

American Medical Women's Association  
Position Paper on Principals of Universal Access to Health Care & Health System  
Reform

**Introduction**

Since 1915, the American Medical Women's Association, an organization of women physicians and medical students, has supported improved delivery of health care. AMWA has been, and continues to be, an active voice for universal access to health care. In 1990, AMWA passed its first resolution addressing this matter and became a national advocate for reforming the health care system in America. We need to reopen the debate on how to remedy the many flaws in the current American health care system. It is important to emphasize that lack of universal access to effective health care is the major impediment to improved health for many residents of our nation.

**The System**

The reimbursement system of public and private payers excludes an ever increasing number of people, over 43.4 million uninsured people in 1997, for whom no reasonable health insurance policies are available. Millions more have marginal, inadequate, or intermittent coverage.

Many reasons exist for people being uninsured: employers who do not provide health insurance for any employees; employers who provide insurance only for full-time employees; increasing numbers of people who work less than full-time, or work in temporary jobs without benefits; self-employed who can not afford private insurance; job changes and waiting periods for eligibility; pre-existing medical problems; divorce; and persons who do not believe they will need insurance.

The proliferation of managed care plans since 1992 has failed to solve the problem of lack of access to health care. New problems have been created by payer efforts toward cost containment: restriction of patient choice of physician; lack of continuity of care when the employer arbitrarily and frequently changes plans to save money; interference with physician autonomy over clinical management of patients; decrease of physician time with patients; confidentiality and anti-trust issues; and lack of parity for psychiatric care.

In spite of efforts to improve reimbursement for primary care services, the system remains tilted toward reimbursing procedures and highly specialized services, while neglecting proper attention to basic primary care, preventive care, and early disease detection. Furthermore, lack of parity in reimbursement for the delivery of mental health services and chemical dependency treatments remains a significant barrier to care. In addition, the system constrains access to appropriate primary care for uninsured persons while allowing

unrestricted access to emergency departments. No federal policy currently addresses universal access to provide for this safety net. Mechanisms to ensure primary care access could decrease overcrowding and delay in our nation's emergency departments.

### **The Physician**

Only one third of the United States physicians are in fields delivering primary care (family medicine, internal medicine, and pediatrics). The proportion of students choosing these fields has been increasing in recent years. However, students are also attracted to higher paying specialties to aid in paying off the large educational debt that most students now accrue. Furthermore, most of their role models in medical school are specialists, who utilize the newest and most costly technology to care for critically ill hospitalized patients. Although medical school curricula have increased exposure to ambulatory, primary, and preventive care, most rotations are still hospital based. The practice and business of medicine have become more complex. The thousands of different insurance systems, multiple and competing review procedures, and piecemeal coverage, all force physicians to spend increasing time on paperwork instead of patient care. This is an inefficient use of the time of highly trained professionals, and physician frustration has resulted in loss of practitioners through early retirement, changes to other professions, or restrictions in scope of practice.

### **The Expense**

The expense of medical care in the United States is still increasing. Health plans have increasingly extracted savings and profits by decreasing payments to physicians and hospitals, as well as by decreasing services to patients. Specialty care may be associated with costly tests and procedures. Medical technology has advanced significantly with more complex and expensive diagnostic and therapeutic modalities. Patients who have not been able to receive preventive care or attention at the early stages of disease then become desperately ill and require significantly more costly treatment. Patients who do not receive primary care at a physician's office or clinic continue to go to hospital emergency rooms for minor illnesses. Not only is this an expensive, inefficient, and piecemeal modality for such care, it disrupts the primary purpose of the emergency room leading to overcrowding and possible injury to severely ill patients because of delays in treatment. Rapidly rising prescription drug costs add a significant burden to patients and drive up premium costs.

### **The Payers**

As the expense of health care delivery has increased, payers for medical care --- government, insurance companies, health maintenance organizations, and employers --- have tried to control costs. These efforts have generated adverse effects on both patients and health care providers. Patients are excluded from care

because they are sick, or have been sick. People with pre-existing conditions cannot get coverage; some people fear changing jobs because they will be disenfranchised from health care. The introduction of the insurance principle of generating profit by catering to a low risk population perverts the fundamental public health mission of caring for all in need and preferably intervening as early as possible in disease states.

Efforts to control costs by the government or private insurers have resulted in intrusive interference with medical decision-making, impairing the physician-patient relationship and the quality of medical care. Some payments in the Medicaid and Medicare systems are so low that physicians either treat patients without charge or discontinue treating these patients altogether, another mechanism for further denial of care.

Many health plans do not cover screening for malignancies or for infections such as sexually transmitted diseases. This ultimately adds to the cost of health care when diagnoses are made later in the disease process and complications develop. Lack of access to early psychiatric evaluations creates a similar problem and also contributes to heightened and unnecessary suffering when psychological aspects of all disease processes are not addressed.

