. Low-income uninsured blacks and other minorities make 1.5 visits to physicians per person annually on average, compared with 3.7 for insured whites. These data suggest that it is simply not the case that the uninsured manage to obtain ambulatory care comparable in amount to that obtained by the insured, by relying on public clinics, teaching hospital outpatient departments, nonprofit health centers, or the charity of private physicians. Without insurance, many simply do without care.[35]

Tremendous differentials in use of hospital care also exist. The insured under age 65 receive almost twice as much hospital care as do the uninsured. Differentials by insurance status are particularly marked in the South, and in rural areas generally. In the South, insured persons receive three times as many days of hospital care annually as do uninsured persons, regardless of race or ethnicity.[36] The lower utilization of health care services by the uninsured is not a reflection of lower need. As noted earlier, the uninsured tend to be sicker, on average, than the insured.[37]

In some communities public hospitals and some private hospitals provide charity care to those without insurance who are unable to pay their own bills. A recent study indicates, however, that charity care expenditures have not been expanded to meet the needs of an increasing uninsured population.[38] In areas with almost a 50 percent increase in the number of those living in poverty, charity care was increased by 4 percent between 1980 and 1982. Nonmetropolitan hospitals—whether publicly or privately owned—provide little charity care. Clearly, in some geographic regions those without insurance find themselves without a source of care—even in cases of serious need.

The health consequences of limited care are not fully known. It is clear that most Americans value and seek medical care for treatment of a wide range of health problems. A major study by the Urban Institute contains persuasive evidence that utilization of medical care services leads to a marked reduction in mortality.[9] This lends considerable support to the importance of medical care utilization in contributing to a healthy population—and at least indirectly provides a basis for concern that the lower medical care utilization of the uninsured contributes to unnecessary deaths and lowered health status.

The financial burden of health care costs is very unevenly distributed. Some families receive employer provided comprehensive health insurance coverage at little direct cost to the employee. Such employment benefits are exempt from personal income taxes. Others pay the full premium for individual private health insurance coverage and still face high bills for excluded services and coinsurance and deductibles. And some families and individuals simply pay the full cost of care directly, or go without.

Out-of-pocket Expenses

The result is that the uninsured and inadequately insured incur rather substantial direct out-of-pocket expenses for health care. Seventy five percent of the U.S. population had some out-of-pocket expense for health care in 1977. Analysis of data from the National Medical Care Expenditure Survey shows that nearly 25 percent of families had out-of-pocket expenses exceeding $500 in that year; and 10 percent had expenses exceeding $1,000.[10]

Low-income families pay slightly [illegible] absolute terms for health care out-of pocket than do higher income families, and considerably more as a fraction of income. In 1977, families with incomes below $3,000 paid an average 10.2 percent of their incomes for health care compared with an average payment of 1.7 percent for those families with incomes in excess of $15,000.

One in 10 families, about 18 million people, spent over 10 percent of their income on out-of-pocket health expenses in 1977. Over 3 million families, or 7.6 million people, had out-of-pocket payments exceeding 20 percent of family income. For this latter category, health care expenses are truly catastrophic.[11]

Given the substantial financial burdens health costs place on some families, it is not surprising that the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research reported evidence that numerous working families were financially devastated by out-of-pocket medical expenses.[12]

Even the aged are not immune from the financial consequences of large health care bills. Despite Medicare, many health care expenses must still be paid by the patient. As noted, Medicare's benefit package excludes most long-term care services, prescription drugs, dental care, eyeglasses, hearing aids, and many other health care services. In fact only 45 percent of the total bill for health care for the elderly is paid by Medicare.[13] Another 14 percent is paid by Medicaid. The remainder is paid by the individual or indirectly through private health insurance premiums. Such private payments came to $1,130 per aged person in 1981, with some very sick individuals incurring especially burdensome outlays for health care.

Out-of-pocket spending by the elderly is expected to continue to grow. The Congressional Budget Office estimated that the amount of Medicare cost-sharing would be $505 per enrollee in 1984. The Part B premium, coinsurance, and deductible would account for 80 percent of this cost. In addition, it was estimated that on average beneficiaries would pay an additional $550 in 1984 for non-institutional care not covered by Medicare, most notably prescription drugs and dental care. If nursing home care were included, it would add another $650 per person, for a total annual average out-of-pocket cost to the elderly of $1,705.[44]

Obviously, the aged differ in their ability to meet these non-Medicare covered expenses. Half of the elderly had incomes under $9,000 in 1981.[45] Medicaid covers only 3.5 million of these 13 million poor and near-poor elderly. Even somewhat higher income elderly can face serious problems paying for very expensive services such as nursing home care or private duty nursing required to recover from a stroke or hip injury, for example.

Out-of-pocket Burden

Out-of-pocket medical expenses are a particular burden for those elderly who do not have coverage supplementary to Medicare—either from Medicaid or private health insurance—and for those with serious health problems. Data from the National Medical Care Expenditure Survey for 1977 indicate that elderly households (excluding those elderly in nursing homes) who are covered only by Medicare spent 11 percent of their household incomes out-of-pocket on health care expenses, compared with 5 percent for those covered by both Medicare and Medicaid and 8 percent for those with both Medicare and private health insurance.[46]

The heavy financial burden on the lower income elderly is in part a reflection of their inability to afford supplementary private health insurance to fill in the gaps left by Medicare. Overall, 66 percent of the elderly have private health insurance in addition to Medicare. However, this coverage varies widely by income. Of those elderly who are poor or nearly poor, 47 percent have private insurance compared with 78 percent of those with high-incomes.[47]

In 1981 the Reagan Administration ushered in a major shift in health policy. Unlike the Carter and Nixon Administrations, it did not propose expanded coverage through a national health insurance plan. Rather, it called for major cutbacks in entitlement to health care for the poor and elderly. Reagan health policy has included proposals to increase the cost of health services to the elderly under Medicare, to reduce the federal matching rate for Medicaid services, to mandate that the poor share in the cost even of basic health services, and to reduce funding for primary care delivery programs. These proposals have been viewed in many cases as so radical and so damaging that they have been largely rejected or modified by the Congress.

The Reagan Administration has proposed major cuts in the Medicare program. Unlike the Carter Administration, which sought tighter limits on payments to hospitals, but did not request cuts that would directly affect beneficiaries, the Reagan Administration cuts would include those that would directly shift costs to beneficiaries. As a result of Reagan proposals, Medicare outlays for FY 1982 through FY 1985 have been held $15 billion

below what they otherwise would have been. Reagan's FY 1985 budget proposed to cut still another $20 billion in Medicare expenditures between 1985 and 1989.[48]

The Reagan Administration has also proposed major cutbacks in Medicaid. Medicaid spending was reduced $4 billion during the FY 1982 to FY 1985 period from the levels originally projected, and further cuts of $3 billion over the next three years are proposed. These cuts represent about a 5 percent reduction in annual federal Medicaid outlays, which totalled $24 billion in FY 1985.[49]

Funds for federally-sponsored primary care services for the poor have been significantly cut under the Reagan Administration. Total dollar funding has been reduced by over $400 million since 1980.[50] If inflation is taken into account, funding levels for these programs already have been cut by over $1 billion from the 1980 level. This includes major reductions in funding for primary care centers, maternal and child health programs, and the National Health Service Corps Scholarship program.

Goal is Ending Care

President Reagan has indicated that his ultimate goal is the total elimination of federal government support for primary care, as well as other health programs, through passage of his New Federalism legislation. A lessened interest in supporting the delivery of care to the poor and elderly is reflected in major proposals to trim back federal financial responsibility for Medicaid and Medicare. These shifts in direction reflect a major step back from a commitment to provide health care for those unable to pay.

It is too soon to evaluate the full impact of these changes. One study has found major deterioration in health status, increased untreated hypertension and diabetes, and deaths resulting from termination of coverage of medically indigent adults in the state of California as a result of fiscal pressures on states.[51] Those subjected to loss of coverage experienced a 40 percent increase in the probability of death as a result of increased risk factors. Congressional hearings have documented the increasing difficulty that many poor people who have no health insurance coverage face in being admitted to hospitals and other health facilities, and the deaths that have occurred as a direct result of denied admission.[52]

More than any other portion of the Reagan Administration's economic and social strategy, its health policy threatens the health and in some cases the lives of some of the nation's poorest and most vulnerable people. In that policy there is great potential for a significant setback in life expectancy, reduction of disability, and access to health care services to relieve pain. Serious retrenchment in the scope and type of federal activities threatens to reverse almost 20 years of progress in improving access to preventive and primary care services for the most vulnerable in our society—the poor, the elderly, the disabled, and members of minority groups.

In summary, despite the significant progress made in improving access to health care for the poor and elderly from 1965 to 1980, serious inequities remain. With the cutbacks in Medicaid, Medicare, and primary care programs in the early 1980s—in the face of rising poverty and high unemployment—these inequities have deepened. Millions of Americans face the prospect of serious illness without access to health services that can im-

prove health and functioning. Even emergency cases are being turned away because of inability to pay.[33]

The U.S. faces a clear choice. It can continue to turn its back on those who lack adequate insurance coverage for health care, or it can begin now to take steps to see that at least those most in need get basic help. Continuation of the policy of reduced coverage for the poor and aged introduced by the Reagan Administration will inflict great burdens. By permitting them to fall through the cracks of our mixed public-private system of financing health care, we are likely to see a reversal of the progress in improving the health of these very vulnerable members of our society.

Several options for moving toward equitable access to health care for all exist.

- Health care access could be assured through *the development of an adequately funded network of public hospitals and clinics*, available to those unable to pay.

- *Pools of funds to assure payment for hospital services to the uninsured (or hospital and physician services) could be established* through provisions in state hospital rate regulation programs, taxes on hospitals or health insurance premiums, or block grants for the care of the unemployed.

- Expanded coverage could be assured through *improvements in existing public and private insurance programs*—extension of Medicaid to cover low-income children and pregnant women, improved benefits in Medicare, and/or standards on employer health insurance plans.

- Finally, *existing entitlement programs could be replaced by a phased-in national health plan* that would incorporate major reforms in coverage, financing and the health system.

Arguments for and against each of these alternatives depend in part on points of view regarding what constitutes adequate access to health care, on beliefs about the appropriate responsibility of the private sector versus that of state and federal governments, and on how much we value the concept of a single system of care for all. Nearly all Americans would agree that society has a responsibility to assure a "minimum" level of care for everyone. Opinions differ, however, about how this level should be defined. Some measure of adequacy of care in relation to a standard of effectiveness, i.e., that which is medically beneficial; others define it by reference to what the average American receives for a given set of health problems. Pragmatically, it may be defined in terms of an insurance benefit package.

Opinions also differ on who should be responsible for assuring access to care. Some would place the major responsibility on local governments to ensure some minimum level of care. Since fiscal capabilities vary across jurisdictions, however, areas with high concentrations of poor are unlikely to be able to afford to provide such care.

Perhaps the strongest division of opinion concerns whether the poor should receive "mainstream" medicine. Should they be free to select their own physicians and to seek care from the same kinds of physicians, hospitals, and other providers as higher income persons? Some maintain that society's obligation can be met by funding a public system of hospitals and clinics to care for those without any other coverage, or by contracting with a set of private hospitals and providers to provide this care at a low cost.

One option for assuring access to health care would be reliance upon a

network of publicly-funded hospitals and ambulatory clinics. Elements of this approach would include expanded funding of community health centers and increased subsidies for public hospitals and clinics. It might also entail converting the Medicaid program from a financing program for all hospitals, physicians, and other health care providers to a managed-care system where only selected hospitals and clinics would be certified as participating providers. Under such a system, these providers—either publicly-operated or nonprofit institutions serving predominantly low-income persons—would contract with state Medicaid programs for the care of defined low-income population groups. Per capita annual payments would ensure budgetary control and encourage all covered persons to obtain care through a single, organized care system.

