Medical Xpress

The ethics of access: Comparing two federal health care reform efforts

February 20 2013

Two major health reform laws, enacted 25 years apart, both try to meet an ethical standard to provide broad access to basic health care. Neither quite gets there—but it's not too late for modern health care reform to bring the nation closer to a goal of comprehensive and coordinated care for all.

That's the conclusion of a commentary published in the new issue of the Journal of the American Medical Association by a team of University of Michigan Health System physicians.

The authors – a family physician, an emergency physician and a primary care pediatrician/internist – take a hard look at the implications of the ethical standard set in 1986 by a law that mandated universal access to emergency care. They assess the ability of both that law, and the Affordable Care Act of 2010, to meet the standard of providing access to basic health care to all who live in the United States. They conclude that both laws fall short of that standard.

But, by learning from the quarter-century of the nation's experience with the emergency care law – called EMTALA – they say the current Congress and administration may still be able to implement and tweak the ACA so it comes closer to the public's ethical expectations.

The crux of the issue, they write, is that the ACA doesn't ensure access to preventive care for all, nor coordination among all types of health care. An estimated 30 million people will still be without insurance even

after all of its provisions take effect.

"Health care in the U.S. is sometimes treated as a right and sometimes as a privilege," says U-M health care policy researcher Katherine Diaz Vickery, M.D., a Robert Wood Johnson Foundation Clinical Scholar who also sees patients at U-M's Ypsilanti Health Center. "When we compare EMTALA and the ACA, we see that while emergency care is treated as a right, primary care, it seems, is treated as a privilege."

EMTALA focused on taking care of individuals in urgent or emergent situations, and did not address how to make all people in the U.S. healthier, say the authors. They cite the need for a balanced health care system that focuses on both illness and wellness, and allows patients and providers the chance to work together to prevent illness and save money.

Co-author and U-M emergency medicine physician Kori Sauser, M.D., notes that while the ACA comes closer to changing that perspective, it does not go far enough.

"As the provisions of the ACA kick in, millions more people will have access to primary care providers and preventive services like vaccinations and routine screenings for high blood pressure and cancer," says Sauser, who is also a RWJF Clinical Scholar. "Even so, demonstration projects haven't convinced us that patients will choose primary care offices over the emergency department for their acute care. A major missing piece in the ACA is in failing to determine how to connect emergency care with primary care resources in ways that meet patients' needs."

EMTALA, which requires hospitals and providers to evaluate, stabilize and provide basic lifesaving treatment to any patient who comes to an emergency department or is in active labor, was passed during President Ronald Reagan's administration. It does not allow a patient's ability to

pay to be considered during emergency care.

Its ethical core, to ensure access to care in medical emergencies, includes an acknowledgement of "community responsibility" and "historic standards" in health care.

But in the years since, it has led patients who do not have insurance or the ability to pay for care out of their pocket to rely on emergency rooms for care. That in turn has burdened hospitals and led to spending that doesn't take advantage of potentially cost-saving primary and preventive care.

The authors note that ACA does not expressly lay out the way to integrate the emergency and primary care worlds in a way that ensures access to care—what the authors call a major oversight.

And, at the same time that the ACA is being implemented, payments to hospitals to fund care for the uninsured are being decreased—in spite of estimates that 30 million people will remain uninsured in 2020.

The authors conclude: "Ultimately, the ability of the US health care system to satisfy the ethical obligation to ensure access to care—first codified in EMTALA—will be a core measuring stick for the success of the ACA and for any future reforms."

The article grew out of discussions that Vickery and Sauser had with Matthew Davis, M.D., M.A.P.P., who is co-director of the RWJF Clinical Scholars program at the University of Michigan and holds faculty positions in the U-M Medical School and U-M Gerald R. Ford School of Public Policy.

Vickery, who had previous experience treating undocumented immigrants at a Federally Qualified Health Center, notes that the issue

of access to primary care for that population, and for others who will not become insured under the ACA, still needs to be addressed. She recalls instances where patients had to be hospitalized for severe complications of diabetes that had never been diagnosed or controlled, because their only health care access came through emergency rooms.

On the flip side, Sauser notes that not having to consider someone's insurance status in the ER feels like a "luxury" – but that every day she sees a need for better ability to coordinate the care of a patient who has been seen for an emergency.

Both say that the accountable care organization, or ACO, model of care encouraged under the ACA may help patients within ACOs get access to more coordinated care.

By looking back at lessons from EMTALA – which will continue to be the law of the land even under the ACA – they hope to inform policy makers and health leaders who are working to implement or introduce potential changes to the ACA.

More information: *JAMA*, Vol. 309, No. 7, pp. 665-666 jama.jamanetwork.com/article.a … px?articleid=1653529

Provided by University of Michigan Health System

Citation: The ethics of access: Comparing two federal health care reform efforts (2013, February 20) retrieved 25 April 2024 from https://medicalxpress.com/news/2013-02-ethics-access-federal-health-reform.html

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