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Securing Access to Health Care

The Ethical Implications of Differences in the Availability of Health Services

Volume Three: Appendices
Empirical, Legal, and Conceptual Studies

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Ethical Implications of Health Care Distribution

III

Equity, Access, and the Costs of Health Services

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Sometime in the last decade, the axis of health policy debate in the United States underwent a fundamental shift. Expanded availability of health care services to the population as a whole or identified groups within it had been the major issue in health policy debate since at least the early days of the New Deal. That issue found expression not only in the 30-year struggle that culminated in the enactment of Medicare and Medicaid, but also in governmental initiatives to expand the supply of hospitals, other health facilities, and then health personnel. Contemporary debate, on the other hand, often takes as a given the oversupply of at least some medical services, tends to focus primarily on issues of cost and cost containment, and frequently involves the proposition that Americans, or at least some of them, use too many health services.

To a considerable degree, Medicare and Medicaid achieved the primary objectives of increased availability of services to beneficiary populations; the recent shift in policy focus might be depicted as an inevitable outcome of success at addressing earlier problems. In an altenative formulation, one could take the frequently heard argument that current problems of cost and expenditure control are the direct results of those programs. As in other areas of social policy, this argument goes, we have fallen victim to the unintended consequences of noble objectives.

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This latter argument is explored in more detail later, but it is important to emphasize at this point that policy debate, perhaps especially in health care, often assumes a certain pendulum-like character. The cycles of oscillation between concerns for cost and access may be relatively lengthy, but the pendulum does appear to be swinging. Before it swings too far, it is not only appropriate but necessary to explore what, in fact, has happened to the availability of health services, why availability has been replaced by cost as the focus of policy concern, and whether the often-assumed diametrical relationship between the two is really grounded in sound evidence or logic.

The basic contention of this paper is that the actual improvements in access to health care that occurred over the last 15 years have already begun to erode alarmingly. Further, those improvements still left a situation considerably short, in many important respects, of what might be considered desirable. This erosion in availability arises to a considerable degree from efforts at cost containment; yet cost containment, properly conceived, need not be inimical to improved service availability. The short-run outlook appears to hold reduced availability as a product of cost containment efforts, which, it can be argued, is a function of political choices that are far from unavoidable.

To make this argument, this paper first very briefly summarizes changes in patterns of medical care utilization since the inception of Medicare and Medicaid; somewhat less briefly surveys current problems in the availability of health services and makes some observations about the implications of some current policy trends; and then turns to a somewhat more abstract exploration of three critical issues. These might be posed as: the distinction between equality of access and the assurance of access to minimally "needed" services; the gap between equity in volume of services and equity in quality of services; and the nexus between access/availability and cost containment. The implications of these issues and their discussion provide the basis for some concluding statements.

Definitions

First, the thicket of definitions must be entered. Terms such as "access," "availability," and "equity" have themselves been the subjects of prolonged and often complex discussions. There is no need, however, for the narrative purposes of this paper, to arrive at definitive and unalterable generic definitions. On the other hand, it is necessary for the reader to have some notion of what the writer is talking about, so the following, rather commonsensical usages are observed.

Access/Accessibility. These terms describe a relationship between a potential user (consumer) of a service and the service, such that a potential user who desires or "needs" the service is able to receive it without being barred for reasons of social status, income, ability to pay, place of residence, or other factors believed extraneous to the appropriate delivery of health care services. In this regard, access and accessibility are often defined in the negative, by the absence of obstructions that may prevent users from receiving services. For the purposes of this paper, no presumption is made about the "objective" need for or desirability of services, although services deemed unnecessary or undesirable by service providers do not, in this definition, constitute problems of access.

Availability. In contrast to accessibility, availability describes the characteristics of a service rather than of the relationship between services and their potential consumers. It is thus closely analogous to the economic notion of "supply," although in discussions of health services the question of "availability to whom?" is often of central concern; while in classic economics "supply to whom?" is almost literally meaningless. Although access is often defined in the negative, "availability" implies a positive. One can talk about a service for which there are no barriers to access, but which is still unavailable because there is no supply. Conversely, the extent to which services that are available are used provides at least a partial measure of their accessibility.

Cost Containment. Two quite different uses of this term are commonly encountered, and it is critical to distinguish between them. At the most basic level, cost containment constitutes a reduction in the rate of increase (because, in the health sector, one apparently can never speak of cost *reductions*) in the amount of resources employed to produce a given volume of services. More frequently, however, cost containment refers to a reduction in outlays by some particular payor or payors (most often governmental), which is often accomplished by a reduction in services. This sort of ersatz cost containment often produces increased expenditures for other parties; often it is achieved even while the unit costs of services continue to increase.

