CRACKS IN THE SYSTEM:
THE GAP BETWEEN THE EMERGENCY DEPARTMENT AND PRIMARY CARE

BY

CORNELIA HENDLEY

A Thesis Submitted to the Graduate Faculty of

WAKE FOREST UNIVERSITY GRADUATE SCHOOL OF ARTS AND SCIENCES

in Partial Fulfillment of the Requirements

for the Degree of

MASTER OF ARTS

Bioethics

August 2016

Winston-Salem, North Carolina

Approved By:

John C. Moskop, Ph.D., Advisor

Mark A. Hall, J.D., Chair

Stacie J. Zelman, M.D.
ACKNOWLEDGMENTS

I would like to thank the faculty and staff at the Wake Forest University Center for Bioethics, Health and Society. A special thank you to my advisor, Professor Moskop, for his time and constant patience, and to the other members of my committee, Professor Hall and Dr. Zelman. In addition, I would like to thank Professor Iltis, for introducing me to bioethics, and Vicky Zickmund, for helping me so often.

I would also like to thank my mother and Tyler Keith, for their unwavering support, as well as my classmates/friends, who kept me laughing both in and out of the classroom.

Finally, I would like to thank my father, for encouraging me to pursue this degree. I have learned an incredible amount in the past year, and I look forward to applying that knowledge in the coming years.
# TABLE OF CONTENTS

List of Abbreviations ........................................................................................................ iv
Abstract ............................................................................................................................. v
Introduction ........................................................................................................................ vi
**Chapter One: Legal Background** .................................................................................. 1
  - Emergency Medical Treatment and Active Labor Act .............................................. 1
  - The Patient Protection and Affordable Care Act .................................................... 7
**Chapter Two: Access to Emergency and Primary Care** .............................................. 19
  - Emergency Department Crowding ........................................................................ 19
  - Emergency Department Use Linked to Lack of Primary Care ............................... 22
  - Issues in Primary Care Access .............................................................................. 24
  - EMTALA, the PPACA, and Primary Care .............................................................. 29
**Chapter Three: Ethical Implications** .......................................................................... 32
  - What is a Right? .................................................................................................. 33
  - Support for a Right to Health Care ..................................................................... 35
  - Opposition to a Right to Health Care ................................................................. 39
  - No Consensus on a Right to Health Care ............................................................ 44
  - Health Care as a Social Ideal ............................................................................... 45
**Chapter Four: Recommendation & Solutions** ............................................................. 52
  - PPACA Provisions and Recommendations ......................................................... 53
  - Addressing the Primary Care Workforce Shortage .............................................. 59
  - Emergency Department Recommendations ....................................................... 66
**Conclusion** .................................................................................................................. 67
**References** .................................................................................................................... 69
**Curriculum Vitae** .......................................................................................................... 81
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAMC</td>
<td>Association of American Medical Colleges</td>
</tr>
<tr>
<td>ACSC</td>
<td>Ambulatory Care Sensitive Condition</td>
</tr>
<tr>
<td>AMA</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>COBRA</td>
<td>Consolidated Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>CMS</td>
<td>Center for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Active Labor Act</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
</tr>
<tr>
<td>GME</td>
<td>Graduate Medical Education</td>
</tr>
<tr>
<td>NHSC</td>
<td>National Health Services Corps</td>
</tr>
<tr>
<td>MSE</td>
<td>Medical Screening Examination</td>
</tr>
<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>PPACA</td>
<td>Patient Protection and Affordable Care Act</td>
</tr>
</tbody>
</table>
ABSTRACT

The recent implementation of the Patient Protection and Affordable Care Act (PPACA) in 2010 expanded health insurance coverage for millions of Americans, but many still lack access to appropriate and timely health care. Federal law grants Americans a legal right to obtain stabilizing treatment for emergency medical conditions, but many depend on the nation’s Emergency Departments (EDs) for more routine care. Patients who lack access to adequate primary care often seek treatment in the ED because they have no other options. As the PPACA is implemented, the US is moving toward more comprehensive health insurance coverage, but there must be a similar increase in access. In this thesis, I evaluate issues associated with crowded EDs and the shortage of primary care. I discuss the ethics related to governmental provision of health care and whether or not there is a universal right to health care. I argue that health care is a social ideal rather than a right and endorse the goals of the PPACA; however, I recommend several improvements to the Act and suggest additional changes to promote the efficiency and effectiveness of the US health care system.
INTRODUCTION

Since its first appearance in the 1960’s, the hospital Emergency Department (ED) has become an integral part of the US health care system. In 1986, Congress enacted the Emergency Treatment and Active Labor Act (EMTALA) as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). EMTALA requires that every patient with an “emergency medical condition” who presents to an ED at a hospital that receives federal funding be evaluated and stabilized, regardless of health insurance status.¹ Physicians and other health care professionals in the ED were now legally required to stabilize patients with “emergency medical conditions” in the ED, and patients seeking acute medical treatment could rely on the ED for stabilizing care.

Due in part to EMTALA treatment requirements, EDs have become a major venue for health care in the United States. In 2011, there were more than 131 million ED visits in the United States, which equates to about 421 visits for every 1,000 people.² Use of the ED is increasing, but the number of EDs has decreased since the 1990’s. Longer wait times and ED crowding have become a worry for patients, physicians, institutions, and policymakers. In addition, many visits to the ED and subsequent hospital admissions are due to ambulatory care sensitive conditions (ACSCs), which are illnesses that could most likely have been prevented by timely provision of primary care. Patients are not receiving optimal care when the ED and the primary care setting are overwhelmed, which compromises patient satisfaction and treatment. Because the ED is

---

now and will remain a major venue for health care for many Americans, provision of appropriate and high quality ED care should be an important goal of the US health care system.