Minimum Care Level

This approach would provide a minimum level of care for all, and could conceivably be accomplished with little or no expansion of existing funds. Its disadvantages are that it would re-institute a two-class system of care, with one set of providers for the poor and a different set for all others. It is likely that it would be chronically under-funded, with substandard staffing, crowding, and low quality services in public facilities. It would create a massive disruption in current patterns of care, since even the poor now receive most of their medical care from private physicians. It seems unlikely that health facilities in a public network would be conveniently located, and the poor in certain geographic areas, such as isolated rural communities would likely have extreme difficulty in using the public facilities.

An alternative approach would be to set aside fixed sums of money for the care of those unable to pay. This care could be provided either through public or through private hospitals. Most proposals of this kind have been restricted to compensating hospitals for inpatient care provided to the uninsured, but they could also be extended to ambulatory care.

The states of New Jersey, New York, and Maryland have established just such mechanisms for financing hospital care of the uninsured. Hospitals are permitted by state hospital regulatory commissions to charge higher rates to the insured to subsidize care of the uninsured. Florida has recently enacted a law which imposes a tax on hospital revenues, with receipts set aside to purchase hospital care for the uninsured.

Another approach is to establish state-wide health insurance pools for those without employer group or individual insurance. Under this option, surcharges on private health insurance premiums are set aside to cover the cost of insurance for low-income people and high-risk individuals refused coverage under private plans. Connecticut and Minnesota have programs which work this way.

Another approach would be to create federal block grants to be administered by state governments for the purpose of subsidizing care for specific groups—such as the unemployed and their families. States could be given flexibility to limit these funds to public facilities or could make them available to health care providers generally within the state. Advantages of this latter approach include budgetary control over the amounts allocated. Funds could be budgeted in advance

rather than committed to cover all costs for care of eligible poor as is the case under entitlement programs. The flip side, however, is that funds set aside might not be adequate to meet the health needs of those otherwise left out of the system.

Hospital Care Only

One primary disadvantage of this approach is that it covers only hospital care—neglecting access to important preventive and primary care services provided on an ambulatory basis. Since individuals would not have direct insurance coverage and would have to request care on a charity basis, many low-income families could be expected to continue to neglect care until illness had reached a serious, and perhaps untreatable, stage.

Another option is to make improvements in existing private and public systems of financing health care services. This could include imposing national standards on employer health insurance plans, expanding coverage under Medicaid to those low-income children and pregnant women not on welfare or Medicaid, and improving Medicare benefits.

The Omnibus Anti-Poverty Act of 1984, sponsored by several Democratic Congressional leaders, is one example of this strategy. This bill mandates that employers who offer health benefits to employees include in that coverage certain protections for the unemployed and their families. Specifically, laid-off workers must be offered continuous group coverage for themselves and their immediate families for 90 days after lay-off and they must be offered the opportunity to convert from group coverage to individual coverage. In addition, laid-off employees and dependents who lose their group must be offered an opportunity to enroll in a working spouse's health plan without having to provide evidence of insurability.

The Carter Administration national health plan also proposed standards for employer-provided benefit plans. This plan would have required employers to offer basic health insurance coverage to all full-time workers and dependents, including comprehensive coverage for prenatal and child health care, to pay at least 75 percent of the premium for that coverage, to begin coverage within one month after employment, and to extend coverage for at least three months following termination of employment, or coverage for dependents for three months upon loss of coverage because of death, divorce, or separation.

Improvements in Medicaid coverage would pick up other groups. For example, the Child Health Assurance Plan introduced in Congress in 1977 would have extended Medicaid to cover all children and pregnant women in families with incomes below 75 percent of the poverty level, or the state Medicaid income eligibility level, whichever was higher. A more modest version of this bill passed by the Congress in 1984 would extend Medicaid coverage to first-time pregnant women and children up to age 6 with family incomes below the state Medicaid income eligibility level. This would focus improved coverage on poor first-time pregnant women, pregnant women in poor two-parent families where the principal earner is unemployed, and poor children in two-parent families. Providing federal matching payments at a 100 percent rate for the costs of expanded coverage would avoid any increased financial burden on states; states that already cover all of these groups would receive an increase in their federal Medicaid rate.

Improved financial protection for the elderly and disabled could be achieved through implementation of a cap on out-of-pocket expenses which Medicare beneficiaries pay. Elimination of limits on covered hospital days and coverage of prescription drug expenses would also be important elements of such improved catastrophic expense protection for the aged and disabled. Requiring physicians to accept Medicare allowable fees would also provide significant financial relief to Medicare beneficiaries. Medicare eligibility could be extended by removing the two-year waiting period for coverage of the disabled, covering all persons age 65 and over, and covering those with major health problems (such as the terminally ill or those requiring organ transplants).

Building on Strengths

Advantages of this approach are that it would build on the strengths of the current system and provide funds where they are most needed. It would be administratively easiest to implement since it represents the least departure from current financing methods. Disadvantages include the lack of budgetary control inherent in entitlement programs. It also poses the problem of uneven burdens on employers, possibly leading to loss of employment for low-wage workers or workers in firms in financial trouble.

Another option would assure universal coverage for health care through a phased-in national health plan. This could involve fundamental restructuring of current entitlement programs, such as the merger of Medicare and Medicaid into a single program and extension of coverage to all those falling outside private health insurance proposed in the Carter Administration national health plan of 1979.

A phased-in plan could begin by extending coverage to those most in need—such as those with incomes below 55 percent of the federal poverty level—gradually increasing the eligibility level to 100 percent of the federal poverty level. Similarly, coverage for workers and their families would be improved by requiring employers to cover all such families in a basic insurance plan with a ceiling on the costs that any family would be required to contribute. This ceiling could be set initially at a higher level, and gradually reduced to assure adequate coverage. Such ceilings would also be a part of the public plan, so that the elderly and disabled would be protected from undue financial hardship. Buy-in provisions would permit anyone falling outside private employer group plans to purchase coverage at a subsidized rate, depending upon income.

Coupling Reforms

This fundamental reform of the coverage and financing of health care services could be coupled with fundamental reform of the provision of health care services. Payment for hospitals, physicians, and other health care providers could be established on a prospective basis to encourage efficiency in the provision of care, with stringent limits on rates of increase in expenditures over time. Organized systems of care delivery such as health maintenance organizations, which charge on a per capita rather than a fee-for-service basis, could be encouraged. Prevention and primary care could be promoted through standards built into the benefit package.

This option undoubtedly would be the most costly to the federal taxpayer.

A comprehensive approach could easily entail over $20 billion in incremental federal budgetary outlays in FY 1985 dollars. It would involve substantial restructuring of public programs, require review and monitoring of employer health insurance plans, and represent major shifts in current methods of paying physicians and other health care providers.

At the same time, it would guarantee adequate access to health care for all, remove the threat of financial ruin from health care bills as a cloud hanging over many Americans, and provide a vehicle for instituting the major cost controls and incentives in the health care system that are missing from the current patchwork of private and public coverage. It could also be a lever for shifting emphasis toward preventive and primary care, and away from a continued over-emphasis on high technology acute care.

It is clear that the terms of debate over national policy to provide access to health care for all have shifted markedly in the last decades. In the mid-1960s, Medicaid and Medicare were enacted to ensure access to care for the elderly and many of the nation's poor. Concern with future health care costs was virtually missing. Medicare and Medicaid have been enormously successful in meeting their access objectives, bringing millions of elderly and poor into mainstream medical care. At the same time rapidly accelerating increases in health care costs switched the focus of debate from filling remaining gaps in access to care to efforts to contain rising costs. The Reagan Administration set on a deliberate course to reverse efforts to expand coverage under Medicare and Medicaid, and proposed and obtained passage of provisions to [illegible] eligibility and benefits.

The economic and fiscal policies of the Reagan Administration have had even more far-reaching impact on the health sector than have the Administration's health finance policies. The major cut in taxes in 1981 sought and achieved by the Reagan Administration together with the build-up in defense spending, have created massive federal budget deficits extending indefinitely into the future. This has placed enormous pressures on all domestic spending.

The resulting climate of fiscal stringency makes any enactment of the major universal and comprehensive health insurance proposals of the early 1970s—such as systems modeled on the Canadian program of publicly-funded care for all—extremely unlikely. Instead the feasible options span a much more limited array—from those that would target fixed sums of money on a system of care for individuals and families unable to pay, to those that would expand coverage to persons most in need under restructured entitlement programs. Expanded access seems likely to come on an incremental basis, accompanied by testing of the effectiveness of various cost control and incentive measures.

Political support for renewed commitment to assuring access to care for all may come from unexpected quarters. With the expanding supply of physicians, concern is already arising about declining patient loads per physician. Newly trained physicians may come to see it as in their own personal interest, as well as in society's, to see that financial mechanisms exist to assure care for those currently unable to pay. Even more likely, hospitals that turn away patients who are unable to pay even when the hospital has low occupancy and unfilled beds may see expanded financial coverage for such

patients as a way of filling beds and generating additional revenue. These motivations may, over time, overcome the medical profession's traditional reluctance to invite governmental encroachment into the health sector.

Political support for expanded coverage may also come as the inequities and unfairness of the current system become more obvious. As hospitals and other health care providers cut back on their willingness to provide charity care and as public programs drop the poor from coverage, the implications of inequities in coverage become more visible. Reversal of progress in improving health outcomes, and inhumane treatment of the poor and elderly, are unlikely to be acceptable in a compassionate and caring society. Evidence that deaths or serious health damage have been caused by cutbacks or by inequities in coverage could well mobilize a public demand for change.

The challenge ahead is to develop a strategy that will channel the savings from improved health care cost controls and efficiency in the health care sector into assured access to health care for all. Genuine commitment to such a goal is likely to require specific mechanisms to generate additional revenues through increased taxes or contributions from those able to pay. Yet, public opinion polls consistently show that the American public is willing to make such a commitment—if convinced that such revenues will assure access to health care for all provided efficiently.

Today's Cuts, Future Priorities

John L.S. Holloman, Jr., M.D.

The Honorable Matthew G. Martinez, M.C.

The Honorable Claudine Schneider, M.C.

Dr. Holloman: Priorities

Why is there so much confusion in our health care delivery system? As health care costs continue to escalate, it seems our concentration is more focused on costs than on any of the other elements—including access—in the health care system. Our priorities are at best askew and at worst they are wrong, and each of us must share the blame.

What health care, if any, do we as U.S. citizens have a right to expect? Our health care system, correctly called by many a non-system, usually finds ways to deliver health care to most of those who need it, and to many who can't afford it. But there is no free lunch; someone always pays. The growth of the for-profit hospital industry, with its high investor payoff in our more affluent communities, serves to foster the illusion that hospital care, efficiently and profitably run, can correct the problems of our hospital industry. Anyone who has worked in a public hospital located in an urban area, providing services to patients who have been victimized by the incestuous relationship between poverty and ill health, knows this isn't necessarily so.

I don't believe that the federal government can be counted on to bail out our health care system. It has been apparent since 1933 that our government does not want the responsibility of providing for the health care of all of its citizens. And it is clear that providers prefer to care for those patients on whom a profit is to be made.

As I look to the future—with the proliferation of for-profit health care delivery organizations—I see enormous problems for those individuals and groups on whom no profit is to be made. The business orientation demands a balance sheet which is written with black ink and pays dividends to investors. Business and industry are becoming the major purchasers of private health care and are manipulating the health system by dumping their financial losses on the taxpayers. These "health care businesses" are divesting themselves of their losses and thereby increasing problems of access for those who use the public system.

I define access to health care as the freedom from barriers to health care. A barrier is anything that constrains, deters, delays, denies, dissuades, discourages, handicaps, or prevents the acquisition or utilization of those services that are ultimately provided by society to its members individually and collectively for the maintenance, preservation and improvement of health.

Poverty provides a barrier and diminishes access to health care for those who often have great need for these services. There is now a new story making the rounds about a farmer who was turned away from the emergency room of three for-profit hospitals because he did not have the necessary down-payment in cash.

The maldistribution of physicians also creates a problem of access to health care for a significant number of our citizens. The prospect of a physician surplus in areas of affluence has triggered the mechanisms which will reduce the supply of available physicians. Meanwhile, the number of areas in which there is a persistent shortage of physicians is far from being eliminated.