Equity. Anyone but a courageous philosopher hesitates to define "equity" simply, but for the purposes at hand, one can fall back on the Aristotelian principle that like cases should be treated alike and unlike cases unlike. In the provision of health services, equity is an attribute of a system that provides roughly similar services to those with similar health problems, and appropriately dissimilar services to those with dissimilar problems. The question of a system's equity is, of course, begged in the absence of agreement as to what similar or dissimilar problems, or what "appropriately" dissimilar services, may be.

Need. Following Boulding, need is that which professionals determine merits their intervention.[1] To avoid the problem of self-serving individual providers, one could borrow lan-

guage from malpractice law and define need as that which the prevailing community standard of best practice determines merits professional intervention.

Past Accomplishments

Historically in this country and elsewhere, two fundamental relationships described the connection between socioeconomic status and health services. First, income (and related measures such as education) is strongly related to health. At the same time, income is closely correlated with the use of health services. The poorer the individual, the more likely he is to have health problems, yet the fewer health services he is likely to receive.

Medicare and Medicaid changed the latter of those equations, and did so with astonishing rapidly given the magnitude of the social transformation. In 1964, middle-class people visited physicians 20% more often than the poor; by 1975, the poor had 20% more visits. More striking still are the data for children. Physician visits by poor children increased by 70% between 1964 and 1975, attaining parity with middle-class children in the latter years. Although the elderly had always used health services more intensively than younger people, hospital use rates skyrocketed after the inception of Medicare, and income differentials in service use fell as dramatically as among the non-elderly.[2]

Poor Americans now use roughly the same amount of physicians' services, and more hospital and nursing home services, than the nonpoor. In general, use of health services across income classes is substantially more equal than it was two decades ago. Yet controlling for measures of "need" or degrees of illness, the correlation between poverty and lesser use remains, although it has also shrunk. That is to say, a system that provides the poor with the same volume of services as the nonpoor has not attained equity, by the definition above, so long as poverty remains a powerful predictor of ill health, as it still does.[3]

Moreover, there have always been substantial gaps in the impact of Medicare and Medicaid on their target populations, exceptions to the general pattern of increasing equality, if not equity. Davis and Schoen have documented well the continuing shortfalls in service use by the rural poor and elderly and the Southern poor.[2] Medicaid eligibility requirements and coverage patterns continue to vary enormously among the states. And Medicaid, like other income-related social welfare programs, has created serious "notch" problems; an individual who barely fails to meet eligibility requirements receives no benefits but an otherwise identical individual who does meet those requirements may enjoy an extensive array of services. The largest

group of those affected by such "notch" problems, and the one that raises the most compelling issue of public policy, are poor children in two-parent households in the majority of states where only poor children in one-parent households are eligible for Medicaid.

Indeed, the availability of Medicaid for the poor has, in a perverse sort of way, exacerbated the access problems of those who are not poor (by a state's Medicaid eligibility definitions) but nearly so. Twenty-five million Americans have no health insurance; a large proportion of that number are the near-poor, and the uninsured are disproportionately (compared with the general population) rural and disproportionately black. The uninsured are younger than the rest of the population, but not apparently healthier.[4] Although specific data linking income, insurance status, and service use are not readily available, the poor now use health services of all kinds more than the near-poor. Indeed, the curve plotting income versus service use describes a rather wide and somewhat lopsided "U," with the highest use among the poorest and the wealthiest, and the lowest use among the almost poor.[2]

Notwithstanding these concerns, Medicare and Medicaid have contributed to an enormous shift in relative patterns of service use. At the same time, however, they have also contributed to the enormous inflation in health care costs that now bedevils policymakers. Some of this cost increase was anticipated; certainly, those who worked for their enactment expected that Medicare and Medicaid would engender increased utilization of services by their beneficiaries—which was what they were intended to do—and some argued that such an increase in demand, in the face of a relatively fixed supply of facilities and professionals, would have an additional inflationary impact. No one foresaw, at least not in writing, how severe the inflation would be.

The extent to which Medicare and Medicaid have independently contributed to cost inflation in health services, apart from a variety of other inflationary causes, is a subject of considerable debate. Hospital costs began increasing at a rate higher than overall inflation *before* 1965, and have continued to grow far faster than the increase in Medicare utilization.[5] Yet peculiarities of Medicare and Medicaid reimbursement policies have undoubtedly had an independent inflationary effect.[6] The supply of physicians has increased dramatically over the last decade as an outgrowth of policy decisions largely independent of Titles 18 and 19; because the growth of physician supply has outpaced the growth in service use, fees have risen according to the rather peculiar, supply-driven economics of medical care. Medicare and Medicaid have ridden on the tail of the cost-inflation tiger, although they have undoubtedly given it an occasional pull or two as well.