The role of the ED has expanded markedly in the past thirty years. Medical emergencies are terrifying experiences for most people, and the ability to go to an ED for help is a source of security and comfort. Today, however, the ED is also a resource for those who need ambulatory medical care and do not have access to a primary care physician. The range of acuity of patients’ medical conditions in the ED is large, from life-threatening symptoms to simple, non-urgent issues. The steady increase in patient visits to EDs across the country puts stresses on resources, which then limits access to ED services. For example, crowding in the ED has become a common phenomenon that can threaten the well-being of patients. The crowding of US hospital EDs occurs when the demand for services in the ED exceeds the resources available. When the ED is crowded, patients triaged with high acuity illnesses are seen first; however, lower acuity patients, who still might have urgent conditions, spend more time waiting to be seen by a physician, and this delay can endanger their health. The boarding of patients in the ED, when patients cannot be transferred to inpatient rooms due to lack of available beds, has recently been shown to be a major factor in crowding.\(^3\) Other factors include front-end problems regarding what types of patients come to the ED and treatment delays in the ED once a physician has seen a patient.\(^4\)


\(^4\) Ibid.
Unlike most other developed nations, for many years the US provided only limited support for patient access to health care, primarily through the public Medicare and Medicaid health insurance programs for senior citizens and some low-income families. Congress’ enactment in 2010 of the Patient Protection and Affordable Care Act (PPACA) has increased the number of people with health insurance, but its effect on the availability of primary care has not been as successful. Some have blamed “overuse” of the ED on patients, but it could be that patients simply have no other option for their health care. Many patients come to the ED because they do not have ready access to a primary care physician for an ACSC. Patients need a place to receive preventive and continuing care, but since that is not easily found, the ED has provided those services. The ED has taken on a role that overlaps with urgent care centers and primary care physicians, which is both inefficient and costly.

In this thesis, I will explore how improving primary care access can relieve pressure on EDs to provide non-urgent care, increase efficiency in the health care system, and improve patient health. Limited availability of primary care physicians and lack of access to satisfactory care have driven many patients to the ED. The shortage of primary care in the US contributes to crowding in the ED, increases avoidable illnesses, and causes more disorganization in the health care system. While improving the efficiency of the ED and further developing primary care access will not solve all of the issues in the US health care system, I will propose changes that can help the ED and primary care become more effective and patient-centered.

CHAPTER ONE

LEGAL BACKGROUND

While physicians and their medical teams are pivotal in providing care to patients who come to the hospital, legislators and government officials have been influential in establishing access to that care. The legislation that has had the most significant effect on hospital EDs is EMTALA. The PPACA does not impose sweeping mandates on EDs like EMTALA, but other measures in the Act will likely have significant effects on EDs. In this chapter, I will describe the major provisions of these statutes that affect access to health care. In subsequent chapters, I will examine the ways that these two prominent federal statutes have shaped the health care system and how care is delivered in both the ED and primary care settings.

Emergency Medical Treatment and Active Labor Act

In April 1986, President Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) that expanded group health insurance coverage in certain circumstances for employees who lost their health benefits.6,7 COBRA also contains the Emergency Treatment and Active Labor Act (EMTALA), which required every federally funded hospital to provide a “medical screening examination” and “stabilizing” treatment to any person who comes to the ED with an “emergency

medical condition". The impetus for EMTALA was continuing reports of “patient dumping,” which had been a problem for several decades. Patient dumping is the practice of transferring patients from one hospital to another without proper regard for the patient’s health. The patients who were transferred were typically uninsured or poor and could not afford medical treatment at private hospitals. Patient dumping also occurred as a result of discrimination due to a patient’s race or sexual orientation. Patients were not provided satisfactory access to health care, which endangered their health and showed a blatant disregard for their well-being.

In 1946, a Congressional response to patient dumping resulted in the Hill-Burton Act, which required hospitals to stabilize patients before discharge in order to receive financial support for hospital construction and upgrades. Prior to that, states had begun implementing various statutes that gave hospitals a duty to treat patients in a medical emergency, but these regulations were ineffective at stemming the practice of patient dumping. After implementation of the Hill-Burton Act, the states again failed to stem the practice of patient dumping, partly due to the fact that the nature of an “emergency” was not defined in the Act.

---

8 42 U.S.C. § 1395dd
14 Ibid.
15 Ibid., 147.
Several studies in the 1980’s revealed the still-pervasive practice of patient dumping, including one study over a six-week period at Cook County Hospital in Chicago, Illinois.\(^{16}\) During this six-week period between 1983 and 1984, 500 transfers to that inner-city public hospital were analyzed, and the researchers found that of those patients transferred, 89% were Black or Hispanic, and 87% were transferred due to inadequate health insurance coverage.\(^{17}\) Transfers were often completed without adequate consideration for the patient’s health, given that 24% of the patients were “unstable” and 22% needed care in the Intensive Care Unit.\(^{18}\) The Cook County Hospital Study illustrated the vulnerability of certain populations to subpar care and the practice of transferring patients without first administering stabilizing care. The ongoing reports of patient dumping led to the enactment of EMTALA as a part of COBRA in 1986.\(^{19}\)

EMTALA requirements apply to all US hospitals that have Medicare funding and EDs. The Act has three main components. First, a person who comes (or is brought) to the hospital must be given “an appropriate medical screening examination.”\(^{20}\) Second, a patient who has an “emergency medical condition” is then entitled to the treatment necessary “to stabilize the medical condition.”\(^{21}\) Third, the patient cannot be transferred to another facility unless he or she is stable or other requirements are met.\(^{22}\)

\(^{17}\) Gionis, “The Intentional Tort,” 193.
\(^{18}\) Ibid.
\(^{20}\) 42 U.S.C. § 1395dd(a)
\(^{21}\) 42 U.S.C. § 1395dd(b)
\(^{22}\) 42 U.S.C. § 1395dd(c)
addition, the law includes definitions and provisions regarding enforcement and punishment for violations.

The medical screening examination (MSE) is used to evaluate whether or not a patient has an “emergency medical condition” that needs to be treated.\(^{23}\) The Act does not specifically define what a MSE should cover, only that the MSE should be “within the capability of the hospital’s emergency department.”\(^{24}\) The Act defers examination standards to each hospital, and the ambiguity of this requirement has led to several court cases. In general, courts have interpreted EMTALA to require hospitals to provide only a similar MSE that is appropriate for its resources to each patient.\(^{25}\) Hospitals are permitted to obtain insurance information before the MSE, but such information cannot delay the MSE or prevent treatment of an emergency medical condition.\(^{26}\) The statute requires an MSE for every patient who “comes to the emergency department,”\(^{27}\) and the Centers for Medicare and Medicaid Services (CMS) and court precedent have extended this phrase to include most hospital areas where patients can come to request treatment.\(^{28}\)

The MSE is conducted so as to identify and evaluate an emergency medical condition. For a patient who is not pregnant, an emergency medical condition is defined by “acute symptoms of sufficient severity (including severe pain),” where lack of medical attention could endanger the patient’s health, cause “serious impairment to bodily

---

\(^{23}\) 42 U.S.C. § 1395dd(a)

\(^{24}\) Ibid.

\(^{25}\) See Repp v. Anadarko Municipal Hospital (43 F.3d 519 (10th Cir. 1994)) and Gatewood v. Washington Healthcare Corp. (933 F.2d 1037, 1041 (D.C. Cir. 1991)).