Residence in a low-income or less affluent neighborhood can provide a barrier to health care because the trend during the years since the Hill-Burton Hospital Construction Act of 1946 has been to construct hospitals in more affluent neighborhoods. It should also be remembered that this Act provided for segregation and allowed the construction of "separate but equal" facilities. This "Jim Crow" approach to health care provided an additional barrier to the black patient.

Attitudes and Access

Access problems have also been caused by attitudes. One recent survey of welfare families found that the majority felt that the physicians who provided services to them were rude and prejudiced against people on welfare. Contempt for the poor is clearly a learned response on the part of the physicians, who are taught medicine and perfect their skills using clinic patients. Once their professional skills are perfected, many physicians feel that they are free to sell these skills in more affluent areas. In the eyes of many physicians, the affluent are more worthy of deferential treatment than are the poor; the poor, they believe, had an equal opportunity to succeed, and failed. Low-income patients, feeling this less-than-sympathetic response, may delay seeking needed medical care in order to avoid humiliation.

Another area in need of improvement is access for the elderly. Medicare has proved to be as much an impetus to the escalating cost of health care as it has been a boon to improving access for some of the elderly.

The biggest barrier to quality health care for all Americans is the absence of a national health policy and a clear understanding of the reason for the existence of our health care delivery system. If our great nation is to survive and reach its potential, it must reorder its priorities so that the materialism of the few will not destroy the humanity of the many. Our health care system must be redesigned to serve all Americans at a cost we can afford. It can be done and I think we should do it.

In 333 B.C., Aristotle wrote that health of both the mind and body is fundamental to the good life. If we believe men and women have any personal rights at all as human beings, we must believe that they have the absolute moral right to such a measure of good health as society, and society alone, is able to give them. Access is fundamental.

Physicians have the responsibility to reassert their role as patient advocates. The medical profession must increase its efforts to provide quality care for all as a matter of principle. As citizens we must abandon the pork barrel approach to health care, remaining silent when our own health care needs are satisfied, even though we know that there are many others in great need. The financing mechanism and the for-profit aspect of our health care delivery system must be made to support the system adequately, rather than to line the pockets of opportunistic investors, who profit from the illness of their fellow man and the confusion that currently exists in our health care delivery system.

Finally, we must realize that we cannot solve our health system's problems by simply taking money away from the system any more than we can solve anything by indiscriminately throwing money at the system.

Mr. Martinez: Funding Cuts

President Reagan, the "great white father" in the White House, has said to the poor, the aged, the children, the women and minorities of this country: "Heal thyself." Then, he recommends cuts in health care and nutrition and builds another missile. Twenty-seven thousand low-income women and children will be removed from the Women, Infants, and Children (WIC) program in 1987 at the Administration's requested funding level; even though we have increased funding for the program by $57 million. By 1991, 140,000 recipients will be removed unless something is done.

Medicaid has been cut by 7 percent, and premiums for Medicare will rise from $15 to $38 by 1991. People just won't be able to take care of their health needs, and, of course, everything that adversely affects the needy of our nation hurts minorities and women even more. Low-income women and minorities make up the greatest percentage of the uninsured in this nation. They are also the least likely to obtain health care when they need it.

The biggest problem to face Hispanics is the lack of information about Hispanic health. Of the 94 tables used in a 1984 nationwide report on health status, no data were given for Hispanics as a group. Until proper health statistics are kept for Hispanics over a number of years, the question of health care cannot be adequately addressed.

Although it sometimes seems like a cry in the wilderness—at least with the current Administration—we must try with all the strength in our lungs to make our voices and our concerns clearly heard on the problems of access to and the quality of health care in our society.

Ms. Schneider: Prevention Coverage

I'm very pleased to be here today, because health care is something I care very deeply about. Regrettably, I do not serve on a committee which has jurisdiction over federal health programs. I am anxious to talk to you, anyway, because you folks in this room are the movers and shakers. And if we are going to see any changes in our health care system on the federal level it's going to be up to all of you to push for a specific agenda.

I've had a little experience with this sort of thing. Prior to coming to Congress, my own moving and shaking was in the environmental movement. I studied the issues and mobilized people. Quite frankly, I am happy to say that I helped prevent the construction of a nuclear power plant in the state of Rhode Island. I told them we'd stop it; but no, they didn't listen. That was how I learned how powerful groups such as yours can be, as long as you stand united and have a specific request to make.

I would like to share with you a few of my own ideas that perhaps you might like to pick up on. And I am giving you these ideas not only because I believe that they're in the best interest of all the people who are in need of health care, but because I believe that they are also the ideas that are the most "do-able" in our current political world.

I was asked to talk about what Medicare doesn't cover. Well, the most blatant thing that Medicare doesn't cover is prevention. Needless to say, prevention is both a cost containment strategy and a quality of life issue. After all, you've got to realize that the average life span will soon be 85 years. I want to live to 130 and I plan to do it in good health. I already had my first, and hopefully last, bout with cancer at the age of 25.

So, what can we be doing better?

First, we should expand the availability of hospice and other home health options. This obviously would be a step in the right direction, particularly when you consider the fact that it costs $350 per day for hospital care, $57 per day for skilled nursing care and only $39 per day for home health care. Right now, Medicare offers a hospice benefit, but it is available only on a limited basis.

Second, we ought to expand the role of health professionals for procedures and services which do not require a medical degree. And that means everybody from midwives to nutritionists, nurse practitioners to physicians' assistants.

Physical and occupational therapists should also be included in Medicare. The argument for including these folks is not only sensitivity; it's fiscal responsibility. It is estimated that if just 20 percent of Medicare beneficiaries received their occupational therapy treatment in a community setting rather than the outpatient department of a hospital the Medicare program would save $4.8 million a year. That's the kind of bottom line that convinced me to co-sponsor legislation which would provide Medicare reimbursement to occupational therapists.

Third, I suggest that we encourage the use of low-cost, low-tech services such as outpatient surgery centers and ambulettes. Whether you know it or not, ambulettes are vans that are specially outfitted to carry wheelchair-bound persons. Medicare will pay for an ambulance to take a wheelchair-bound senior citizen to the hospital for dialysis treatment, for example, three times a week at an average cost of $180 per round trip. But it won't pay for an ambulette which would cost only $30 per round trip. Now, there is something wrong with our health care delivery system if we don't use the most efficient method.

Fourth, I would suggest that we promote innovation in health insurance options. This is something the previous speaker focussed on, mentioning that health maintenance organizations are becoming more and more popular. In fact, the number of people enrolled in HMOs has doubled over the past six years. Medicare has even included funding for 26 demonstration HMOs. The kinks need to be worked out so these benefits will be available nationwide.

Fifth, as I said at the outset, one of the best investments we can make is in preventive care. It's much more cost effective to subsidize nutrition supplements for pregnant women than it is to pay for the intensive care costs of low birth weight babies. The research shows plainly that for every dollar we spend for prenatal care under the Women, Infants and Children (WIC) program, there is a potential savings of $3 in postnatal care. This is the kind of hard-core, specific argument that you should throw at your legislators. They provide a very convincing case for the value of the preventive approach.

It's also much more cost effective to reduce the likelihood of coronary by providing counseling on diet, stress

management and other personal habits than to perform a bypass operation. But right now Medicare doesn't cover periodic check-ups, cancer screenings or nutritional counseling. We just got a few demonstration projects approved but we're a long way from the finish line.

Smoking Problem

Smoking is also a serious problem. Fortunately, it is getting more and more attention by a number of different sectors, including the American Cancer Society. Cigarettes are responsible for 320,000 premature deaths each year. What is particularly discouraging to me is the number of young women who are smoking more instead of less. Educating people about the risks can make a difference. In fact, one study estimated that strong public health campaigns could decrease the incidence of lung cancer by 50 percent. The potential annual savings amount to $10 billion.

Another thing that the federal government can do—and we're already hard at work on this—is to take strong steps to discourage smoking. There are a lot of options here. We can reduce tobacco price supports, raise excise taxes on cigarettes and disallow tax deductions for expenses associated with tobacco advertising. The House recently passed legislation to put warning labels on smokeless tobacco products. That, too, is a step in the right direction.

The potential savings from pursuing preventive approaches are quite impressive. Another good place to start is with seat belts. The statistics show that anywhere from 50 to 65 percent of all auto deaths and injuries could be prevented by seat belts. The potential annual savings from seat belt u[illegible] be about $15 billion. In addition, paramedics will tell you that they never unbuckle a dead person. I think that speaks pretty clearly about the value of seat belts. Many states, and most recently the District of Columbia, have passed mandatory seat belt laws.

A third and final area for preventive action is stroke. Stroke is the third leading cause of death in the United States. Studies show that proper diet, combined with not smoking and a good exercise program, could prevent two-thirds of all strokes. The potential savings would be about $9 billion annually.

Oftentimes when we have to make decisions in Washington, whether it's about health care or anything else, there is the question of cost-benefit analysis. This is particularly evident now with the greater dedication and willingness to reduce the federal deficit.

Well, I can share with you my experience in the environmental field when everyone used to say, "it costs too much money to put up this preventive measure, or to build in these scrubbers, or to do this or to do that." Finally, years later, the American public has learned that not installing these features was not a cost effective move, because we wound up paying for these mistakes anyway. We didn't pay for it in taxes or in clean-up money; we paid for it in our human health. And that can be clearly demonstrated by the number of cancers that have occurred around hazardous waste sites and in areas that are highly polluted. Once we recognized that we are interconnected with everything in nature—with the air we breathe, with the water we drink—then we can better protect not only our environment, but we end up protecting ourselves as individuals and as a society as well.

Prevention vs. Crisis

When it comes to prevention, you are not going to find too many members of Congress that are all hyped up. You don't get much glory for pushing preventive legislation. When you get the attention is when you have a crisis. That's when someone jumps up and says, "I'm going to solve this problem." Quite frankly, by then it's usually too late.

I guess that one of the things that disturbs me most in the political arena is that it is geared towards crisis management. We simply cannot afford to be crisis managers when we are dealing with our health. We cannot wait until we get cancer in order to decide that we are going to change our eating habits. We cannot wait until we have a heart attack to decide we are going to lose weight, give up smoking, and slow down the drinking. These are the kind of messages that are critical and they don't cost a lot of money. We can and should persuade our coworkers, our friends and family members about the value of preventive medicine.

There is a tendency in Congress to focus on health care costs and the use of high technology. We really should be focusing on how we could prevent some of those costs and forego some of these sophisticated machines. The real question is: wouldn't it be better, less painful for the patients, and more cost-effective financially if we could have prevented some of those health problems right at the start?

Those are just a few of my ideas and just a little insight as to my own objective, both personal and legislative. I hope that you'll grab on to some of these ideas and push them. You can't sit back and say, "Oh, well, we'll let Congress solve these problems," or "Washington is at fault." Believe me. The only way we are going to have a just and enlightened solution is if we have full participation on the part of all of you. Members who are on the Armed Services Committee or the Merchant Marine Committee or whatever have different and varied interests. But the one area that hits home to everyone is his or her health. In national poll after national poll, people say that what they truly treasure most is their health.

You have a very valid agenda and crusade ahead of you. I encourage you to be very strong and persuasive activists. You know that I will be more than happy to help you in any way that I can.

Points of View:

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Dr. Lightman: The Past Still Haunts Us

Reasonable and rational people of all political affiliations would concur that every American should have access to, and the ability to pay for, the finest available health care. Reasonable and rational people have engaged in a public debate over "the practical advantages and disadvantages" of different approaches to health insurance since the Progressive era before World War I. I would like to propose today that although this debate has been entwined with larger social and economic transformations over the past sixty years, a consistent historical theme has both shaped the political discourse and limited our imagination of the reasonable, the rational, and even the possible.