It is clear that most efforts to contain the program costs arising from the compounded effects of increased utilization and increased prices have involved service reductions or the imposition (or reimposition) of other barriers to access rather than direct attempts to control prices or increase efficiency. That has been the case with Medicaid in particular, where cutbacks in eligibility and service coverage began as early as 1967, and where "cost containment" has almost always referred to program cost containment.[7] Whether or not Medicare and Medicaid are primary causes of the inflation in health care costs, inflation has been a primary cause of limitations on their impact.

The Erosion of Access

Largely because of cost inflation, the improvements in access achieved by Medicare and Medicaid by the mid-1970s may have represented the high-water marks of such improvements, and the tide may have begun to recede even before last year's election. Medicaid enrollment fell between 1975 and 1979, despite general economic stagnation and increases in the population. Certainly, in most states, income eligibility standards for Medicaid have not increased nearly as fast as inflation. The most dramatic case is that of New York, with the nation's largest Medicaid program, where eligibility standards were essentially not changed between 1974 and 1980.*

As the population ages, Medicare enrollment continues to increase, but the proportion of all health expenditures for the elderly paid by it has fallen continually—to roughly 40% in 1978 (although another 20% of health care costs for the elderly is borne by other public programs, primarily Medicaid).[8] That phenomenon arises primarily from the falling proportion of physicians who accept Medicare assignment (payment in full) and the increasing proportion of long-term care costs, especially for nursing homes, in health expenditures for those over 65.

These aggregate figures conceal more than they reveal about problems in the accessibility and availability of health services, however; to get a fuller picture of those problems, a more detailed, descriptive approach is necessary, one that separately records the variety of persistent and new barriers to the receipt of services.

The Urban Poor. Although Medicaid led to a substantial increase in the quality of services received by the poor, it had a less dramatic effect on the character of the services delivered—

*For an extended discussion of this topic, see BC Vladeck, W Carr, *Health Policy*. In: SETTING MUNICIPAL PRIORITIES, 1982, R Horton, C Brecher, eds. (New York: Basic Books).

the "two-class" system of urban medical care has never been entirely eliminated. More recent program cutbacks have begun to lead to a return to past patterns of differential kinds of services for the poor and near-poor. Historically, the urban poor have been much more reliant on hospital-based or freestanding clinics—as opposed to private practitioners—for outpatient services, and public rather than private hospitals for inpatient services. In the early years of Medicaid, these patterns were altered, and use by those eligible for Medicaid of both private physician visits and private hospitals increased dramatically. But physician fee schedules in most of the larger Medicaid programs have been increased only slowly, if at all, over the last decade, and private physicians—like pharmacists, banks, and supermarkets—have been part of the general migration of services from inner-city areas. In many parts of the country, therefore, the urban poor are once again reliant on clinic services.

Apart from whatever esthetic differences such a pattern might imply, the fact remains that the poor—and to an even greater extent, the near-poor, who lack even the limited access to private physicians Medicaid provides—have no continuing relationship with individual physicians. This means that access to other services resides in the hands of bureaucratic strangers. The poor and near-poor are more likely to be admitted to hospitals through emergency room than a scheduled admission, and more likely to be sicker when they are admitted. They are more likely to be treated by a foreign medical graduate, or a house staff physician still in training (often both) than a fully trained American graduate. Their drug prescriptions are written by physicians with less personal knowledge and understanding of the patients' characteristics and problems, and they are likely to be seen on a follow-up visit by a physician other than the one who treated them originally.

Moreover, particular institutions that the urban poor have traditionally relied on for care, which were "their" hospitals or clinics, have begun to disappear, creating problems of access even when the total volume of services in the community falls no faster than the population. Public hospitals have closed in Philadelphia, St. Louis, and New York, and inner-city private hospitals throughout the country have closed or relocated. The accelerating shrinkage of the inner-city population has meant that inpatient capacity has fallen less than inpatient demand in most cities, so the acutely ill poor person who appears in an emergency room is still likely to be admitted and treated, even if in a strange hospital. But the availability of non-emergency outpatient services in many cities is much more tenuous; if nothing else, longstanding patterns of care and service utilization are irrevocably disruptive by the closure of a Philadelphia General or Homer Phillips Hospital, or the relocation of a Wilmington Medical Center.