\(^{27}\) 42 U.S.C. § 1395dd(a)

function”, or result in “serious dysfunction of any bodily organ or part.” A pregnant woman is in a medical emergency if she is having contractions, and there is either not enough time or it is too dangerous (to her or the baby’s health) to transfer her to another facility.

If an emergency medical condition does exist, then the hospital must either provide stabilizing treatment or transfer the patient under certain guidelines, as follows. The stabilization of a patient should involve treatment such that “no material deterioration of the condition is likely,” either during transfer or because the patient was transferred. An unstable patient cannot be transferred unless both of two specific conditions are met. First, the patient (or an authorized surrogate decision-maker) asks for the transfer, and written consent is obtained. Second, the physician determines that the benefits to the patient (and an unborn child, if applicable) of receiving medical treatment at another medical center with a higher level of care outweigh the medical risks incurred by transferring the patient. If the patient is stabilized, the transferring hospital has to provide enough treatment “within its capacity” to minimize dangers to the patient’s health and send the patient’s medical records, including “the name and address of any on-call physician.” The “receiving facility” must have a bed and medical team available for the patient and must agree to the transfer.

29 42 U.S.C. § 1395dd(e)(1)
30 42 U.S.C. § 1395dd(e)(1)(B)
31 42 U.S.C. § 1395dd(e)(3)
32 42 U.S.C. § 1395dd(c)(1)(A)(i)
33 42 U.S.C. § 1395dd(c)(1)(A)(ii)
34 42 U.S.C. § 1395dd(c)(2)(A,C)
35 42 U.S.C. § 1395dd(c)(2)(B)
Enforcement of EMTALA relies on penalties of up to $50,000 for a violation and the government’s ability to revoke a hospital’s eligibility to receive Medicare funding. While the instances of patient dumping have significantly decreased, EMTALA also transformed public hospital EDs into a safety-net care facility for many patients who have nowhere else to go. Patient dumping revealed a fundamental flaw in the US health care system that left many without satisfactory access to health care. I suggest, however, that patient dumping was a symptom of greater issues in the health care system that still exist today, and simply requiring EDs to stabilize patients does not address those larger issues. Today, many patients are treated in EDs for illnesses that could be prevented or avoided with satisfactory primary care, but access is limited to that care. EMTALA was meant to provide a treatment for those with emergency medical conditions, but was not meant to cover deficiencies in access to outpatient or primary care. The requirement that hospitals provide stabilizing treatment under EMTALA does not provide adequate access to care for many Americans. The Act was not intended to cover all of the gaps in the health care system, but until recently, providing last-resort access to care has been the default role of the ED. With the enactment of the Patient Protection and Affordable Care Act, some of those shortcomings in the system are being addressed to give Americans greater access to continuing primary and preventive care.

36 42 U.S.C. § 1395dd(d)
The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA), which was signed into law by President Obama on March 23, 2010, is arguably the most significant health care law since the implementation of Medicare and Medicaid in 1965. Before the PPACA, more than 47 million Americans, or almost 18% of the population, did not have health insurance. Lack of health insurance has been shown to affect people’s health and well-being adversely. The PPACA is a sweeping reform that will continue to change the landscape of the US health care system as the various parts of the law are implemented.

Among several goals, the PPACA is meant to expand health insurance coverage, bolster the nation’s primary care foundation, support the medical needs of the elderly, improve the quality of patient care, contain costs, and regulate aspects of the health insurance industry.

While the PPACA has numerous detailed provisions, the measures that affect insurance coverage and access to care will directly affect both the ED and primary care. There are four general measures in the law pertaining to insurance expansion. First, an individual mandate and insurance exchanges are meant to encourage Americans to purchase health insurance, along with subsidies to supplement the cost of insurance for

---

41 Ibid.
lower income families and individuals.\textsuperscript{43} Second, the law provides additional funding to encourage states to expand Medicaid eligibility requirements to include many of those previously without insurance.\textsuperscript{44} Third, employers with a specific number of employees are required to provide health insurance benefits or face a penalty.\textsuperscript{45} Fourth, the PPACA imposes multiple new restrictions on health insurance plans in order to expand coverage.\textsuperscript{46} For example, the Act prohibits insurers from putting annual or lifetime limits on coverage, rescinding coverage, denying coverage due to pre-existing conditions, or requiring waiting periods of more than 90 days.\textsuperscript{47} Even though the longer-term effects of the PPACA are still uncertain, the Act has expanded health insurance coverage to include 20 million more Americans as of March 2016.\textsuperscript{48} In addition, there are several provisions within the Act that affect primary care practices, such as changes in reimbursement rates, efforts to increase the number of primary care physicians, and support for medical homes.\textsuperscript{49}

The individual mandate is a provision of the PPACA that applies to most Americans. This mandate requires every non-indigent American citizen and legal resident to have health insurance or pay a fine.\textsuperscript{50} (There are limited exceptions to the

\begin{footnotes}
\item[43] Ibid.
\item[44] Ibid.
\item[45] Ibid.
\item[46] Ibid.
\item[47] Ibid.
\item[49] “Summary of the ACA,” \textit{Kaiser Family Foundation}.
\end{footnotes}
mandate for low-income people and others who do not qualify for public health insurance programs or subsidies.\textsuperscript{51)} This insurance must meet a minimum standard defined by the government, known as “minimum essential coverage.”\textsuperscript{52} This coverage must include emergency services, maternal and newborn care, preventive services, and wellness services, among many others.\textsuperscript{53} When the law was enacted, there was a “grandfather” clause that allowed those with health insurance plans to maintain their original plans, which may not have fulfilled the requirements for minimum essential coverage.\textsuperscript{54}

The PPACA also implemented a plan for “exchanges,” where individuals who are not covered by employer-provided or public plans can compare different coverage plans from various insurance companies and purchase a suitable plan.\textsuperscript{55} The Act encouraged individual states to build their own health insurance exchanges.\textsuperscript{56} States that did not provide a state-run exchange platform would have to defer to the federal exchange or a federal-state cooperative version of the exchanges.\textsuperscript{57} Today, the federal exchange platform is known as the Health Insurance Marketplace. Plans in the exchanges are offered at four levels based on actuarial value of the plan, which is the percentage of

\textsuperscript{51} “Summary of the ACA,” \textit{Kaiser Family Foundation}.
\textsuperscript{53} Ibid., 3.
\textsuperscript{54} Ibid., 4.
\textsuperscript{55} Ibid., 9.
\textsuperscript{57} Ibid.
the cost that the insurance company pays.\textsuperscript{58} The actuarial values of the plans are 90% for Platinum, 80% for Gold, 70% for Silver, and 60% for Bronze.\textsuperscript{59} Americans under 30 years of age and other exempt individuals also have the option to buy a catastrophic plan, which has much lower benefits.\textsuperscript{60}

In 2014, individuals were required to declare on their income tax return forms whether they had health insurance that met the mandate for minimum essential coverage.\textsuperscript{61} If one did not have insurance or one’s insurance did not meet the coverage standards, then a fine would be imposed, and the amount of that fine will be adjusted for each subsequent year. When the penalty went into effect, it was calculated as whichever is greater of one percent of one’s income or $95.\textsuperscript{62} The fine increased in 2015 to the greater of $325 or 2% of annual income and to $695 or 2.5% of income in 2016.\textsuperscript{63}

In each year, the maximum that will have to be paid is equal to the cost of the average “bronze” plan on the Health Insurance Marketplace.