Let me begin with a rapid overview of highlights in the history of health insurance and then move to an examination of its historical implications. In the opening decades of this century, when the forces of urbanization, immigration, and industrialization had already transformed the American landscape and the economy, social insurance became a focus for reform. Reformers' arguments rested on the relief of poverty and the economic rationality of health insurance for industrial workers. Their arguments held to the existence of a narrow margin between earned income and poverty. Health insurance could help avoid the fall into poverty through the provision of support during periods of illness. The Progressive reformers succeeded in furthering the cause of state based disability insurance and "sick pay." They failed utterly, however, in their efforts to establish national health insurance.

In the 1920s the debate over health insurance shifted in emphasis when rising medical costs began to affect the middle classes. Doctors' fees and the cost of hospital care had been rising for several decades. Hospital care, which had undergone a virtual revolution at the turn of the century, was increasingly the locus of care for the seriously ill among all social classes. A new professionalism among doctors, symbolized by the greater power and prestige of the American Medical Association, saw the AMA successfully consolidate control over the medical establishment with the support of an "enlightened public sentiment" enamored by the promise of scientific medicine and on the warpath against "quackery."

Rising costs alone, however, were not the heart of the problem; rather, it was the variable nature of the costs. Although the average cost for medical care remained within the financial capability of middle-class families, a serious illness requiring hospitalization could now destroy a family's savings. The uncertainty over costs and the belief in the greater efficacy of medical care combined to create a risk for the generally risk-aversive middle classes that turned health insurance into a reasonable and prudent investment.

With the election of Franklin D. Roosevelt in 1932, social legislation was again in the political foreground. National health insurance was a part of the reformers' agenda. Yet, despite the enactment of Social Security, the Fair Labor Standards Act, and unemployment insurance, a national health insurance program failed to gain the

full endorsement of the president and come before Congress with the Administration's imprimatur. In the complicated world of balancing needs and political allies, health insurance was unalterably opposed by the AMA. Instead, to ameliorate strain on the charitable system caused by the Depression, Congress appropriated funds for relief efforts undertaken by the states, most often through welfare departments. Toward the end of the decade when major social legislation had already addressed some of society's grossest inequities, including regulation of child labor, the minimum wage, and old-age support, foreign affairs upstaged the effort to implement health insurance.

The absence of national health insurance did not eliminate the growing need or demand for its coverage. From the 1930s onward, voluntary health plans had been multiplying. The Committee on the Costs of Medical Care in 1932 reviewed 25 medical care and health insurance plans, among which was Blue Cross. Founded in Dallas in 1929, Blue Cross benefited from the Depression which had severely lowered hospital income thereby making attractive to hospitals a direct service payment plan for group hospitalization. The plan itself addressed many issues that had bedeviled earlier efforts, not the least of which was that the hospitals themselves, via the services provided, constituted the plan's capital, making unnecessary large cash reserves. The nonprofit aspect of the plan, moreover, had an immeasurable appeal to public psychology, separating crass moneymaking from the business of health care. Indeed, the appeal of Blue Cross was, in some sense, measured by its rapid spread and the special status it received from state l[illegible]s. It was but a natural step from assuring hospital costs to assuring physicians' payments for hospital services through the doctor-controlled Blue Shield.

Since both programs were "producer" controlled, they gained the reluctant approval of the omnipresent AMA. Vigorously, the AMA had opposed any infringement by third parties, especially the government, on the determination of treatment or the setting of fees. Only reluctantly, when facing the threat of sufficient political force to bring forth legislation, did the AMA House of Delegates modify its position. Blue Cross and Blue Shield mark a major shift in the AMA stance —the acceptance of voluntary programs so long as they remained controlled by the medical profession.

The AMA, however, was not the only powerful interest group for whom voluntary insurance was more palatable than compulsory national insurance. By the 1930s the "spot" labor market immortalized by Adam Smith had long given way to the implicit, longer term contract in which the holding of workers' loyalty was a key factor. Early in the debates over health insurance, labor leader Samuel Gompers had sided with conservatives against the reformers who pressed for government-sponsored plans. Insurance for health care would in time become an instrument for union loyalty no less than for management. The coincidence of interest between labor and business was given a further boost during the years of World War II, when a 5 percent increase in benefits was excluded from wage controls. Even before the war, the way had been cleared for benefit packages to become part of the collective bargaining process. The Wagner Act, as well as the later Taft-Hartley Act, had both included working conditions as one area of collec-

tive bargaining. The courts interpreted working conditions broadly, and from the Wagner Act onward health care became a part of contract negotiations.

Post-World War II

After the War, full employment and compulsory national health insurance were brought to the head of the political agenda. Truman's health-care package, built on a series of national studies reaching back into the 1920s, was not dissimilar in its essentials from that of the Roosevelt years. Circumstances, however, had changed. The expansion of voluntary programs had begun to ease pressure for national insurance from the middle classes. The introduction of health care into union contract negotiations had eased pressure from the unionized workforce. Emergency relief during the Depression, not only continued but had evolved into a system of support by the federal government for categories of people considered at risk, including programs for children, mothers, and the elderly.

Although Congress failed to pass a national compulsory health insurance, in 1946 it had passed the Hill-Burton Act, which supported the development and expansion of hospitals. In an historical thread unbroken since well before the Twentieth Century, Americans of the late 1940s believed that science and technology were the way of the future. Indeed, the war, and the advances it brought in medical care, only reinforced the love relationship. Modern hospitals spread across the nation would give access to the magic of medicine.

Capital investment was the key—buildings, equipment and ever newer technologies. As hospitals proliferated and became more expensive through the 1950s and 1960s, so too grew third-party payment plans. Insurance companies that had eschewed health insurance entered the arena. Unlike the early forms of industrial life insurance that required an army of agents, employer-based health benefits provided insurance companies with built-in wholesalers and previously nonexistent delivery systems. Moreover, employers provided a screened pool of applicants—those healthy enough to hold a steady job. The growth of market share for health insurance by established insurance companies challenged the dominance of Blue Cross and Blue Shield. Over time, the moral distinction between nonprofit and traditional insurance carriers declined.

In the 1960s, social legislation yet again came to the fore. Unlike the 1930s, this was a decade of economic expansion. It was also a period when earlier developments in social policy were beginning to reveal latent consequences. The older population covered by Social Security was, for the most part, a group whose work life spanned the Depression and World War II; their retirement had come before the growth of private pension plans. Inflation since the 1950s had significantly increased living costs, not least of which were increased medical and hospital costs for older people, who were, in fact, living longer. By the 1960s the elderly were the poorest group in the population. Amidst a decade of plenty, the plight of the elderly became a highly charged political issue. In 1964, Medicare and Medicaid were passed. Hailed as the first national compulsory health insurance, they were perceived as one of the decade's great social victories.

Insurance Patchwork

With the successful passage of Medicare and Medicaid, all the historical

elements of our contemporary debate were in place. On the surface, this quick view suggests the particular amalgam of American interests which during the past 60 years has produced a patchwork of health insurance: private voluntary plans tied to employment which cover workers and their immediate families; Medicare for the elderly; and, Medicaid, along with a host of other special programs, designed to assist categories of the needy and the poor. What I would like to propose as more interesting, however, is the constancy of an assumption that interweaves the historical tale.

Foremost is the relationship between labor force participation and health insurance. Beginning with the reformers of the pre-World War I years, through the development of voluntary plans tied to employer and union benefit packages, the spread of health insurance has retained a justification which equates protection and productivity.

As an historical corollary to this proposition, I will add that some labor is more equal than others. Again reaching back to the Progressives, who focused on the industrial labor force, on through successfully unionized labor and the application of a proto-industrial model of organization to large corporate and public bureaucracies, we follow the trail of health insurance. Initially aimed at the lowest industrial wage earners, where income maintenance provided the only margin between household sufficiency and poverty, adjusted to take account of the rise in medical costs which created a comprehensible risk factor for the better employed and middle classes, and finally applied to the elderly under Social Security for whom medical costs once again were the margin between adequate and inadequate retirement means, the history of health insurance reveals the character of the most equal work to be within the industrialized and product-producing heartland. Contemporary statistics vividly capture history. While approximately 61 percent of the overall labor force has some health benefits, in the manufacturing sector the percentage of covered employees rises to 82 percent and in mining to 83.4 percent. In contrast, coverage drops to 34 percent in the service sector, barely rising to 49.4 percent for business related services.

The linkage between health insurance and labor force participation has also carried with it all the associated structural biases of the labor market toward women and minorities. The historically lower rate of female labor force participation, compounded by women's clustering in a limited number of occupations, for example, structurally limits women's likely access to health insurance. Intermittent labor force participation and casual labor are similarly penalized. Thus, I would expand the historical corollary and note that access to health insurance which incorporates the biases of the labor market represents a mean and narrow view of a productive life. It is a view whose logical antithesis defines those outside the paid labor force as atypical and different; whose needs, in most cases, form the special categories supported by private and public assistance.

Clearly recent expansion in the service sector and the manifest changes in numbers of families headed by women pose a challenge to our historical time lag, so to speak, when the new reality—who works, where the jobs are and which kinds of jobs provide health benefits—is out of kilter with our inherited assumptions. If we

are only out of step with change, and seek simply to expand voluntary health benefits more evenly through the new employment sectors, we will still remain wedded to our first assumption that health insurance ought to be linked with labor market participation. We remain the prisoners of a narrow definition of human capital which fails to measure adequately socially useful work outside of paid labor. It is a definition which places on those outside the burden of finding alternative access to health insurance, or looking to the relief of traditional charity and government-sponsored programs which identify participants as worthy or needy. We are, in sum, condemned to debate continuously the "practical advantages and disadvantages" of different approaches toward health insurance: trapped within an equation of insurance and paid labor force productivity or poverty and charity first put forth by social reformers more than 60 years ago.

Mr. Schiffer: The Private Sector

I want to thank WREI for this unique opportunity. It is unique, first of all, because I more frequently find myself listening to Senators and Congressmen rather than appearing on the panel with them, and secondly, as the father of seven daughters, I have spent much more time listening to predominantly women's groups, then addressing them. Under the circumstances, I hope you forgive my enthusiasm.

Your program asks me to address the question: Is there a role for the private sector in solving problems of indigent care? I would like to add four additional questions to the agenda: 1) Is the private sector currently playing a role in solving the problem of indigent care? 2) Is that role likely to increase? 3) Is it important that the problem of uncompensated care be solved? 4) What, in a practical sense, can be done about it?

The first three questions, I can dispense with relatively quickly with a quote from the February, 1986 report of the Prospective Payment Advisory Commission (PROPAC). It said:

> The emergence of competitive [illegible] in health care may curtail the provision of care to the uninsured indigent patient. In the past, profits have come from patients who pay actual hospital charges—patients with commercial insurance or some Blue Cross plan, and patients who pay their own bills. Because many hospitals are not paid on the basis of charges, for most patients, the cost of uncompensated care is not distributed evenly across hospital users.
>
> Hospitals may find it increasingly difficult to finance uncompensated care as insurance companies limit hospital payments in a competitive environment. Price will approach the actual cost of caring for an additional patient, with no allowance for charity care or bad debt. At the same time, this method of financing uncompensated care may be eroding while the need may be increasing. State limits on Medicaid programs and an increased number of persons without coverage could leave more persons unable to pay for their own hospital care.

So, in response to our first three questions, is there a role for the private sector? The answer is absolutely. Are we currently playing a role? Emphatically yes. Is that role likely to increase? Absolutely not; unless some

stringent measures are taken to handle uncompensated care.

Now let's address the question of whether it is important to solve this issue of uncompensated care. As commercial insurers, we certainly think so, from a social, economic and political standpoint. Let me take each of these separately.

Socially. Our business is built on satisfying social needs. And, while I would never argue that there are not a few bad insurance apples in the barrel who take advantage of the population at large, generally, insurers and their management, have acted in a socially responsible manner. It certainly is our policy and belief, and that of most of the large insurance companies, that health care is a right and it is our job to help achieve universal coverage.

