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HOUSTON LAW REVIEW

FOREWORD

NONFINANCIAL BARRIERS TO HEALTH CARE

*Thomas Wm. Mayo**

Health care policy traditionally has been seen as a three-legged stool. Three interdependent variables—cost, quality, and access—have largely defined the domain of health policy.¹ Ignore one of the variables, and the stool topples.² It is not surprising, therefore, that health care policymakers have tended to view the problem of access to health care resources primarily in economic terms.³ Economic analysis of the access problem is useful because it gives policymakers a common methodology, vocabulary, and set of analytical tools that provide insights into the related problems of cost containment and quality, as well as the access issue. This in turn provides insights into the economic tradeoffs that each variable entails for the

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1. See, e.g., COST, QUALITY, AND ACCESS IN HEALTH CARE: NEW ROLES FOR HEALTH PLANNING IN A COMPETITIVE ENVIRONMENT 2 (Frank A. Sloan et al. eds., 1988) (arguing that health policy in the United States has emphasized access and quality to the detriment of cost control); THEODORE R. MARMOR, UNDERSTANDING HEALTH CARE REFORM 14-15 (1994) (recognizing the need to improve the balance among these variables while warning that improving one may harm the other two).

2. MARMOR, *supra* note 1, at 14 (asserting that "[w]e cannot solve one problem without attending to the other two").

3. See, e.g., *id.* at 6-14 (reviewing 60 years of health reform proposals concerning health insurance, financing mechanisms, budget processes, and spending controls).

other two.

After defining, measuring, and analyzing access in economic terms, economic analysis naturally tends to frame solutions in economic terms. Thus, in the Great Health Care Debate of 1994,⁴ the competing proposals to provide near-universal access to health care were primarily economic—for example, insurance reform, vouchers and tax credits, and medical savings accounts.⁵ Conventional, or political, wisdom told us that altering the rules of health insurance, revitalizing competitive markets for health services and health insurance, or replacing competitive markets for insurance with a single-payer plan might hold the key to expanded access.

Imagine, if only for a moment, that the Great Health Care Debate of 1994 had not sputtered and ultimately fizzled out. Suppose the financial barriers to health care had been removed and the ability to pay was no longer a factor in the cost-quality-access puzzle. What nonfinancial barriers would still impede access to health care goods and services? This question, or a similar one, was presented to the Texas Legislature, resulting in a grant to support a study on this issue. This study yielded the splendid report *Nonfinancial Barriers to Health Care in Texas*,⁶ as well as a conference⁷ and papers from which the articles for this Symposium issue of the *Houston Law Review* were derived. In light of the failure to enact the 1994 health care reforms and with economic relief nowhere in sight, the topic of noneconomic barriers to health care is more timely than ever.

The *Nonfinancial Barriers* report deserves to be reviewed carefully by all who are concerned with the access question, not only in Texas but nationwide. Texas is a state of great contrasts and great diversity. It has large, populated urban centers, as well as many rural communities and vast expanses of undeveloped land.⁸ The state boasts medical facilities,

4. See Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1334 n.59 (1995) (noting the difficulties of passing health care legislation, as discovered during the health care debate of 1994). Not everyone agrees that there was a "great health care debate" at all. E.g., Daniel Yankelovich, *The Debate That Wasn't: The Public and the Clinton Plan*, HEALTH AFF., Spring 1995, at 7, 10.

5. See generally MARMOR, *supra* note 1, at 4-14 (recounting the history of health care reform).

6. UNIVERSITY OF HOUSTON HEALTH LAW & POLICY INSTITUTE, NONFINANCIAL BARRIERS TO HEALTH CARE IN TEXAS: REPORT TO THE TEXAS LEGISLATURE (1995) [hereinafter NONFINANCIAL BARRIERS].

7. The Health Law and Policy Institute of the University of Houston sponsored a conference on nonfinancial barriers to health care in Houston, Texas, February 16-17, 1995.

8. See NONFINANCIAL BARRIERS, *supra* note 6, at 2 (noting that, as of June

providers, and educational systems that are world-class,⁹ while 56 of its 254 counties have two or fewer physicians.¹⁰ The state is racially, culturally, and ethnically diverse.¹¹ Texas, in short, provides an opportunity to study nearly every nonfinancial barrier to health care imaginable.

As a Baedeker for these barriers, the report depicts the breathtaking complexity of the nonfinancial obstacles to obtaining needed health care. The two longest chapters examine the supply and (mal)distribution of health care services and providers¹² and health transportation in Texas.¹³ The obstacles to overcoming these barriers are impressive: a mix of public and private interests and behaviors; sometimes competing federal, state, and local governmental policies that discourage coordinated, comprehensive solutions; and competing private interests of often great intensity.