One of the goals of the PPACA is to strongly encourage Americans who can afford health insurance to buy it, while also subsidizing those who cannot pay. Another central tenet of the PPACA is the expansion of Medicaid. Although states were originally required to expand Medicaid coverage or risk losing all Medicaid funding, the US Supreme Court decided that mandate was unconstitutional.\textsuperscript{64} Instead, the decision to

\textsuperscript{58} “PPACA Detailed Summary.” \textit{Responsible Reform}, 2.
\textsuperscript{59} “PPACA Detailed Summary.” \textit{Responsible Reform}, 2
\textsuperscript{60} Ibid.
\textsuperscript{62} Musumeci, “Guide to ACA Decision,” 2.
\textsuperscript{63} Ibid.
\textsuperscript{64} Ibid., 5.
expand Medicaid was left up to each state, and as of February 2016, 32 states and D.C. have opted to expand Medicaid. Before the PPACA, only certain populations were eligible for Medicaid coverage. Medicaid covered pregnant women and children younger than 6 years old, if their family income was at or under 133% of the federal poverty level (FPL). As of 2016, the FPL for individuals is $11,880 and $24,300 for a family of four. Before the PPACA, federally mandated coverage made Medicaid coverage available to children between the ages of 6 and 18 with family incomes at or less than 100% FPL, parents and caretakers who meet financial requirements, and the elderly and/or disabled who are eligible for Supplemental Security Income. The PPACA Medicaid mandate expanded coverage to include many adults without disabilities and without children who still could not afford insurance. Specifically, all people who had annual incomes at or below 133% FPL would be eligible for Medicaid coverage starting in 2014. For the states that did expand Medicaid under the PPACA, federal funding paid for all of the state expansion costs until 2016. In 2017, the federal government will gradually decrease funding of Medicaid for states, eventually covering 90% by 2020.

---

69 Ibid.
70 Ibid.
71 Ibid.
In addition to covering more people under Medicaid, the PPACA created subsidies for people with incomes below 400% of the FPL in order to help with the cost of health insurance coverage.\(^7\) The subsidies are reimbursed as tax credits and are applied to both premiums and out-of-pocket costs. With the premium tax credit, the maximum an individual or family will pay in insurance premiums during the year increases from 2% of income for individuals/families at 100% FPL to 9.8% for those at 300-400% FPL.\(^7\) This subsidy means that a family at 100% FPL would pay a maximum of 2% of their income for health insurance coverage for one year.\(^7\) For out-of-pocket costs, those with an income below 150% FPL have to pay a maximum of 6% of the actuarial value of the plan. If one’s income were between 250-400% FPL, then the out-of-pocket costs would be a maximum of 30% of the plan’s actuarial value.\(^7\)

In an effort to encourage employers to provide health coverage, small businesses can receive a tax credit that covers up to 50% of the cost for the employee’s plan. In order to qualify for the highest tax credit, small businesses must have fewer than 10 employees and have an average salary below $25,000.\(^7\) Although it decreases as firms’ sizes grow, the tax credit also applies to companies with 25 employees who earn on average less than $50,000.

Larger companies with more than 200 workers are required to purchase plans for new full-time employees or pay a fine for each employee not insured.\(^7\) Beginning in

---

\(^7\) Manchikanti, “PPACA: Reform in the New Decade,” E41.
\(^7\) “PPACA Detailed Summary.” Responsible Reform, 2.
\(^7\) Manchikanti, “PPACA: Reform in the New Decade,” E41.
\(^7\) Tanner,”Bad Medicine,” 10 – 11.
\(^7\) Ibid., 11.
\(^7\) “PPACA Detailed Summary.” Responsible Reform, 3.
2016, companies with more than 50 employees had to offer plans to at least 95% of full-time workers and their families, provide coverage at an actuarial value of 60%, and be sure that their workers do not pay more than 9.66% (for 2016) of their income for coverage. If any of these regulations are not met, and one or more of the full-time employees of a company is eligible for a government subsidy for his or her coverage, then the company is subject to certain penalties.\textsuperscript{78}

In addition to individual and employer mandates, the PPACA has implemented new restrictions on insurance companies and their business practices. The Act disallowed insurance companies from denying coverage to anyone based on a pre-existing condition, and they cannot withdraw coverage if a consumer gets an illness.\textsuperscript{79} Also, insurers have to provide a policy to anyone who applies for one,\textsuperscript{80} and the prices for healthy consumers have to be the same as policy prices for sick consumers.\textsuperscript{81} Prices can only fluctuate due to age, smoker status, geographic location, and whether the policy is an individual or family one.\textsuperscript{82} The price for the oldest person’s plan can be no more than three times as expensive as the premiums for the youngest person’s coverage.\textsuperscript{83} Similarly, those who smoke tobacco might be charged up to 50% more than those who do not use tobacco.\textsuperscript{84}

\textsuperscript{79} Tanner, “Bad Medicine,” 6.
\textsuperscript{80} Manchikanti, “PPACA: Reform in the New Decade,” E41.
\textsuperscript{81} Tanner, “Bad Medicine,” 6.
\textsuperscript{82} Manchikanti, “PPACA: Reform in the New Decade,” E42.
\textsuperscript{83} Tanner, “Bad Medicine,” 6.
\textsuperscript{84} Ibid.
As millions gain health care insurance coverage, efforts must be made to ensure those patients also have access to health care. Primary care is often considered to be the backbone of an efficient health care system, so it is not surprising that several provisions in the PPACA revolve around strengthening the nation’s primary care system. The primary care-related measures are numerous and complex; I will review several here that are the most applicable to ED and primary care. Chapter 4 will examine these measures more fully. The provisions focus on Medicare and Medicaid reimbursement, funding primary care sites to support quality patient care, and increasing the number of primary care physicians. The PPACA temporarily increased Medicaid reimbursement levels to Medicare levels from 2013 – 2014, and there was a 10% bonus for providers treating Medicare patients from 2011 through 2015. The Act also established a new Center for Medicare and Medicaid Innovation (CMMI) to create and evaluate different payment options and methods in order to control costs and improve patient care.

