COLLOQUIUM

ACCESS TO HEALTH CARE: WHAT ARE THE BARRIERS TO EQUITABLE ACCESS AND HOW CAN THEY BE OVERCOME?*

VICTOR W. SIDEL, M.D.**

The constitution of the World Health Organization states that "the attainment of the highest possible level of health is a fundamental human right." This principle has consequences for government under a variety of political theories. For those who, like the framers of our Declaration of Independence, accept the concept of natural or "inalienable" rights, a right to the highest possible level of health suggests that government has a duty to promote and protect the health of its people. For those who do not accept the concept of natural rights but who instead embrace utilitarian principles, the promotion of the greatest good for all also suggests that the government has a responsibility to provide equitable access to health care for all its people. For those who accept John Rawls' *Theory of Justice*, health care is a "primary good" that must be distributed fairly and justly, and government has a responsibility to ensure that this is done. For those who eschew theoretical constructs but who believe that modern health care should not be regarded as commodity to be bought and sold in the marketplace because of its unprecedented ability to relieve suffering and to preserve life and health, government has a responsibility to ensure that the highest quality health care is equitably accessible.

Government's responsibility to protect health, prevent disease, and alleviate unnecessary pain and disability is generally held to have three components: the organization and oversight of a medical care system that provides care equitably to all who seek it because they are ill or are concerned that they may be ill; the provision of a public health system that promotes and protects the health of everyone in the community; and, most importantly, the assurance of social conditions that promote health and prevent disease.

---

* This introduction is in part based on the author's keynote address for the Conference on Equity in Reforming Our Health Care System, University of Delaware, Sept. 21, 1994.

** Dr. Sidel is the Distinguished University Professor of Social Medicine at Montefiore Medical Center and Albert Einstein College of Medicine in Bronx, New York. He is a past president of the Public Health Association of New York City and of the American Public Health Association, and is currently a member of the Board of Directors of Physicians for a National Health Program.

Imaged with the Permission of N.Y.U. Review of Law and Social Change

The concept of equity in this context has two dimensions. The first, relatively noncontroversial, is that the care provided must be tailored to the specific medical care needs of the patient; care for a patient with congestive heart failure who lives in a third-floor walk-up apartment is more difficult and usually consumes more public resources than care for a patient with similar pathology who lives in a mansion. Also, patients whose language or culture differs from that of the majority must have access to culturally-sensitive care in the language in which they are comfortable.

The second dimension of equity is much more controversial. It may be illustrated, to highlight the controversy, by the first principle that Mao Zedong established for the health care system of the newly founded People's Republic of China: "Serve the Workers, Peasants and Soldiers." In Mao's view, those who previously had less access to care than others should receive better access than others, regardless of their current need. Equity, in this sense, entails using resources appropriately to meet differing needs and to compensate for past injustice, both of which mean that the poor and the otherwise underserved are likely to receive *more* than their equal share.

Virtually the entire debate on health care reform over the past two years has focussed on only one of the elements of health care: medical care. Medical care does play an important role — in treating and caring for the sick, in reassuring the worried well, and in using the clinical opportunity to provide preventive medical services to patients and their families. Protection of the right to health requires that the highest possible quality of medical care be made readily accessible to everyone, including those who face special problems in obtaining it, such as the poor, the undereducated, the undocumented, and those who face barriers based on skin color, gender, or sexual orientation. Equitable accessibility requires that there be no financial barriers at the time of service, that the services be appropriately distributed geographically, and that the medical care be culturally-sensitive. But even under conditions of equitable accessibility great differences have been found in the use made of the services and in the quality of care provided to specific groups, such as poor patients, black patients, and female patients. These differences must also be addressed if equity in care is to be achieved.

The changes in medical care organization during the first two years of the Clinton Administration were striking, once the Administration conceded that no significant changes would occur in corporate ownership and control of the U.S. medical care system. A dramatic percentage of the population has now been brought into *managed care* by inducement or by coercion linked to their Medicaid financing. Simultaneously, corporate control of the managed care system has led to increased attention to the economic bottom line rather than to the access to care or its quality. The net result for patients is an increasing lack of choice of doctors, increasing loss of control over the circumstances and the quality of their care, and diminished

Imaged with the Permission of N.Y.U. Review of Law and Social Change

access to culturally-sensitive care. Attainment of equitable access to care has therefore become even *more* difficult than if remedial legislation had been adopted by the 103rd Congress. Equitable access to care requires substantial reversal of the corporate takeovers that have occurred.

Equity in access to medical care, while a necessary condition, by itself is not alone sufficient to ensure the equitable protection of the right to health. Adequate resources and improved organization must also be made available for public health services, which in recent years have been increasingly underfunded and ineffectively organized. Additionally, vast new resources must be made available to reduce homelessness, hunger, violence, lack of education, unemployment, and poverty, all of which cause illness and frustrate medical care.

Where are these public resources to come from? Resources can be shifted from medical care, through cost containment measures such as single-payer medical care financing. These measures will eliminate the costs generated by medical care insurance companies and other corporate structures and will reorganize medical care to emphasize primary care and to avoid unnecessary technological intervention. The funds saved through single-payer financing and other changes in medical care will then be available to provide medical care with improved access.

Other resources, however, will be needed to fund improved public health services and to reduce homelessness, hunger, violence, lack of education, unemployment, and poverty. Some of these resources can be gained by reductions in military spending, although changes in the Congress may make this peace dividend even more difficult to achieve. More importantly, since the United States is among the lowest taxed industrialized countries of the world, the remaining needed resources can be equitably obtained through steeply progressive income or wealth taxation. Again, however, the new Congress appears to have a different agenda for taxation.

Despite the new political landscape, I believe we can enact legislation to accomplish equitable access to medical care with appropriate cost and quality control, a strengthened public health system, and a healthier quality of life for all our people. In the 1994 elections only 39 percent of those eligible to vote actually voted. A large percentage of those who did not vote are those who have inadequate access to medical care and public health services, and whose conditions of life are destructive to health, but who see little hope for change. So far, their cynicism has been justified. But if all of us work in our communities to organize the unorganized, to insist that change is possible, to explain how change can be achieved, and to create the political will to achieve it, we can have the medical and health care system, and the social and economic conditions, that the protection of the right to health demands.

Imaged with the Permission of N.Y.U. Review of Law and Social Change

Imaged with the Permission of N.Y.U. Review of Law and Social Change