Economically. Now let me give you the self interest side of the issue. A solution to the uncompensated problem is critical to the survival of the commercial insurance industry. Currently we pay a disporportionate share of the uncompensated bill because we are basically charge-payers. As long as containing health care costs and containing health care premiums sells business, we cannot compete and still pay a disproportionate share of those costs. Moreover, as long as the current Administration here in Washington advocates competition as the solution to the health care cost problem, it has the responsibility to help create a reasonably competitive environment.

Uncompensated care is the Achilles' heel to having real competition in the health care system. Those providers that deliver a disproportionate share of uncompensated care cannot compete for patients with providers who, in one way or another, avoid this burden. And, by the same token, insurers w[illegible] saddled with the disproportionate share of uncompensated care, cannot adequately compete with payers who avoid this burden. As the disadvantaged party among the payer community, we desperately want to see a solution.

Politically. Finally, from the days of the Truman Administration right through the Carter Administration, we have fought proposals to federalize the health care system. We believe that we can and should achieve universal health care in the United States, but that it can be done through the partnership of government and the private sector. The only thing that in fact could destroy this partnership is the inability to deal adequately with the issue of providing care to the indigent.

Let us pause for a moment and examine what we really know about the issue. First of all, we know that the problem is growing. In 1976, 4 percent of hospital care was uncompensated. Today, the figure is 6 percent. And the estimate among physicians' services runs even higher than that. Secondly, we know that the private sector through cross subsidies, is putting between $8 and $10 billion into the hospital system and probably an equal amount into the physician payment system, to cover the cost of uncompensated care. So, in a real sense, the use of the term uncompensated care is a misnomer. Really what we are talking about is indirectly compensated care. That is, somebody other than a person receiving the care, is actually paying the bill. Third, we know that the burden of uncompensated care is spread disproportionately and as long as we are dealing in a competitive environment, this has to be corrected. So, we have a distributional issue that needs solutions. Fourth, as best we can tell, 75 percent of uncompensated care is caused by those who lack insurance,

predominantly, the poor and near poor. And yet 70 percent of this group has some relation to the workforce, as either part-time, seasonal or marginal workers. We therefore, have to think of the employment relation as a potential source of solving the problem. And finally, I am convinced that the resources are there to solve this problem if we can develop a fair way to distribute them responsibly.

So what can really be done? First of all, we have to think in terms of partnership solutions. The private sector has a responsibility to its policyholders and shareholders that precludes it from meeting the needs of people who cannot take care of themselves. I think I learned in Civics 101 that the principal role of government was to take care of those people who cannot take care of themselves. And that applies to all levels of government. I find it very disturbing when I hear comments coming out of Washington that the federal government has no responsibility for the indigent, but rather this is a problem that needs solving by the state and local governments and by the private sector. We simply cannot afford to let the federal government abdicate its responsibility in this regard. I know that in the current budget environment, looking for additional revenues may be a pipe dream, but nevertheless, much of our legislation is developed only over the course of several years and we must not lose sight of the fact that the government has real responsibilities in this area.

With respect to the private sector, there are a number of things that can be done. First of all, the Congress has already taken some important steps in the Consolidated Omnibus Budget Reconciliation Act of 1985 by requiring employers to extend coverage on widowers, divorcees and their dependents for a period of three years and for the unemployed for a period of 18 months, at the same rates which are paid for active workers. To be sure, this requires some resources on the part of the individual to continue coverage, but at a price that is much more affordable than individual coverage. As such, this fills an important gap in preventing the growth of uncompensated care.

Mandated Insurance?

Second, in line with my comments that 70 percent of the uncompensated care is generated by people who have some relationship to the workforce, let's be cautious in jumping to the conclusion that mandating all employers to provide insurance benefits is necessarily a desirable solution. The large employers of this country generally already provide benefits. So the mandate essentially would apply to small employers, and marginal operations who are not in a position to afford to provide health benefits. In my judgment, it would be imperative that any kind of mandate be accompanied by some kind of tax incentives and subsidies to help the small and marginal employer institute benefit programs. In the absence of that kind of governmental assistance, the impact on employment could be disastrous. To be sure any kind of mandate will evoke some, negative reaction from the business and insurance community. Frankly, I am not sure how else to assure universal coverage.

Third, for a number of years we have advocated the development of pools to insure high risk and uninsurable individuals and groups. Currently, eight states have enacted this kind of legislation. Naturally, it tends to attract a poor class of risk. The pools are guaranteed money losers, but provided

the cost of subsidizing is spread equally among all payers, they are not an unreasonable burden for the private sector and they work. Mrs. Kennelly, who happens to be the Congresswoman from the First District of Connecticut and my representative, has introduced federal legislation to encourage further development of these pools. We support that and I hope you will support that also.

Finally, a number of states have already taken the initiative of seeing that the uncompensated care burden is distributed more equitably among hospitals. They have created pools in which each hospital contributes a portion of its revenue and the pool then distributes the monies to those hospitals with the highest uncompensated care burdens. States like New York, Massachusetts and Florida, and even South Carolina, have already taken this move. It is a relatively painless and effective way of getting at a portion of the issue.

Obviously, there is no single perfect solution. But certainly, with government and the private sector joining forces, we can do better, at least at the margin. Nobody is going to convince me that the resources to do this job are not available. It is important to remember that the private sector already is contributing $15–$20 billion towards the payment of care of the indigent through the reimbursement system. The positive way to look at this issue is to say, "if we already have $20 billion going into the system, we do not have that far to go in solving it." My guess is that another $10 billion or so would be all we needed to ensure universal access to care, and when you look at $10 billion against a $1 trillion budget, we really are talking small potatoes. So, in conclusion, let me say that collectively the private sector and the federal government have the bucks to do the job. Politically, the power is there to make it happen, although at the moment, the political will seems to be lacking. I think it is incumbent upon all of us who are concerned about this issue to work together to make the solutions happen.

Dr. Treviño: Cross-Cultural Differences

It is a great privilege for me to be able to appear today before the honorable members of the Congressional Women's, Black, and Hispanic Caucuses. I wish to take this opportunity to commend each of you for the foresight and concern you have demonstrated by holding this hearing. The provision of appropriate and effective health services to our ever-growing Hispanic population may well be one of the most serious challenges facing medicine and public health in this decade.

It is difficult to realize that despite t[illegible]nat Hispanics have resided in this country for well over 400 years and now constitute the fifth-largest Hispanic population in the world, we do not even know how many of them die each year in our country.[1] The state of our knowledge of Hispanic health needs should serve as a national embarrassment for even the least developed nation, let alone the country with the most elaborate and most highly financed health monitoring system in the world.

Our most recent decennial census conducted in 1980 enumerated 14.6 million Hispanics (59.8 percent of

Mexican origin, 13.8 percent of Puerto Rican origin, 5.5 percent of Cuban origin, and 20.9 percent of other Hispanic origins). If one adds to this figure the more than 3 million Hispanics on the island of Puerto Rico (who are not enumerated in the census), considering the possibility that some undocumented Hispanic workers were missed by the census (estimates of the number of undocumented workers in the United States range from 3 million to 12 million) and allowing for the growth that occurred in the Hispanic population from 1980 to 1986, it is probable that well over 20 million Hispanics live in the United States at the present time. Furthermore, at its present rate of growth, the U.S. Hispanic population is doubling in size every 25 years.[2] Should social or economic conditions change in Mexico (the world's largest Hispanic country with which we share a 2000-mile border) and Central or South America, a possibility that is not entirely remote, we could absorb an unprecedented number of documented and undocumented Hispanic immigrants.

Hispanics are a heterogeneous group comprised of individuals of numerous national origins. Their families may have resided in the United States for hundreds of years or only a matter of days. They may be proficient in English, proficient in Spanish, proficient in neither, or proficient in both. They share a common denominator however, the effects of neglect by the health research community. You can appreciate that if our health monitoring systems cannot even tell us how many Hispanics die in the course of a year, they also cannot give us more sophisticated information such as the number of Hispanics who have untreated hypertension or diabetes. At present time we simply do not know how many of our children are properly immunized, have adequate nutrition, need eyeglasses but do not have them, or how their life expectancy compares with white and black children. Legislators know better than anyone else what it is like to have to make decisions regarding the allocation of scarce resources to serve people whose needs are unknown. For all too long we have dealt blindly with the health care needs of our Hispanic population.

Progress on Data

Fortunately, we are beginning to make some progress in providing data on the health needs of Hispanics. For the last six years, it has been my pleasure to have had the opportunity to collaborate with the staff of the National Center for Health Statistics (NCHS). Through that collaboration, we were able to produce the first national estimates on a variety of health indicators for the Hispanic and non-Hispanic populations using data from the National Health Interview Survey.[1]

Physician Visits. Data collected during 1978–80 revealed that the white, black, and Hispanic populations experienced approximately an equal number of physician visits per person per year (4.8, 4.6 and 4.4 visits, respectively). However, Hispanics were found to differ significantly by national origin in their use of physicians. When analyzed separately, it was found that Cuban Americans and Puerto Ricans see a physician considerably more frequently (6.2 and 6.0 visits, respectively) than do whites or blacks.

On the other hand, Mexican Americans see a physician less frequently than all other groups investigated (3.7 visits per person per year). These ethnic and racial differences in physician utilization could not be accounted for

on the basis of age because the differences remain even after the data are age adjusted. Further investigation revealed that the lower utilization of physician services among Mexican Americans was primarily due to a large proportion of Mexican Americans who do not go to a physician in the course of a year. One-third of Mexican Americans do not consult with a physician in the course of a year compared with one-fourth of non-Hispanics, Cuban Americans and "other Hispanics," and one-fifth of Puerto Ricans. Similarly, proportionately more Mexican American children (35 percent) did not see a physician in the past year as compared with other Hispanic and non-Hispanic children. In contrast, less than one-fifth of all Puerto Rican and "other Hispanic" children did not see a physician in the past year.

Dental Visits. Each year approximately one-half of all Americans four years of age or over see a dentist. Mexican Americans and blacks are the lowest users of dental services with only about one-third of them seeing a dentist during a given year. Puerto Ricans, Cuban Americans, and "other Hispanics" are more likely to have seen a dentist than are Mexican Americans and blacks, but are less likely to have done so than whites.

When overall estimates of persons never seeing a dentist were compared among specific populations, even larger disparities were found. Virtually all (97.5 percent) white non-Hispanic persons four years of age and over have been to a dentist. In contrast, almost one out of every five Mexican Americans has never been to a dentist during his or her lifetime. The percent of Mexican Americans never receiving dental care was almost seven times as [illegible]or white persons (the greatest users of dental care) and twice that of black persons (the second highest nonusers after Mexican Americans). Low-income Mexican Americans were over one and a half times more likely to have never seen a dentist than were Mexican Americans with annual family incomes of $10,000 or more (22 percent compared with 14 percent).

Preventive Dentistry

Relative to preventive dentistry, almost one-third of Mexican American children 4 to 16 years of age have never received dental care. This percent is three times greater than that for white children and almost twice that for other Hispanic children.

Health Insurance Coverage. In another investigation, we compared public and private health insurance coverage among white and black non-Hispanic people, Mexican Americans, Puerto Ricans, and Cuban Americans under 65 years of age residing in the standard metropolitan statistical areas (SMSA) in the United States.[4] The data obtained in 1978 and 1980 revealed that blacks, Puerto Ricans, and Cuban Americans were twice as likely as whites not to have health insurance. Among Mexican Americans, the non-coverage rate is 3½ times greater than that of white non-Hispanics. The percent of the population which was uninsured for medical expenses ranged from a low of 8.7 percent of whites to a high of 29.9 percent of Mexican Americans. Almost one-half of Mexican Americans with an annual family income of less than $7,000 were uninsured, compared with approximately one-third of Cuban Americans, one-fourth of whites and blacks and one-fifth of Puerto Ricans.