The PPACA provides funding for primary care sites that are approved as “health homes” for chronically ill Medicaid patients. “Health homes” are based on the patient-centered medical home (PCMH), a model that focuses on continuity of care, a stronger patient-provider relationship, preventive medicine, sustainable chronic disease

---

87 “Summary of the ACA,” Kaiser Family Foundation.
88 Davis, “How the ACA Will Strengthen Primary Care,” 1202.
management, and coordinated care. Teams of providers work with eligible patients in numerous ways, including transitioning to primary care from the hospital, focusing on disease management and health, and incorporating the family in care. Additionally, the PPACA encourages use of primary care by lowering or removing co-insurance, deductibles, or co-payments for certain preventive visits and procedures for all insurance plans. The PPACA also covers co-insurance, deductibles and co-payments for seniors seeking preventive measures and annual wellness checks from primary care providers. In addition to health homes, the PPACA funds Federally Qualified Health Centers, or FQHCs, which are health centers in medically underserved areas that meet the necessary requirements to receive federal funding. These health centers existed before the PPACA but are now under its auspices; they provide comprehensive primary care to anybody who seeks services there, regardless of insurance status. FQHC’s were already providing care to many uninsured patients who now have coverage under the Medicaid expansion, so the increase in funding from the PPACA has propelled FQHC growth.

The measures to improve primary care reimbursement would be almost useless without efforts to expand the supply of primary care physicians. From 2011 – 2015, the
PPACA invested $1.5 billion in the National Health Service Corps, which funds scholarships and loan forgiveness for physicians, nurse practitioners, and physician assistants who serve as primary care providers in underserved areas. Measures also focus on reinforcing training programs for primary care physicians and increasing the number and size of residency programs for primary care specialties. Growth in the number of advanced practice providers is expected through similar methods, such as educational loans and better training programs. Many are hopeful that these new measures will help to lessen the shortage of primary care providers and increase access to health care.

In its short existence, the PPACA has faced numerous legal challenges. Most notable among these are three challenges adjudicated by the US Supreme Court, National Federation of Independent Business v. Sebelius (2012), Hobby Lobby v. Burwell (2014), and King v. Burwell (2015). The first case challenged both the individual mandate and the federal requirements to expand Medicaid in the states. In a 5-4 decision, the Court decided that the individual mandate was constitutional under Congress’ ability to levy taxes, but that the requirement that states expand their Medicaid programs was unconstitutional. States could therefore choose whether or not to accept the federal funds offered for Medicaid expansion. The case of Hobby Lobby v. Burwell questioned the PPACA on religious grounds due to a requirement that corporations provide

---

98 Abrams, "Realizing Health Reform’s Potential," 12.
99 Ibid., 13.
100 Ibid.
employees with health insurance plans that cover contraception.\textsuperscript{102} A 5-4 ruling in favor of the plaintiffs struck down the PPACA mandate in favor of religious freedom. The third case, \textit{King v. Burwell}, focused on the wording of the PPACA that allows insurance subsidies through the exchanges “established by the State.”\textsuperscript{103,104} A 6-3 majority held that coverage subsidies could be provided through both state and federal exchanges. As these decisions illustrate, the Act has weathered several attempts to derail it, and the fundamental parts of it are still standing today. Additional legal challenges are in process, and the fate of ongoing legislative efforts to repeal the Act will likely depend on the outcome of the 2016 Presidential and Congressional elections.

According to the Gallup-Healthways Well-Being Index, almost 90\% of nonelderly Americans were insured in early 2016;\textsuperscript{105} there are, however, still millions of Americans without adequate health care coverage, and of those with coverage, many do not have access to appropriate health care. EMTALA improved issues related to patient dumping, and the ED is now a major source of care for millions of Americans, regardless of ability to pay. While EMTALA certainly helped patients who otherwise would have had no place to go, it did not solve many of the major issues related to access to care. Lack of insurance and the subsequent inability to pay exorbitant costs for health care represent a significant barrier to access, and the PPACA has been hailed as a solution to this


\textsuperscript{104} Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

\textsuperscript{105} “20 Million People Have Gained Health Insurance,” \textit{HHS}. 
problem. While millions have gained insurance under the PPACA, strain on primary care and EDs in the six years since its enactment still blocks patients from getting quality health care. As the various provisions of the PPACA are implemented, the effects of the law on health care access and costs continue to unfold. One of the main goals of the PPACA was to expand health insurance coverage to Americans, but has or will a complementary expansion in the availability of health care services be successful? In order to determine its effectiveness and identify ways to improve the efficiency of the health care system, the issues in primary care and its effect on EDs need to be examined.
CHAPTER TWO

ACCESS TO EMERGENCY AND PRIMARY CARE

It is widely accepted that changes need to be made to reform the US health care system, but improvement cannot proceed without first having identified the problems. Many consider ED use to reflect the performance of the health system,\(^\text{106}\) while others consider primary care to be the backbone of health care.\(^\text{107}\) The US health care system is both complex and dynamic, and when one branch falters, other parts of the system are affected. Many studies have correlated patient care in the primary care sector to ED visit and hospitalization rates. In this chapter, I will examine the data and research regarding current problems with access to appropriate primary care, the subsequent rates of ED visits and hospitalization, and the effects of the PPACA on those issues.

*Emergency Department Crowding*

Both the ED and primary care are fundamental parts of the US health care system. Since the enactment of EMTALA, the ED has provided safety-net care for those without insurance or other options. In addition, communities rely on ED providers for urgent and emergency treatment, disaster response, and 24-hour care, which are all vital aspects of a health care system.\(^\text{108}\) Between 2007 and 2010, about 20% of US adults

---


visited the ED as patients within the previous year,\textsuperscript{109} and about 68\% of inpatients are admitted through the ED.\textsuperscript{110} The number of ED visits has increased from 96.5 million in 1995 to more than 131 million in 2011.\textsuperscript{111,112} Both Oregon and Massachusetts saw a continued increase in ED visits after implementing health reform that expanded insurance coverage.\textsuperscript{113,114} In addition, a 2015 poll of ED physicians showed that providers perceive an increase in ED visits since the implementation of the PPACA.\textsuperscript{115} Meanwhile, the number of in-hospital EDs declined by 11\% from 1993 to 2013, which means there are more and more patients going to fewer EDs.\textsuperscript{116} These trends in the past two decades have led to crowding; more patients are demanding access to relatively scarcer ED resources, which leads to longer wait times and delays in treatment.\textsuperscript{117} In addition, crowding is correlated with worse patient outcomes for admitted patients, which illustrates a danger to health and a decline in the quality of patient care.\textsuperscript{118} For example, crowding is correlated with medical errors, which can put patients at risk.