This report provides ample evidence that access to health care was seldom a concern when many of these patterns and behaviors were developing. Physician shortages, for example, are a function of maldistribution across geography and medical specialties.¹⁴ The factors that historically have influenced physicians' choice of medical specialty—prestige, the structure of and financial incentives within medical schools, personal financial incentives, and personal values—tend to direct medical students away from primary-care practices in rural and other medically underserved areas.¹⁵ Improving patient access is low on the list of reasons that motivate physicians in these choices.¹⁶

1994, rural counties cover 213,297 square miles, almost 80% of the state, and that 16% of the 18,278,694 Texas residents live in rural areas).

9. See Chuck Appleby, *Health Care's New Heavyweights*, HOSPS. & HEALTH NETWORKS, May 5, 1995, at 26, 30 (noting that the city of Houston is the home of the Texas Medical Center, a world-class medical complex containing several nursing schools and two medical schools and employing 55,000 people).

10. See NONFINANCIAL BARRIERS, *supra* note 6, at 5 (noting that 20 counties have no physician, 17 counties have only 1 physician, and 19 counties have only 2 physicians). In addition, 25 counties lack direct patient care, 35 counties have no dentist, and 57 counties have no hospital. *Id.* at 6-8.

11. See *id.* at 190 (reporting that 60.8% of Texas residents are Anglo, 24.8% are Hispanic, 11.7% are African-American, and 2.2% belong to some other racial or ethnic group).

12. See *id.* at 1-90.

13. See *id.* at 126-89.

14. See *id.* at 2-3 (asserting that health care availability is not merely a function of numbers, but that practice specialties, geographical distribution of physicians and hospitals, and the backgrounds of medical providers play a part in determining the sufficiency of medical care).

15. See *id.* at 32-39.

16. See *id.* at 38 (reporting that lifestyle and economic issues predominate in

Medical students and physicians, moreover, are hardly alone in their historical disregard of patient access issues. Public policies and laws that historically have limited the growth of alternative health care practice¹⁷ and the evolution of a complex and fragmented health-care delivery system in both the public and private spheres¹⁸ are further evidence that the system too often is driven by factors that at best disregard their impact on access and at worst frustrate attempts to expand access through either systemic or incremental reforms.

Beyond such structural barriers to health care, personal access barriers reflect, if anything, even more deeply rooted attitudes and patterns of behavior that transcend the problem of access and even the subject of health care itself. The report documents patterns of discrimination, as revealed by the disparate impact of various personal characteristics upon individuals' access to health care: culture, language, and ethnicity¹⁹ and socioeconomic status, race, gender, age (both children and the elderly), immigrant status, and the like.²⁰

The Articles in this Symposium address both systemic and personal barriers to health care and provide ample proof of the complex and often subtle characteristics of nonfinancial barriers. Lori Andrews makes a strong case for expanding our use of alternative health care providers as a means of increasing access to needed health care.²¹ Against a backdrop of active physician opposition to such an expansion, combined with the cooperation of legislators and regulators, hospital administrators, and insurers, Professor Andrews argues for state law

medical student's choice of practice area). *But see id.* (recognizing a recent trend towards more altruistic ideals by medical students). Some of these same factors now may be moving more of today's medical students to prefer primary-care practices over the specialties. *See Turning to Primary Care: Cost-Effective Use of General Practitioners*, 346 LANCET 111, 111 (1995) (noting that the percentage of U.S. medical students choosing primary care has doubled from 14.6% three years ago, at least in part, because of improved career prospects).

17. *See* NONFINANCIAL BARRIERS, *supra* note 6, at 68-71.

18. *See id.* at 91-107.

19. *See id.* at 190-232. After careful review of the literature, surveys, and interviews, the report states that, "other than language barriers, the respondents were not able to articulate explicit examples of the cultural practices that limit access to medical services." *Id.* at 228. However, "advocates and providers perceive cultural practices as potential barriers to health care." *Id.* at 229; *see also* Margaret Harrist, *¿Qué esperan los Hispanos de los servicios de salud? [What Do Hispanics Expect from Health Care?]*, HEALTHTEXAS, Aug. 1995, at 1, 5 (reporting on a recent study that found language differences to be a significant barrier to health care for Hispanics).

20. *See* NONFINANCIAL BARRIERS, *supra* note 6, at 233-73.

21. *See* Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273 (1996).

reform and wider judicial acceptance of the notion that the constitutional right of privacy embraces the right to choose an alternative health care provider.²²

Marc Rodwin addresses another structural nonfinancial barrier—the rise of managed care.²³ Managed care organizations use a mixture of financial incentives and structural barriers to reduce the availability of potentially beneficial care.²⁴ Beyond these features, however, managed care organizations can promote an “organizational pathology” that subverts access.²⁵ Once in a managed care plan, consumers may find their range of choices restricted in a variety of ways they had not anticipated and are powerless to change.²⁶ Professor Rodwin offers a comprehensive critique of existing consumer protection initiatives²⁷ and considers the significant role that government policy must play until consumers are able to organize effectively their efforts to tame the excesses of managed care organizations.²⁸

Karen Rothenberg’s contribution to this Symposium addresses a nonfinancial barrier related to personal characteristics of the consumer—gender.²⁹ A powerful and growing consumer movement is challenging many of the gender biases that limit women’s treatment choices,³⁰ and the nature and extent of these gender-based treatment biases continue to be studied and documented.³¹ Professor Rothenberg contributes to this effort by documenting the systematic exclusion of women from medical research and by demonstrating the powerful link

22. See *id.* at 1308-17.

23. See Marc A. Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319 (1996).

24. *Id.* at 1328.

