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HEALTH CARE AND POVERTY - PART 2

by Pamela Tellew

Is there a health care safety net? What kind of health care is available to the 40 million uninsured Americans and to those "poor enough" to be eligible for Medicaid?

People who still receive Medicaid have great need for medical care because of the adverse health effects and higher incidence of chronic illness associated with poverty. For the many poor who are uninsured (and for the Medicaid recipients who can't get to a government approved provider), low cost outpatient and preventive care is usually unavailable. Those in poverty and those who are uninsured thus tend to obtain much of their medical care from the emergency rooms of public hospitals, only when the health problem has become an emergency. Public emergency rooms routinely report that they deliver babies to women who have received no prenatal care, and care for diabetics who don't take medication solely because they can't afford it. Several studies have found that a large portion of the uninsured forego recommended medical care, including hospitalization and prescribed drugs, for financial reasons.

Medicaid Cuts -- The adverse health effects of cuts in Medicaid have been documented. In 1982, California eliminated some 270,000 "medically indigent adults" from its MediCal rolls. "Medically indigent adults," or MIAs as they are called, are people who do not fit into one of the federal government's eligibility categories (including AFDC, the blind, and the permanently disabled) but who are too poor to afford private health insurance. The 1982 reforms transferred responsibility for MIAs to the county governments, which were already in dire financial straits following Proposition 13.

While the quantity and quality of care provided to MIAs varies from county to county, in all counties the transfer resulted in confusion and disruption of services. A **New England Journal of Medicine** study of the MIA transfer compared MIAs with a control group which remained on MediCal. Following MediCal termination, fewer MIAs had a regular source of medical care, more had higher blood pressure, more had uncontrolled diabetes, and more had poorer health generally.

Even among patients still eligible for MediCal there have been adverse health effects. Changes in MediCal which required patients to pay more of their own money have led to patients waiting longer until health problems are more severe, before seeking treatment. In addition, MediCal now requires prior authorization before many services are performed and patients face nervewracking and sometimes dangerous waits for treatment.

"Dumping" -- The poor are having a more difficult time finding medical care. As Medicaid reimbursement rates have fallen farther and farther behind physicians' "usual and customary" charges, more and more physicians are refusing to treat Medicaid patients. Relatively few health care providers are left with the burden of caring for the vast majority of poor patients. Medicaid reimbursements often do not cover the costs of treating these patients.

Private health care providers routinely refuse to treat uninsured patients, except in emergencies. Studies have shown that when patients are refused treatment at one facility, most do not get needed treatment anywhere else. Even in emergencies, the uninsured cannot count on receiving care. Newspapers are full of reports of private hospitals "dumping" emergency patients who are suspected of being uninsured on already overburdened public hospitals. At Chicago's Cook County Hospital, for example, there has been a 500 percent increase in emergency room transfers from private hospitals since 1980. In Alameda County,

legislative action has followed incidents of private hospitals "dumping" seriously injured or unstable patients without first stabilizing them.

Poor and non-poor receive medical treatment in separate and usually unequal facilities. Public hospitals and clinics provide most of the treatment for the poor. Many are under staffed and under funded. San Francisco General, for example, recently closed one of its hospital wards because of coun budget cuts. Those who have a choice seldom go to a public hospital. Public hospitals average only 13% of their revenues from private insurance, while the rest comes from government funding and whatever the poor can afford to pay out-of-pocket. Although precise numbers are unavailable, more than 100 public or voluntary hospitals have closed in recent years. Some of these have been purchased by the big hospital chains. Many public hospitals face a continuing funding crisis and have tried to get the federal government to step in to resolve the problem.

Leaving Health Care to the Market -- The federal and most state governments, caught up in deregulation mania, have been unwilling to resolve this health care crisis through direct intervention. Governments have instead become preoccupied with "cost containment." Eager to stop the abuses that stemmed from the simple cost-plus-profit reimbursement system of public and private insurance, both government purchasers of health care and private health plan purchasers have experimented with various "cost containment" efforts. While the intent is to use the pressure of competition to induce the health care industry to reduce costs, the result has often been simply to shift costs from one group of consumers to another.

The Reagan Administration has claimed that health care cost containment will only come from increased competition in the health care industry. Presumably, if consumers (including the government purchasers of health care for the poor and the aged) are more "cost conscious," health care providers will have to control costs to compete for customers. The Reagan Administration has even attempted to tax workers' health benefits, claiming that this will make workers more "cost conscious" health care consumers.

But instead of inducing providers to compete and to control their costs in the process, the policy changes and the funding cuts of the Reagan administration have only freed the private sector health care providers from past obligations for the poor. When hospitals began receiving fewer Medicare and Medicaid dollars, they reacted by cutting services to the poor and competing instead for guarantee high income clientele like plastic surgery patients.

High profits in health care in the last two decades led many profit making firms to enter the health care business. Over building of hospitals, followed first by a recession and now by concerted efforts at "cost containment" by governments and employers, have led to a profit squeeze. But the sqeeze did not lead to competitive reduction of costs; instead, it has brought about a wave of mergers which threaten to make health care a highly monopolized industry. The "big four" hospital chains now own or manage 12% of U.S. hospitals and experts predict that by the mid 1990s, 10 big chains will control 50% of the market. If this trend continues, it seems likely that consumers will be able to choose only between expensive health care and no health care. Even more foreboding is the probability that as the big chains gain market and political power, they will be able to dictate to governments the terms of health care for the poor, charging more for less service.

A two tier system of health care has been in place in this country for many years. Regulatory neglect and the changing structure of the health care industry threaten to erode still further the care that the poor receive. Current experiments have shown that leaving health care to the market means that an increasing part of our population will go without medical care altogether. Unless current policies are reversed, we will allow ourselves to become a nation of haves and have-nots of the cruelest kind.

-Pamela Tellew