\textsuperscript{112} Weiss, “Overview of ED Visits, 2011,” 1.
\textsuperscript{114} Peter B. Smulowitz et al., ”Emergency Department Utilization after the Implementation of Massachusetts Health Reform,” \textit{Annals of Emergency Medicine} 58, no. 3 (2011): 229.
unnecessarily.\textsuperscript{119} Also, crowding leads to longer wait times, which can be dangerous for patients with time-sensitive conditions.\textsuperscript{120,121} It is sometimes assumed that patients without health insurance come to the ED for “free” care and contribute the most to ED crowding. In actuality, this assumption is unsupported by current data, and simply insuring more patients will not remedy the situation.\textsuperscript{122} While crowding is a multifaceted problem, “boarding” of ED patients has been identified as one of the main contributing factors.\textsuperscript{123} Boarding of patients occurs when there are no vacant inpatient beds, and an admitted patient must remain in an ED bed for hours or days.\textsuperscript{124} While the boarded patients continue to receive care, the number of available ED beds dwindles and patients are forced to remain in the waiting room.\textsuperscript{125} According to the US Government Accountability Office, emergent patients presenting to the ED in 2006 who needed care within one to 14 minutes typically had to wait 37 minutes instead.\textsuperscript{126} After arrival, patients are in the ED for an average of 2 hours and 15 minutes until being admitted or discharged.\textsuperscript{127}

\textsuperscript{122} Newton, “Uninsured Adults Presenting to US EDs,” 1921.
\textsuperscript{123} Moskop, “Emergency Department Crowding, Part 1,” 607.
\textsuperscript{124} “ED Wait Times, Crowding, and Access Fact Sheet,” \textit{ACEP}.
\textsuperscript{125} Ibid.
\textsuperscript{126} “Hospital Emergency Departments, Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames,” \textit{United States Government Accountability Office} (April 2009): 44.
\textsuperscript{127} “ED Wait Times, Crowding, and Access Fact Sheet,” \textit{ACEP}.
Emergency Department Use Linked to Lack of Primary Care

The issue of “overuse” of the ED does not seem to be directly linked to insurance status or patients with minor problems. In reality, many patients are simply seeking appropriate and timely care. These patients come to the ED for convenience or due to lack of access to a primary care provider, as, for example, if the patient’s primary care office is too busy or not open. In a survey done by the Centers for Disease Control and Prevention (CDC), almost 80% of adults cited lack of access to another source of care as a reason for the ED visit, while only 66% went to the ED due to the urgency of the medical issue. Inability to be seen by a primary care provider has been identified as a central reason that patients visit the ED instead of an outpatient office.

One study proposes that about 13.7 – 27.1% of visits to the ED could be managed at another care site, such as retail clinics or urgent care centers, which could save about $4.4 billion per year. Some estimate that non-urgent medical issues could comprise up to 30% of ED visits (although other estimates are less than 10%). Again, a majority of non-urgent patients found the ED to be more convenient than a primary care provider. In addition, “physician deflection” occurs when a primary care physician refers a patient to the ED for various reasons, including reluctance to take a

128 Ibid.
129 Gindi, “ER Use Among Adults,” 2.
130 Kristy G. Morganti et al., The Evolving Role of Emergency Departments in the United States (Santa Monica, CA: RAND Corporation, 2013), 4.
131 Robin M. Weinick, Rachel M. Burns, and Ateev Mehrota, “Many Emergency Department Visits Could be managed at Urgent Care Centers and Retail Clinics,” Health Affairs 29, no. 9 (2010): 1630.
133 Ibid., 51.
difficult case, better access to specialty care in the ED, medical liability issues, and guaranteeing that the patient is seen when the primary care clinic is closed.\textsuperscript{134}

The strain on the ED to serve a wide range of patients, from emergent to non-urgent, suggests that the US health care system is failing to provide optimal care for these patients. For example, more than 8% of adult (18+) patients in the ED from 2007-2009 presented with ambulatory care sensitive conditions (ACSCs), which resulted in about 8 million visits.\textsuperscript{135} ACSCs were defined by John Billings as illnesses that could either be treated by or avoided with a primary care visit to an outpatient clinic.\textsuperscript{136}

Patients who cannot get a primary care appointment soon enough or who have to wait too long to see a primary care provider regularly turn to the most convenient care option that is left: the ED.\textsuperscript{137} Studies have shown that patients admitted to hospitals with ACSCs are more likely than other patients to lack satisfactory access to primary care.\textsuperscript{138} ACSCs range from acute illnesses, such as urinary tract infections (UTIs), to chronic conditions, like congestive heart failure (CHF).\textsuperscript{139} Patients presenting to the ED with an ACSC were more likely to be admitted than patients who came to the ED with non-ACSC illnesses.\textsuperscript{140} One study found that in 2010, 13.2% of pediatric ED visits (aged 0 – 19) were for ACSCs and about 60% of those visits were ear, nose, and throat (ENT).

\textsuperscript{139} Dresden, “ACSH through the ED,” 135.
\textsuperscript{140} Johnson, “Disparities in Potentially Avoidable ED Care,” 1022.
related. The study also saw correlations between pediatric ACSC ED visits and uninsured or publicly insured families. Children presenting to the ED with an ACSC often faced barriers to primary care access or issues related to parental refusal or inability to follow physician orders. Patients with an ACSC not only increase the number of patients presenting to the ED, but ambulatory care sensitive hospitalizations (ACSHs) exacerbate the issues associated with patient boarding in the ED. Both of these factors contribute to ED crowding, which endangers patient health and reduces the productivity of the system. Hospitalizations not only represent potentially avoidable, higher acuity issues, but can also cost 20 times more than an ED visit. These hospitalizations are considered largely preventable and represent subpar patient care and efficiency within a health system.

**Issues in Primary Care Access**

Despite increases in health insurance coverage and efforts to promote primary care, many patients still do not have adequate access to primary care, and several problems have been identified as exacerbating this lack of access. Among many advantages, primary care provides continuity of care, preventive treatment, and management of chronic illness. It has been associated with lower mortality rates for

---

141 Jaeger, “Emergency Care of Children with ACSCs,” 734, 731.  
142 Ibid., 734.  
143 Ibid., 735.  
144 Dresden, “ACSH through ED by Payer,” 139.  