25. *Id.* at 1329.

26. *Id.* at 1331.

27. *Id.* at 1344-59.

28. *Id.* at 1359-74.

29. See Karen H. Rothenberg, *Gender Matters: Implications for Clinical Research and Women’s Health Care*, 32 HOUS. L. REV. 1201 (1996).

30. See Emily Friedman, *Money Isn’t Everything: Nonfinancial Barriers to Access*, 271 JAMA 1535, 1535 (1994) (noting that debates over cesarean sections, less aggressive treatments of heart disease in women, and the merits of lumpectomy and mastectomy recently have become publicly debated political issues).

31. See, e.g., Beryl Byman, *Less Than Equal Treatment: Women Battle Sex Bias in the Health Care Arena*, MINN. MED., Jan. 1992, at 16, 17-18 (reporting that women with end-stage renal disease receive fewer kidney transplants than men with the same condition because of “society’s stereotype that men’s social worth is greater than women’s”); Dina Wilke, *Women and Alcoholism: How a Male-as-Norm Bias Affects Research, Assessment, and Treatment*, 19 HEALTH & SOC. WORK 29, 29 (1994) (acknowledging the dearth of research concerning alcoholism in women).

between that exclusion and gender-based treatment biases.³² After reviewing the constitutional and statutory arguments against such exclusion, Professor Rothenberg identifies areas of federal human-research policy that continue to be contradictory or incomplete.³³

The Articles in this Symposium point unambiguously toward some central truths about the problem of nonfinancial barriers to health care. Although achieving a national consensus on an economic answer to the problem of access continues to be difficult, nonfinancial barriers may prove the hardest of all to overcome. All of the barriers that this Symposium's authors address are deeply embedded in social and cultural patterns of belief and behavior. As such, they are often harder to identify and are impervious to an economic quick fix.³⁴ Moreover, any solution will challenge many political, social, economic, and psychological "truths" that we as a society have constructed for ourselves. This Symposium, and all of the related work of the University of Houston's Health Law and Policy Institute, is an ambitious and necessary first step toward the

32. Rothenberg, *supra* note 29, at 1205-41.

33. *Id.* at 1242-71.

34. Two additional examples from the medical literature make this point. First, a recent report in the *Journal of the American Medical Association* discusses "physicians' knowledge and beliefs regarding communication with deaf people and compare[s] their knowledge and beliefs with [their] methods of communicating with deaf patients in their practices." David A. Ebert & Paul S. Heckerling, *Communication with Deaf Patients: Knowledge, Beliefs, and Practices of Physicians*, 273 JAMA 227, 227 (1995). Physicians' practices and beliefs were seen as having a bearing on the quality of physician-patient communication. *See id.* at 228 (revealing that incomplete communication with deaf patients may result from physicians' tendency to abbreviate messages and from many deaf patients' lower level of proficiency in spoken and written English). Most physicians, however, apparently undervalue the impact of these differences upon the accessibility of health care. *See id.* at 229 (recognizing that many physicians may not use sign language interpreters because of cost, even though other means of communicating with a deaf patient may be insufficient).

Second, cultural differences may also drive a wedge between patients with traditions that do not value individual autonomy and modern Western physicians who do. *See* Leslie J. Blackhall et al., *Ethnicity and Attitudes Toward Patient Autonomy*, 274 JAMA 820, 820-21 (1995) (discussing the attitudes of Korean Americans and Mexican Americans toward the Western model of informed consent and a patient's right to decide on the use of life support during terminal illness); Joseph A. Carrese & Lorna A. Rhodes, *Western Bioethics on the Navajo Reservation: Benefit or Harm?*, 274 JAMA 826, 826 (1995) (reporting on a study of Navajo attitudes toward disclosure of bad news to patients). Carrese and Rhodes suggest that candid discussions of the risks of medical treatment may be perceived as not helpful and even harmful by patients from these non-Western backgrounds. *Id.* Within an existing physician-patient relationship, such candor may interfere with effective communication and undermine the patient's trust in the physician. Additional studies are needed to determine the extent to which the denial of culturally appropriate medical care might create a barrier to health care that is as real as language, race, and gender.

development of answers to “one of the great unsolved social policy questions of the century.”³⁵

35. Donna E. Shalala, *Federal Efforts to Remove Nonfinancial Barriers to Health Care*, 32 Hous. L. Rev. 1195, 1200 (1996).