Reported reasons for not having health insurance were obtained for

uninsured persons. Inability to pay was the most frequent reason provided by all ethnic/racial groups. Mexican Americans, the group with the highest percent uninsured, were among the most likely to report they could not afford insurance and the least likely to report unemployment as their chief reason for non-coverage. While not providing direct evidence, these findings would lead support to the hypothesis proposed by Aday and others that low rates of private health insurance coverage among Mexican Americans may result largely from their low income and employment in firms that generally do not provide such coverage as a fringe benefit.[5]

Blacks and Hispanics were considerably less likely than whites to be covered under private health insurance. Eighty-six percent of whites, 61 percent of blacks, and 59 percent of Hispanics have private health insurance. Among Hispanics, Cubans are the most likely to have private health insurance (74 percent) and Puerto Ricans are the most likely to have Medicaid coverage. About one-third of Puerto Ricans have Medicaid (20 percent), followed by Mexican Americans (11 percent), and Cuban Americans (5 percent).

Analysis of Medicaid coverage among the poor revealed that almost two thirds of the Puerto Rican population under 65 years of age with an annual family income under $7,000 has Medicaid coverage, compared with one-half of the black population, one-third of the Mexican American population, and almost one-fifth of the white and Cuban American populations.

There are several possible reasons for the greater Medicaid coverage rates among Puerto Ricans and blacks. First, 40 percent of Puerto Rican and [illegible]ilies are headed by a female with no husband present, compared with 12 percent of white families, and 16 percent of Mexican American families[7] (Figure for Cuban Americans is unavailable). Therefore, it is probable that greater numbers of Puerto Ricans and blacks are qualifying for Medicaid coverage under Aid to Families with Dependent Children (AFDC). Second, Puerto Ricans and blacks may be more likely to reside in states that provide greater optional coverage under Medicaid (e.g., coverage for medically indigent individuals). Third, almost 5 percent of Mexican Americans reside in Arizona which did not participate in the Medicaid program during the time period covered by this study. Finally, it is unknown how many undocumented Mexican workers, who may be less likely to have public health insurance, were interviewed in the National Health Interview Survey.

Obviously, the lack of health insurance reduces an individual's financial access to health care. Persons without insurance were found to be 50 percent more likely than insured persons to not have visited a physician in the past year. Of all the ethnic/racial groups investigated, Mexican Americans experienced the lowest utilization of health services and the lowest health insurance coverage. Among other reasons, large numbers of Mexican Americans may be deferring needed medical care because they cannot afford it.

Our public health insurance programs have greatly increased the access to medical care of many minority groups. To the degree that utilization reflects access, our findings would signify that blacks enjoy equal access to health care (but not necessarily equal quality) as whites. Cubans and Puerto Ricans exceed the utilization of whites. Mexican Americans appear to have the lowest access. Given that 50 per-

cent of the poorest Mexican Americans in this country have no coverage, it would appear that our public health insurance programs are not working very well for them. I urge you to seriously study the possibility of redefining the Medicaid eligibility requirements for mandatory coverage by states. Eligibility for public health insurance coverage should be established on one's medical and financial needs, and not on one's marital status.

Ms. Jones: For-Profit Hospitals

I am Marcia G. Jones, Health Policy Specialist in the Public Policy Department at the American Federation of State, County and Municipal Employees (AFSCME). AFSCME represents more than 100,000 public hospital workers nationwide and has a history of supporting public health care services.

Prior to my AFSCME employment, I worked for many years as a legal services advocate. I assisted clients who had been denied medical treatment because of an inability to pay. I saw the unnecessary physical and emotional trauma that these persons suffered as a result of this denial of service.

These patients were denied care by private, nonprofit facilities with Hill-Burton obligations, so fortunately there was a legal recourse in many of these cases. Last year, Congress enacted legislation that may provide indigent patients with some limited access to for-profit hospitals. Still, there is no federal provision similar to the Hill-Burton Act that requires a for-profit hospital to provide a reasonable volume of free or reduced cost care. Even on acquisition of a nonprofit facility by a for-profit firm, a free care obligation is not mandatory.

I will focus on problems created by the impact of for-profit hospitals on [illegible]nsated care.

What are some of these problems?

- An uninsured Texas laborer with third degree burns over his back and side arrived at Dallas's Parkland Memorial Hospital with an IV attached after having been denied care at three different for-profit facilities.[1]
- At a Kentucky hospital, indigent pregnant women are denied admission unless they pay a $1,200 deposit.[2]
- In Nashville, Tennessee, a hospital owned by the Hospital Corporation of America refused to treat an indigent lung cancer victim who was in great pain until a family member paid a $500 pre-admission deposit.[3]
- In Prince George's County, Maryland, 650 employees were laid off from the public hospital system under contract management by the Hospital Corporation of America (HCA). These firings were HCA's response to the financial problems of the hospitals, although conflicts of interest and mismanagement may have also contributed to the problems.[4]

Why should the general public be concerned about these problems and the growth of for-profit health care firms? We should be concerned because, as the examples show, for-profit hospitals do not have the same commitment to the

community as public facilities do. The difference in commitment results from the fact that for-profit hospital corporations are required by law to protect their shareholders' investment. Public hospitals are required by law to provide adequate care for all of the community members in which they are located without regard to their ability to pay.

"Danger" Reported

A recent report issued by the National Council of Senior Citizens (NCSC) described for-profit health care firms as a "growing danger to our health care system."[5] Studies published by the Urban Institute and in the *New England Journal of Medicine* document that the community loses because: 1) for-profits contribute considerably less, and sometimes not at all, to providing care to the community's poor. The Urban Institute and American Hospital Association data show that in the 100 largest U.S. metropolitan areas, for-profit hospitals provide only 0.1 percent of the charity care;[6] 2) for-profit hospitals charge 15 to 24 percent more per admission than public and non-profit hospitals as a result of drug markups and increased use of ancillary services;[7] and, 3) for-profit hospitals contribute little to medical research and education, thus depriving their staff of new knowledge needed to care for the community.[8]

Another reason for public concern, particularly in these deficit years we are experiencing, is the loss to taxpayers that results from a takeover of a nonprofit hospital by a for-profit firm. Any hospital accepting federal funds under the Hill-Burton Act must continue to provide indigent care for the duration of its 20-year obligation, or repay the funds as required by the Deficit Reduction Act of 1984.[9] Based on a Department of Health and Human Services Inspector General's (IG) report, the NCSC charges in its report that the federal government has failed to enforce this provision of the Act. This failure has cost taxpayers millions of dollars in uncollected funds.[10]

Why should for-profits have to provide any free or reduced cost care if there are public and nonprofit hospitals that can provide for the poor? For-profit hospitals should have to provide services to indigent patients because: 1) patients transferred to public hospitals without first being stabilized are placed in jeopardy of losing life and limb;[11] 2) for-profit hospitals are overburdening public hospitals by transferring large numbers of indigent patients;[12] and, 3) for-profits receive tax subsidies through Medicare payments, and thus, they owe a debt to the public which should be repaid through services to the poor.[13]

Management personnel for these for-profit firms candidly declare that their affiliate hospitals have no responsibility legally,[14] and apparently feel none morally to treat the indigent sick.[15]

This attitude is especially offensive when for-profit hospitals gain control by taking over a public hospital facility. For-profit firm spokespersons, however, have denounced critics who are appalled by their profit-making motives and tactics in taking over public facilities. The firms claim to save public hospitals from "probable demise."[16] They claim to improve the acquired public and nonprofit hospitals by purchasing state-of-the-art equipment, streamlining staff, attracting new physicians, and contributing to tax revenues rather than depleting them.[17]

To be sure, the for-profit hospitals do indeed "streamline staff" which often results in dangerously low staff-

to-patient ratios.[18] Lower staffing patterns are particularly problematic at public hospitals where patients tend to be more severely ill. For example, at Highland General Hospital in Oakland, California, the management firm, Pacific Health Resources, set a standard of 15 hours of nursing care per patient, instead of the existing standard of 18.73 hours. Well-documented earlier studies at Highland showed a need for greater nursing care because "the condition of many of the patients on the wards at Highland was similar to that of patients in the intensive care units in private hospitals."[19]

For-profit hospitals generally try to avoid treating the poor altogether by either eliminating, or not having comprehensive, less profitable services such as, extended care services, physical medicine, rehabilitation units, and substance abuse units. Those services are often necessary in treating the poor.[20] In essence, for-profit hospitals disable themselves to treat the poor. There is ample documentation that after having disabled themselves to treat the poor, the for-profit hospitals then transfer the indigent sick to public hospitals.[21] The public hospitals are already overburdened with indigent patients and have financial problems from treating a large number of poor patients.[22] This "skimming" of profitable services and patients by the for-profit hospitals reduces the ability of both the nonprofit and public hospitals to compete for paying patients and to continue operating. Consequently, many nonprofit and public hospitals are left open to takeover by the for-profit firms which claim to be the cure-all for the financial problems of these hospitals. This potential for monopolistic control is dangerous to the community because the community will pay higher prices for hospital treatment that has not proven to be any better.[23]

There is no doubt that the poor are the "major victims" of the growth of for-profit hospitals.[24]

This victimization of the poor occurs through the practice of "patient dumping"--the transfer of patients from for-profit hospitals to nonprofit and public hospitals solely for financial reasons, and through bill collecting and advance payment demands.[25] Both of these practices are of questionable legality.[26]

In many patient dumping cases, these patients are at risk of dying en route to a nonprofit or public hospital because these transfers are often done without the for-profit hospitals stabilizing the patients.[27] In instances where the patient is stabilized before transfer, sufficient medical data to assist in continued treatment of the patient is not supplied.[28]

What can be done about these risks that for-profit hospitals are posing for indigent patients through transfers? What can the federal, state, and local governments do to require these hospitals to make their profit independently of the burden they put on public and nonprofit hospitals through these transfers and takeover attempts? What can be done to get them to share in the provisions of a reasonable volume of free or reduced cost care? With respect to the first question concerning the dumping of patients, the federal government has already taken a giant step towards correcting this abuse. As part of the Consolidated Omnibus Budget Reconciliation Act of 198 (COBRA),[29] patient anti-dumping legislation has been included entitled "Examination and Treatment for Emergency Medical Conditions and Women in Active Labor." This provision requires Medicare-participating hospitals to evaluate all patients who come to their emergency

rooms.[30] Patients must be examined, irrespective of whether they are Medicare patients, to determine if an emergency exists, or if a woman is in active labor. If so, the hospital must stabilize the patient or care for the woman in labor unless that patient requests a transfer, or a physician or qualified medical personnel certifies in writing that the *medical* benefits of transfer outweigh the risk of the transfer.[31]

Patient Transfers

If a patient is transferred without being stabilized, the transferring hospital must obtain an agreement from the hospital to which the patient is being referred that it will accept the patient. The transferring hospital must send medical records and use qualified personnel and equipment during the transfer.[32]

This legislation gives the Secretary of Health and Human Services the option to assess a civil penalty of $25,000 for each violation against the transferring hospital and physician, or to terminate the hospital Medicare agreement. The transferred patient also has a private right of action.[33] Texas has enacted similar legislation.[34]

Second, the federal government should recognize through the Medicare and Medicaid programs the special costs of all facilities which provide a large volume of free care. This reimbursement structure would reduce the competitive edge for-profit hospitals gain from patient dumping. Ten states have already developed such rate structures although they vary widely.[35]

Third, the federal government should enforce the legal provisions which require the for-profit firms to repay the money they owe for acquiring a public or nonprofit facility with an existing Hill-Burton obligation if they choose not to fulfill it.

Fourth, states should establish protections such as requiring public hearings, or involving states' attorneys general, when for-profit hospitals attempt to acquire nonprofit and public facilities. For example, in addition to obtaining assurances from a prospective corporate buyer or lessor that indigent care will continue to be provided, North Carolina also requires public hearings before a public hospital can be sold or leased to a corporation.[36] In Massachusetts, the state's attorney general filed suit to enjoin the sale of Hahneman Hospital in Brighton, Massachusetts to a for-profit corporation, Community Systems, on the grounds that the sale was beyond the authority of the Board of Trustees of the hospital.[37] New York prohibits the operation of health care corporations controlled by out-of-state interests.[38]

Finally, the federal and state governments should enact laws that provide funding for a reasonable volume of free or reduced cost care. The labor movement, the Villers Foundation, and others are working collaboratively on developing model legislation to fund uncompensated care.