24
several conditions\textsuperscript{146} and higher rates of adherence to physician recommendations.\textsuperscript{147} A strong primary care foundation is correlated with better population health and fewer preventable hospitalizations in Europe.\textsuperscript{148} Since primary care is an essential part of health care for many Americans, it is worthwhile to ensure that the system supports a strong primary care foundation.

A large majority of primary care is provided during office-based visits by physicians, nurse practitioners, and physician assistants.\textsuperscript{149} According to a 2013 AMA survey, almost 60\% of offices had fewer than 10 practicing physicians. Solo practices and offices with 2 – 4 physicians each represented 20\% of all primary care offices.\textsuperscript{150} In 2008, there were 206,369 office-based physicians in primary care, or 1 primary care physician for every 1,475 people, and about 462 million patient visits.\textsuperscript{151} The number of primary care physicians grew to almost 209,000 in 2010, but it has been projected that the number needs to grow by 52,000 by 2025 due to population increase, aging patients, and insurance expansion.\textsuperscript{152} One study estimated that population needs for primary

\textsuperscript{146} Barbara Starfield, Leiyu Shi, and James Macinko, “Contribution of Primary Care to Health Systems and Health,” \textit{The Milibank Quarterly} 83, no. 3 (2005): 461.
\textsuperscript{147} Abrams, “Realizing Health Reform’s Potential,” 2.
\textsuperscript{149} Bodenheimer and Pham, “Primary Care: Problems and Solutions,” 800.
\textsuperscript{152} Ibid., 507.
care would grow by 29% between 2005 and 2025, but the primary care workforce would only increase by 2-7%.

The shortage of primary care physicians is exacerbated by the low rate of entry of medical students into primary care-related residencies. One reason new physicians choose other specialties is financial, as residency positions that lead to higher-paying medical specialties are more likely to be filled. Between 2000 and 2013, the percentage of family-practice residents who had graduated from US allopathic schools of medicine fell from 73% to 46.1%. Medical student debt, school culture, and experiences in training have been cited as reasons dissuading new graduates from pursuing a primary care residency. If this trend continues, the shortage of primary care physicians will grow, which will worsen problems related to access for patients. In addition to a shortage of primary care physicians, there is also a “maldistribution” of primary care in the US. A 2007 report by the Council on Graduate Medical Education estimates that in urban areas there are 100 primary care physicians to every 100,000 people, but in rural areas, the number of physicians for the same number of people drops to 46. This dispersal means that while 21% of people in the US live in rural areas, only about 10% of physicians practice in those same areas. When the ratio of

153 Bodenheimer and Pham, “Primary Care: Problems and Solutions,” 801.
155 Ibid.
156 Ibid.
157 Bodenheimer and Pham, “Primary Care: Problems and Solutions,” 802.
primary care physicians to people is so low in rural areas, the issues relating to the shortage of primary care physicians are exacerbated.

Publicly insured patients, especially Medicaid patients, are often blamed for burdening the ED with unnecessary visits and frequent use; blaming these patients ignores other factors that lead publicly-insured patients to seek care in the hospital, however. For example, in 2012, only two-thirds of primary care physicians would accept Medicaid enrollees as patients.\textsuperscript{159} A recent study in Brooklyn, NY found that almost 30% of patients visiting the ED for self-stated non-emergent issues either could not schedule a timely primary care appointment or were instructed to go to the ED by a care provider.\textsuperscript{160} In part, this reluctance to accept new Medicaid patients is due to lower reimbursement rates compared to other insurers. In a 2013 article, Peter Ubel noted that the average reimbursement rate for Medicaid was 61% that of Medicare; although many physicians accepted an ethical duty to care for some Medicaid patients, “they did not want to commit career suicide” by financially burdening their practices.\textsuperscript{161} Other factors that deter acceptance of Medicaid enrollees include problems with Medicaid reimbursement procedures, issues with Medicaid patients missing appointments, and other negative views of these patients.\textsuperscript{162}


Timely care is another barrier that patients face when attempting to make appointments with primary care offices. In one survey, about 20% of respondents found it “very difficult” or “somewhat difficult” to speak with a clinician during non-business hours. Only about 30% of primary care practices in the US have after-hours care, which is significantly lower than the 95% in the U.K. and 94% in the Netherlands. Only about 35% of ED visits occur during usual office hours of 8:00 a.m. to 5:00 p.m. Patients who could more easily contact a primary care provider after hours were less likely to visit the ED or to have “unmet medical needs.” Patients who work when the office is open or who have to schedule child care or transportation needs do not have convenient access to primary care. The demand for more physicians and more office hours puts a burden on primary care offices. A 2009 study estimated that primary care physicians would have to work 21.7 hours each work day (for a panel size of 2,500 patients), instead of 8 hours per day, to overcome the shortage of primary care access in the US. Primary care providers cannot reasonably be expected to work 108 hours per week in order to increase access to primary care; instead, solutions should focus on improving reimbursement rates and increasing the number of primary care providers available.

---

164 Ibid., 1.
165 Ibid., 3.
166 Ibid., 6.
167 Cheung, “Barriers to Timely Primary Care,” 9.
EMTALA, the PPACA, and Primary Care

In the US, the ED has become a safety net for shortcomings within the primary care setting and perhaps even the entire health care system. Some blame EMTALA for allowing uninsured patients to overuse the ED, but, as I have explained, there are other factors contributing to lack of ready access to primary care. The definition of “emergency medical condition” in EMTALA is fairly vague, and turning away non-urgent patients is not as simple as it sounds. A complaint like “abdominal pain” might just be a bad stomachache or it might be appendicitis requiring emergency surgery. Treatment in the ED includes both determining that a condition is not life-threatening and treating a true emergency.169 The stomachache would be documented as non-emergent, but that does not mean that ED clinicians should forgo treatment for the patient’s pain.170 Some hospitals have begun charging patients before treatment if their condition is categorized as non-urgent;171 I will discuss other recommendations for non-urgent patients presenting to the ED in Chapter 4. According to EMTALA, these patients must first undergo a medical screening examination, but if their symptoms do not represent an emergency medical condition, then the uninsured patient can be charged an upfront fee of up to $350 (or a deductible for the insured).172 While hospitals certainly have to make enough money to remain open, imposing more barriers to care on the uninsured or

170 Ibid.
172 Ibid.
underinsured has some worrying consequences. If patients who lack access to outpatient care can no longer obtain treatment in the ED, then there are no alternatives left for them. EMTALA has increased access to ED treatment for many, but it does not address the broader issue of providing access for patients to effective primary care.