### **Medical Liability**

Another factor that greatly increases the cost of medical care is the way states deal with medical liability and malpractice. High contingency fees for lawyers, jury trials, and unlimited awards for pain and suffering all contribute to extremely high liability insurance premiums. Physicians and medical groups must absorb these increased premiums and may practice "defensive medicine," ordering procedures and tests that might not be deemed initially necessary for the patient. This system does not prevent malpractice nor does it necessarily punish physicians who practice in an unacceptable manner. Health plans shift all the responsibility and cost for malpractice to the individual physician although many claims result from policies and denials imposed by the plan's utilization management process, which is beyond the control of the physician.

### **Fraud**

Fragmentation of payment for medical care and current policies for monetary control make it difficult to know what overall expenditures for health care are and whether or not they are effective. Payments for specific procedures have led to fraudulent activities as well as erroneous billings in many sectors of the medical care community. "Medicaid mills," abuses of psychiatric and chemical dependency hospitalization, exploitation of geriatric care, or the promotion of medical equipment to Medicare patients, work to the detriment of those with genuine medical need and drive up the costs for everyone.

## **Confidentiality**

Physician-patient confidentiality has been severely eroded by the inappropriate access to medical records by health plans for administrative purposes and inquiries relating to utilization review. The possible release of patient information to payers may cause patients not to seek necessary and effective care due to the fear of lack of confidentiality and/or loss of medical coverage.

## **Goals for Reform**

### **1. Universal Access to Health Care:**

Access to health care should not be linked to a person's employment, place of residence, sex, age, marital status, or health status. Health care should be available to all persons on the basis of medical need rather than financial ability or employer contracts.

### **2. Comprehensive Care:**

Available care should be appropriate to the needs of the individual and society. It should emphasize basic primary care, prevention, early detection, chronic care, mental health, and chemical dependency treatment as well as acute and specialty care.

### **3. Distribution of Resources for Care:**

Geographical distribution and specialty mix of physicians should be adjusted to meet the health care needs of the public. Distribution of tertiary care centers and diagnostic equipment should be directly related to the health needs of the population.

### **4. Oversight Reform:**

Oversight mechanisms need to be restructured, separating direct day to day patient care from more global monetary matters. The medical profession should structure and supervise oversight of decision making about direct patient care.

### **5. Planning, Oversight, and Data Monitoring:**

Comprehensive data analysis is essential for planning and implementing a universal health care plan with equal access for all persons, including a basic benefit package. A unitary payment system would reduce administrative expenses and also facilitate data collection on health care. These data could be used to monitor the overall health of the country, public health initiatives and costs. These data could also be used to improve the geographic and specialty distribution of medical care.

## **6. Payment Mechanisms:**

Payment systems should be simplified for patients and physicians. An access card issued to each person, presented to the health care provider when services are provided, could lead to automatic reimbursement for the provider.

## **7. Medical Liability:**

The medical liability system should be restructured so that injured patients receive fair restitution; physicians who are incompetent or negligent should receive further training to correct their faults or be removed from practice. Alternative methods to the tort system, such as arbitration, should be used. Utilization management decisions should be subject to medical liability claims.

## **8. Funding for Graduate Medical Education:**

All participants in the health care system ultimately benefit from the training of future physicians, yet most of the cost of graduate medical education is borne by Medicare. All payers in the health care system should share equally in funding graduate trainees.

The American Medical Women's Association recognizes that reforming health care in the United States is complex and challenging. American society is multicultural with many levels of need. Success in reaching health goals may depend on effective outreach to disparate groups and such nonmedical elements as improvement in educational attainment in individuals and the community. With these factors in mind, AMWA specifically endorses the following priorities to be implemented immediately.

1. Universal access to health care for all pregnant women including prenatal and obstetrical care throughout pregnancy, delivery, and postpartum care.
2. Education and care for reproductive health in females and males, beginning with age-appropriate sex education, contraception, abortion, and protection against sexually transmitted diseases, particularly AIDS.
3. Universal access to care for all children to age twenty-one, including visits, immunization, dental care, acute care, psychiatric care, and chemical dependency treatment.
4. Equal access for all persons to cost-effective interventions and early detection programs based in the community, the workplace, and public and private health care plans. This access should include immunizations, pre-natal care, screening tests, and interventions appropriate to the patient's age and health risk.
5. Increased availability of scholarships, low or interest-free loans, the National Health Service Corps and other loan forgiveness programs for medical students, and required primary care rotations in medical curricula, to encourage a higher proportion of students to enter primary care.

6. Rapid approval for innovative state Medicaid programs that address the problems of access and more equitable delivery of health care. The efficacy of these programs should be evaluated and further reforms made on the bases of lessons learned from the outcomes of these studies.
7. Formation of medical and consumer groups supporting universal health care. Promotion of discussions of equal access to health care in order to increase public awareness and support for universal health care. Encouragement of physician support and physician leadership roles in proposing workable solutions to these problems. Proposing criteria for a universal health care plan with the understanding that incremental reforms will be necessary to reduce the number of uninsured persons and improve access in the interim.

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