Even if this, or similar legislation is enacted, we must continue to exert public and political pressure to encourage for-profit management to change its attitude toward treatment and billing of indigent patients.

With greater public awareness of the problem, proprietary hospitals may soon have to concede some of their profits in favor of a greater common good—the individual's right to health care.

Dr. Trowell-Harris: Assessing The Care Group

America is rich in the diversity of its minorities. This diversity among populations is reflected in language differences; in cultural practices and beliefs with respect to illness and health; differences in needs for types of health services and the duration of health care; and differences in birth rates and differences in the afflictions which kill.

Minority women are increasingly disadvantaged, and further separated from necessary health care for themselves and their familie.

The purpose of this paper is to describe the critical health care gap for women, minorities and their families, access to care, and the social factors and health status that contribute to concerns around access to care. The American Nurses' Association's current activities and recommendations to address these needs are outlined here.

Access to care is the most critical health care concern for women and minorities, and their families. Access as defined by Penchansky (1977) consists of four factors: 1) adequacy of supply, 2) geographical accessibility, 3) ability to pay, and 4) ease of entry. While lack of resources and reimbursement mechanisms (public and private insurance) place severe barriers in the way of access, the presence of resources and funding does not guarantee access. Continued population growth, the changing distribution of health care providers in the country, rapid change in health care delivery, rapid change in the health care industry, client understanding of the importance of the need for services, and economic problems in certain areas of the country contribute to the problems of access to health care by indigents.

The medically indigent are primarily those persons without adequate health insurance. There are 35 million people in the country who do not have medical insurance, according to Dr. David Rogers, president of the Robert Wood Johnson Foundation. That is 20 percent more than there were in 1980. The foundation study estimated that one million families were refused health care for financial reasons in 1982 (Robert Wood Johnson Foundation, 1983).

Important strides in the provision of health care have been made in the last several decades. The introduction of Medicare and Medicaid in 1965 and the development of employee-related health insurance have been major accomplishments in increasing access to health care. However, the adequacy of health insurance is a growing problem for many, especially the elderly who are concerned about what services are covered by Medicare and whether they can afford the co-payment and deductibles required.

The issue of uncompensated care is another critical health concern for women, minorities, and their families. Uncompensated care is composed of charity care and bad debt according to a leading health policy researcher, Gail R. Wilensky, Ph.D., director of Project HOPE, Center for Health Affairs at Millwood, Virginia. Uncompensated care is not a hospital issue alone. It is a social issue. The real question that needs to be addressed is, "Can we, as a society, do what is necessary to enable the health care poor to obtain access to needed health services?"

As states facing budget limitations tighten eligibility criteria the number of people who have no protection, either private or public, against the cost of services, injury, or illness will grow. This is a critical national issue, not involving just hospitals, but also health care practitioners, health planners, third-party payers, employers, and most importantly, legislators at the state and national levels.

In recent decades, women in the United States have undergone a revolution in their self-perception and their traditional relationships to work, money, marriage, family and society in general. These societal changes have implications for every aspect of women's lives, including health and illness (Department of Health and Human Services, 1985a).

Various social and ethnic factors contribute to identification that certain groups of women have higher morbidity or mortality rates, or both, than others. For example, maternal deaths are four times as high for black women, and three times as high for Hispanic women as they are for white women (Public Health Service, 1985a). Rates of depression are higher among married women with children at home than they are among women who have never married or those whose children have left home (Public Health Service, 1985a).

Numerous biological and social factors are thought to contribute both to women's greater morbidity and to their longevity: for example, cultural and social values and attitudes affecting women's health; economic status; participation in the labor force; family, household structure, and age; and interaction with the health care system.

Human behavior is shaped by current cultural and social values and attitudes (Public Health Service Task Force on Women's Issues, 1985a). Women's behavior, which is often less risk-taking than that of men, may protect them from violent accidents and death, but it may also keep them from competitive activities that lead to physical fitness and greater mastery of the environment.

As a group, women are economically disadvantaged in comparison with men, regardless of age, race, ethnicity, education, or employment status. Data from the Bureau of the Census, the Bureau of Labor Statistics, and the Congressional Budget Office confirm that women in the United States are becoming increasingly disadvantaged. Poverty and ill health are interrelated. Disadvantaged people become ill because of poor nutrition, poor living conditions, high levels of stress, and reduced access to health care. As a result of these conditions, illness may occur with greater frequency, causing those persons to miss work or lose jobs and become even poorer.

The Task Force on Women's Health Issues (1985) reported that the rapid rise in the participation of women in the labor force has been the most far-reaching change in recent years. Currently, 52 percent of all women are in the labor force. The most rapid shift in participation has occurred among women with children still in the home. Sixty-six percent of mothers with school-age children are now employed.

The long-term effect of multiple roles on the health status of women has received some attention from researchers, but results are equivocal. Studies have shown that gainfully employed women are healthier and generally more satisfied than housewives. It is not known whether this is the case because healthy women take and keep jobs outside the home, or whether the jobs by providing self-esteem,

income, and status result in better physical and mental health. Symptoms of stress have been found to be more frequent in women with jobs that offer limited opportunities for women. Lack of occupational mobility is greater still for minority women than for white women.

In addition to income and occupation, health status is also related to various demographic factors. Marital status, age, household structure, and the timing and number of children all have implications for women's health. A family or household is important not only because it is the place where health behaviors are learned, practiced, and reinforced, but also because it is where most short-term acute and long-term chronic care occurs (Department of Health and Human Services, 1985).

Studies have repeatedly shown that women are more likely than men to report symptoms of illness and to utilize health services. What is not clear is whether these statistics reflect real differences in morbidity or some combination of gender-related differences in income and age structure, illness behavior, access to care, and response of the health care system. Differences in access to care by men and women, whites and minorities, and rural and urban dwellers all have been examined, as have differences in the way the health care systems respond to women. Some research indicates that women are treated with less respect and dignity, that male physicians may be less sensitive to women's needs, and that psychotherapeutic medications are disproportionately prescribed for women as compared to men. The women's movement, more female physicians, and the development of alternate treatment services for women [illegible]ge this trend.

Because women use health services more than men, it is important to address those conditions that tend to increase women's need for services and to promote those conditions and behaviors that maintain health.

According to the Public Health Service Task Force on Women's Issues (1985a), fundamental to the achievement of improved health for all women is the recognition that their lives have changed dramatically in recent years and the future changes are likely to be even greater. The three most important social changes affecting women's health at the present time are:

- The increasing numbers of women living in poverty,
- The unprecedented entry of women into the labor force, including women with infants and young children; and
- The continuing increase in the longevity of women.

Society as a whole must begin to take these changes into account if programs and policies are to be of maximum benefit. While most health disorders are not sex-specific, some problems occur more frequently in women than in men, and thus contribute to a significantly higher morbidity rate among women.

Minority women in the United States carry a disproportionate burden of disease. Life expectancy is shorter and rates of infant and maternal mortality are higher for minority women than for white women. Minority groups also have a higher prevalence of chronic diseases such as diabetes, hypertension, and cardiovascular disease. The death rate from certain cancers is significantly higher in black than in white women. Since many minority women are socioeconomically disadvantaged, their health problems are compounded by

poverty, poor nutrition, low motivation and self-esteem, and adverse environmental factors (Public Health Service Task Force on Women's Health Issues, 1985a).

In January 1984, the Secretary of the U.S. Department of Health and Human Services established the Task Force on Black and Minority Health in response to the national paradox of steady improvement in overall health, with substantial inequities in the health of U.S. minorities. The report documents the disparity in key health indicators among certain groups of the U.S. population. A comprehensive study was carried out to investigate the longstanding disparities between the health status of U.S. blacks, Hispanics, Asian/Pacific Islanders, and Native Americans compared to that of whites.

The task force found that 60,000 excess deaths occur each year in minority populations (Department of Health and Human Services, 1986). Excess deaths express the difference between the number of deaths actually observed in a minority group and the number of deaths that would have occurred in that group if it experienced the same death rates for each age and sex as the white population. One of the task force's major concerns was the quality of available data, especially on Hispanics.

According to the Department of Health and Human Services (1985b), age-adjusted death rates reached new lows in 1984 for each race-sex group except black females. White females had the lowest estimated age-adjusted death rate (391.4 deaths per 100,000 population), followed by black females (586.2), white males (694.6), and black males (1,016.1). Between 1983 and 1984, age-adjusted death rates decreased [illegible]nt for white females, and increased three percent for black females (from 571.5).

The American Nurses' Association (ANA) has a long history of promoting efforts to assure quality health care to all individuals, affordable health insurance for the unemployed and their families, continued federal funding for maternal and child health programs, state programs to meet the cost of providing uncompensated care and continual federal funding for the Medicaid program.

One purpose of the American Nurses' Association is to shape public policy about health care to benefit the health and welfare of the nation's citizens. While policies and goals put forth by the ANA House of Delegates guide this process for the profession, it is recognized that health policy for the people is determined by legislative bodies as they adopt laws, by executive bodies as they administer laws, and by judicial bodies as they interpret laws.

Each year, specific legislative priorities are adopted by ANA and shared with nurses and policymakers. ANA's 1987 legislative and regulatory priorities include a number of goals and activities relevant to this paper.

Access to Care. To address access to care the association framed two goals:

- to assure access to quality health care services especially to vulnerable populations, such as children, the disadvantaged and the aged; and
- to assure access to nursing care services with emphasis on the role of nurses as qualified providers of health care services.

To achieve these two broad goals, ANA is actively pursuing legislation and regulation that will provide:

- a prominent federal role in and increased federal funding for the delivery of maternal-child health care

services and related programs, such as immunization and school health programs;

- health insurance for the unemployed and their families;
- reform of the Medicare program without limitation in the accessibility to health care services or an increase in the financial burden to the Medicare beneficiary;
- access to long-term care services without the imposition of excessive emotional and financial burdens on families;
- legislation that is responsive to the health care needs of both urban and rural Americans with respect to accessibility and availability of essential health care services;
- continued federal funding for nursing education programs, especially graduate education, designed to enhance the quality of patient care and the cost effectiveness of nursing services; and
- establishment of a visible and viable organizational entity at the federal level which focuses on nursing research.

ANA has targeted active support of particular legislation and regulation to accomplish its human rights goals. These include: passage and ratification of the Equal Rights Amendment; continued enforcement of the Voting Rights Act; a strong and independent U.S. Commission on Civil Rights; and federal legislation to assure that essential health care services are provided to the nation's people.

Maternal and Child Health.

- One of ANA's goals is to increase funding for the delivery of maternal child health care services. To address this goal ANA is collaborating with state and federal legislators in undertaking initiatives aimed at increasing funding for maternal-child health care services. These initiatives include support for increased federal funding for the Maternal Child Health (MCH) Block Grants, Immunization Programs, Aid to Families with Dependent Children, and the Women, Infant and Children (WIC) Program.

In 1987 the American Nurses' Association published a summary of data obtained from conferences of expert perinatal clinicians and policy makers on access to prenatal care and prevention of low birth weight. This publication also provides recommendations for health policy based on conference data.

Uncompensated Care. Another ANA goal is to work to attain adequate health care services for the poor and uninsured.

To achieve this goal, ANA is strongly encouraging state nurses' associations to support state legislation for coverage of uncompensated care. This goal also includes the development of federally coordinated financial mechanisms, and a comprehensive policy with the individual states to meet the cost of providing uncompensated care.

Federal Financing for Medicare. Another ANA goal is to support financing of quality health care services to Medicare beneficiaries. To achieve this goal, the association urges congressional representatives and federal agencies to pursue legislative initiatives to increase federal financing for Medicare.

ANA has identified as a final goal, the need for continued state and federal support of quality health care services to Medicaid beneficiaries.

To address the goal of federal financing for Medicaid, ANA urges state and federal legislators to develop initiatives aimed at increasing funding for the Medicaid program.

ANA Recommendations. The critical health care gap is access to care. Filling the gap will require concerted efforts on the part of many people and organizations. In order to promote improved access to care for women, minorities and their families, ANA recommends:

1. Support for health promotion/disease prevention programs and research that specifically addresses the needs of women, minorities, and their families.
2. Support of legislative and regulatory measures that ensure health insurance coverage for women, minorities and their families.
3. Support for expanded prenatal care benefits under Medicaid, the federal health programs for the poor.
4. Health programs and educational efforts that are tailored to the linguistic and cultural needs of diverse populations.
5. Development of models for providing quality care to culturally diverse groups.

Access to care is the most critical health care concern for women, minorities and their families.

The American Nurses' Association has a long history of promoting efforts to assure access to care. Several legislative priorities and resolutions to address specific goals have been adopted by ANA and shared with nurses and policymakers.

Access to care is a monumental problem which has generated increased concern among health care professionals. The scope of the problem is unwieldy and would require considerable effort on the part of politicians, health care professionals, and policy analysts to reduce or alleviate it.

There is as yet no generally recognized procedure for assessing the total of programs and services for access to health care in terms of use, results, quality and cost; in short, who, when, where and how to refer at-risk individuals in order to meet their needs most effectively. What is needed is a simplified system so that people who need care, but cannot pay for it, will know how to access the system.

Concluding Comments:

The Honorable Edward M. Kennedy, U.S.S.

The Honorable Mickey Leland, M.C.

Senator Kennedy:

I am glad to see that there are groups that are still committed to good quality health care. We don't hear the words said very often these days but I must say I continue to be strongly committed to the concept of national health insurance. I join with all of you this morning in focusing attention on some of the most important health care issues and questions that we are facing in our country.

I congratulate all of those who have been a part of this conference, and I hope that as you leave this caucus room you will continue your good work. Your effectiveness is increasing in spite of a long and difficult period the past several years.

You know that many of us in Congress continue to work on these issues. Basically we are attempting to provide decent and quality health care to all Americans as a right, and not a privilege. I believe in that very deeply. Now we are trying to deal with it in a variety of different approaches. I welcome the chance to participate with you in your efforts.

Recently, the Thurmond-Durenberger-Kennedy-Hollings bill was introduced to extend the various health benefits of Medicaid to expectant mothers up to the poverty level. This was a recommendation made by the National Governors Association, and it truly is an idea whose time has come. We got that legislation passed. It will provide some important services to a very vulnerable group in our society. We're interested in further extending the program to needy children; perhaps, with Durenberger-Kennedy legislation later on in this session.

Last year, as part of the reconciliation bill, we were able to pass legislation which prohibited hospitals from "dumping" patients who can't pay. This outrageous practice has affected so many people in communities across this country. As we all know, they're obviously the poor individuals in our society.

Also, as a part of the reconciliation bill last year, we were able to enact legislation enabling individuals who had lost their jobs to buy back into their health insurance program for a period of at least 18 months. It also applied to spouses and dependents.

All of us are very much aware, as Congressman Martinez pointed out, of the increasing number of people in our society who are losing any kind of insurance. Currently, 37 million people are uninsured. We all recognize that these are really limited provisions to try and deal with that problem. We are going to propose more comprehensive legislation in this Congress to try once again to insure that there will be a further extension of health insurance for those who lose their jobs. Hopefully, we'll be successful.

Another issue which concerns us is the increasing deductible under Medicare. We've seen the increase in the deductible really explode because of the prospective payment system under Medicare. It has gone up 43 percent in the last two years. And now rather than being a disincentive to rising costs or a cost-sharing device, it is actually preventing great numbers of people, elderly people in our community, from going into the hospital. I am hopeful that we will be able to address that issue in this Congress. We were able to at least halt the exploding rise in the deductible for our elderly people.

But even though some progress has been made for the elderly, we know

that a number of children in our society that would qualify under Medicaid are not receiving the health care they need. We know that the infant mortality rate has not been decreasing. We know how to decrease infant mortality, and we know what has to be done. It is really a question of national priority, national commitment, and national concern. Although there are many issues in Congress with which we really have difficulty finding solutions, in these areas we know what to do. It really is a question of resources, priorities, and commitment.

It is imperative that we raise these health issues again. I strongly believe that the American people want us to deal with this in a comprehensive way. I am very hopeful as we move on through in the course of the elections, that we will make decent health care an issue all across this country. I find it absolutely repugnant as an American to believe that whether a child is born of poor parents, or to middle class parents, the chances of survivability really depend on the pocketbook of that parent. And in our society, if we care about the things that we say we care about—that is, our children and insuring a healthy society—then that kind of blatant hypocrisy needs to be confronted by the American public. And I believe that if we do that over a period of time, we will be able to deal with the issue in a comprehensive way which will reflect our humanity and insure quality health care at an affordable price.

So I applaud your meeting here. I just want you to know that as long as I have a voice and as long as I have a vote, it's going to be speaking to your concerns, and the concerns of millions of our fellow citizens, who ought to be able to have quality health care as a right in our society and not as a privilege.

Mr. Leland:

I feel honored to have been asked to offer the closing remarks and benediction on this special occasion. The issue of health care has long been one of my major legislative interests.

No health service can be a truly progressive service without opening itself and extending itself to all needy peoples.

Accessibility has long been a problem for poor people who need health services. People of color, and women, have been effectively isolated from health care services through a decline in the number of hospitals and other health facilities which serve the poor and the uninsured.

To conserve time, I will offer you one example of an issue which is deserving of our attention: the problem of access to health care for migrant and seasonal farm workers. Despite advances in medical care delivery and the growing network of nearly 800 community and migrant health centers across our nation, the centers still reach less than one-quarter of America's 25 million underserved residents.

Sixty percent of the people served by these centers are living below the federal poverty level. Nearly 30 percent of them have no health insurance, public or private. As a result, many of the poor and underinsured rely on the existence of community and migrant health centers exclusively to meet their health care needs.

Of course, in considering the problems of migrant and seasonal workers, we must consider the special plight of their children. Almost 40 percent of the population served in these centers are children under the age of 14. These children suffer more frequently and more severely than does the general population of children from both acute and chronic illness. This is an injustice we must correct.

Migrant and seasonal farm workers are primarily concentrated in the Gulf area and south-central Texas, but they travel and work in all 50 states. Often their working conditions are unsanitary and unhealthy. The health of these workers is at high risk because of the unclean and unprotected nature of their working environments. First, we must strive to improve the working conditions of these workers by stimulating their employers to provide better facilities for them. And, we also must combat the high incidences of disease and illness by making quality health care more readily available to them.

Twenty-eight percent of the women who use the health centers are of childbearing age, and in most cases these centers provide the only prenatal care available to them. High infant mortality rates for migrant workers attest to the great need for expansion of these services.

Clearly, in light of the growing number of poor people, and people with inadequate health coverage, access to health care is a moral imperative. Treatment shoud be focused on disease prevention and health maintenance, in order to keep health care costs down in the long run. Health care centers should be conveniently located within communities, so that transportation and access to transportation do not remain barriers to health care. Finally, the appalling working conditions of migrant workers must be remedied to avoid even greater risk of disease.

In concluding, I want to thank the Women's Research and Education Institute (WREI), the Congressional Hispanic Caucus, and the Congressional Black Caucus for their work in putting together this very informative and important forum on bridging the health care gap.

This issue certainly warrants our concerted attention as legislators, as researchers, and as activists. I hope that everyone here will continue to work toward achieving equality in access to health care.

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11. *See* NCSC report *supra* at 8–10; Dallek and Waxman, *supra* at 1413. This article begins with chilling accounts of patient death and further patient injury that occurred when the patients were transferred without stabilization.

12. *Id.*

13. Medicare-participating for-profit hospitals have a great financial advantage over public and non-profit hospitals. The latter hospitals are only reimbursed for cost of services. The for-profit facilities are reimbursed not only for cost, but also for a portion of their "capital related costs, including depreciation and interest on the large loans they take out in order to pay high prices for community hospitals." *See* Dallek and Lowe, "The For-Profit Hospital Juggernaut," 13 *Southern Exposure*, Mar.–Jun. 1985, at 83. The recently enacted Consolidation Omnibus Budget Reconciliation Act of 1985 will phase out this return on equity advantage by October 1, 1989, however. *See* H.R. 3128, Consolidated Omnibus Budget Reconciliation Act of 1985, 99th Cong., 1st Sess. at S9107.

14. At present, there is no federal requirement that for-profit hospitals provide uncompensated care, unless the for-profit firm which purchases a "Hill-Burton" facility (i.e. one constructed with, or modernized under Hill-Burton) *voluntarily* accepts that obligation. *See* Deficit Reduction Act, *supra*. There is a financial incentive for the for-profit firm to accept the obligation. If it accept it, the Hill-Burton funds must be repaid to the federal government on a strict timetable. Failure of the firm to repay the funds within 180 days following notice to the Department of Health and Human Services of the sale of the non-profit facility to the for-profit could result in interest being charged. *See* H. Rep. No. 98–432, 98th Cong., 2d. Sess., reprinted in 1984 *U.S. Cong. & Ad. News*, at 1365.

15. The following colloquy is said by critics to sum up the prevailing attitude of administrators of for-profit hospitals regarding making services available to indigent patients. This exchange occurred between a member of the Georgia Health Planning Board and Charles Davis, administrator of Hospital Corporation of America:

> Question by member: "Why don't you put up a sign saying, 'This hospital will provide free care to people who are unable to pay'?"
>
> Davis replied: "I'll answer that question with a question: 'Why don't department stores put up signs inviting shoplifters to shoplift more?'"

The New York Times, Jan. 25, 1985 at A-17, col. 1.

16. *Id.*

17. *Id.*

18. Relman, "Investor-owned Hospitals and Health Care Costs," 309 *New England Journal of Medicine*, Aug. 11, 1985 at 370–372. *See also* Graham, "The Private (Mis-) Management of Public Hospitals: The Case of Highland Hospital," *Health Law Project Library Bulletin*, Mar. 1981 at 97.

19. Graham, "The Private (Mis-) Management of Public Hospitals: The Case of Highland Hospital," *supra* at 77–82.

20. NCSC report, *supra* at 6.

21. Dallek, "State Study Health Care for the Poor," 18 *Clearinghouse Review* 740 (November 1984). *See also* Frank, "Dumping the Poor: Private Hospital Risk Suits," *ABA Journal*, Mar. 1985 at 25; Frank reports that "several studies confirm that transfers to public hospitals are up 200 to 375 percent in some cities over the past few years."

22. *Id.*

23. Alexander and Rundall, "Public Hospital Under Contract Management: An Assessment of Operating Performance," 23 *Medical Care* 209.

24. *The New York Times*, Jan. 25, 1985 at A-17.

25. NCSC report, *supra* at 4–12.

26. *Id.* Recently enacted COBRA provisions outlaw the patient transfers in certain instances. *See* text *supra* at 8–9.

27. *Id.* at 8. *See also* Dallek and Waxman, "Patient Dumping: A Crisis in Emergency Medical Care for the Indigent," *supra*.

28. *Id.*

29. H.R. 3128, Consolidated Omnibus Budget Reconciliation Act of 1985, 99th Cong., 1st Sess. (1985).

30. *Id.*

31. For an excellent discussion of this legislation, *see* Dallek and Waxman, *supra* The legislation had not been passed by Congress at the time the article was written. A compromise version was passed as the article went to press according to an explanatory note in the article

32 *Id.*

33. *Id.*

34. *Id.*

35. These states are Massachusetts, Connecticut, Maine, Maryland, New Jersey, New York, Rhode Island, Washington, West Virginia, and Wisconsin. Eby and Cohodes "What Do We Know About Rate-Setting," 10 *Journal of Health, Politics, Policy and Law* 299 (1985).

36. N.C. Gen. Stat. S131E-13(d)(3)(1984) as amended.

37. *Bellotti v Hahneman*, No. 85–86 (Mass., filed February 12, 1985).

38 N.Y. Public Health Law S28091-a(4)(e) (McKinney 1984).

39. *The New York Times*, Jan. 26, 1985 at 5.

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