The PPACA represents a major effort by policymakers to increase access to health care, including specific measures meant to bolster primary care. While some of these measures provide incentives to increase access to primary care, they might not be sufficient to achieve the goal of ready access to primary care for all. The PPACA increased Medicaid primary care reimbursements to Medicare levels for two years (2013 – 2014) to encourage physicians to take on more Medicaid patients.\textsuperscript{173} While many states are continuing to reimburse at the same rate or a lower, but still elevated, rate, 23 states have opted to revert to the pre-PPACA Medicaid rates.\textsuperscript{174} Although reimbursement levels vary, even Medicare rates are only about 80\% of what private insurers would pay.\textsuperscript{175} In 2014, gall bladder removal in New York could be reimbursed by a private insurer up to $1,352, but Medicare would only pay $654.\textsuperscript{176} A provision in the PPACA afforded a 10\% bonus to primary care providers who accepted Medicare patients,\textsuperscript{177} but this was only in effect from 2011 through 2015.

The ED provides timely and quality care to patients at any time of the day or night, but the care is not necessarily the most appropriate or satisfactory treatment for

\textsuperscript{173} Paul Cheung et al., “National Study of Barriers to Timely Primary Care and Emergency Department Utilization among Medicaid Beneficiaries,” \textit{Annals of Emergency Medicine} 60, no. 1 (2012): 10.
\textsuperscript{174} “15 States Continue Bump in Medicaid”
\textsuperscript{176} Ibid.
\textsuperscript{177} Davis, “How the ACA Will Strengthen Primary Care,” 1201.
some patients. The PPACA has changed the insurance status of the patient population, and that change has influenced, and will continue to influence, the role of the ED. Many patients now have insurance but do not have regular access to primary care. The Act was predicted to relieve some of the stress on the nation’s EDs, but available evidence suggests that patient visits are continuing to rise.\textsuperscript{178} Access to primary care needs to be improved in order to provide patients with continuing and high-quality care, as well as improve some of the issues related to ED crowding by reducing the number of patient visits related to primary care factors. The PPACA has increased health insurance coverage for millions of Americans, but that measure will not be as effective if the provisions to expand primary care are not successful.

Some scholars argue that access to health care should be expanded because health care is a human right. Others claim that there is no right to health care and that the PPACA represents unauthorized use of governmental power. Still others argue that an efficient health care system should be a social ideal or should focus on protecting a normal level of human functioning. In the next chapter, I will discuss the theories behind a right to health care, the arguments against that right, and how the ethical foundation of the health care system shapes who has access to its resources.

CHAPTER THREE
ETHICAL IMPLICATIONS

At a 2008 presidential campaign debate with Senator John McCain, the soon-to-be President Barack Obama announced, “I think [health care] should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can’t pay their medical bills...there’s something fundamentally wrong about that.”179 While the mention of rights in politics is not surprising, President Obama still makes a significant claim by stating that the US should recognize a right to health care. The existence of a right to health care is a fiercely debated issue, and it is an integral part of the conversation surrounding the PPACA.

What exactly is meant by a right to health care? Some claim that a right to health care means governments should provide universal access (or insurance coverage) for all, regardless of ability to pay. Others argue that imposing a right to health care violates fundamental rights to property and liberty, especially if some citizens are required to subsidize the health care costs of other individuals. The existence and scope of a right to health care are essential issues for this thesis because they have significant consequences for the role of government in this area. Do governments have an obligation to refrain from mandating health care coverage or a duty to fulfill a right to health care? A legal right to some (emergency) treatment was established through EMTALA, and the implementation of the PPACA brings the US closer to supporting a right to health care coverage. In this chapter, I will define a “right,” discuss the

arguments for and against a right to health care, and offer an alternative perspective on
government-funded health care access.

What is a Right?

Before discussing whether or not there is a right to health care, it is imperative
to delineate what is meant by a “right.” In their book *Principles of Biomedical Ethics*,
Tom Beauchamp and James Childress state that “a right gives its holder a justified claim
to something (an entitlement) and a justified claim against another party.”¹⁸⁰ Rights can
apply to one’s property, one’s medical decisions, and one’s religion or spirituality. The
existence of universal rights is contested, but the right to not be harmed by others
(without justification) is generally accepted as a fundamental right.¹⁸¹ In *Two Treatises
on Government*, John Locke states that “no one ought to harm another in his life, health,
liberty, or possessions.”¹⁸² Locke describes a “state all men are naturally in,” or a state
of nature, as “a state of perfect freedom to order their actions, and dispose of their
possessions and persons, as they think fit, within the bounds of the law of nature.”¹⁸³
Locke’s ideas heavily influenced Thomas Jefferson, as is seen in *The Declaration of
Independence*.¹⁸⁴ In now-famous words, Jefferson wrote about “unalienable Rights” to

¹⁸⁰ Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* (New York: Oxford University
Press, 2013), 368.
¹⁸¹ John C. Moskop, *Ethics and Health Care: An Introduction* (Cambridge: Cambridge University Press,
2016), 33.
¹⁸³ Locke, *Two Treatises on Government*, 189.
¹⁸⁴ Carl L. Becker, *The Declaration of Independence: A Study in the History of Political Ideas* (New York:
Harcourt, Brace and Company, 1922), 62.
“Life, Liberty, and the pursuit of Happiness.” With Locke and Jefferson, I believe that all “men” (humans) inherently have certain natural rights that should not be violated without justification. I interpret Locke and Jefferson’s concept of a right to life, liberty, and property as negative rights, which means others have a duty of noninterference. Today, it is widely accepted that their references to “men” should include all human beings, regardless of race, gender, or age.

The natural rights affirmed by Locke and Jefferson can be understood as negative rights, which means that others ought not interfere with a person’s life, liberty, and property. These negative rights are commonly distinguished from positive rights. A positive right is an entitlement to some specific good; it implies a corresponding duty of another to provide that good. For example, a negative right to life requires that others simply refrain from taking one’s life. A positive right to life means that others are obligated to do whatever is necessary to keep one alive. Similarly, a positive right to health care puts a duty on governments, societies, medical providers, or others to provide certain medical services and treatments. Many negative rights, such as a right to life and free speech, are widely recognized in developed countries and have become legal rights in the US. Legal rights come from laws and statutes and may or may not be based on ethics. Thus, a legal right to complete an action does not mean that action is moral, and a exercising a moral right may not be legal. For example, citizens are free to express racist opinions through free speech, but many would not consider that to be moral. Similarly, some Americans believe in a moral right to marry whomever they wish,

---

185 The Declaration of Independence para. 2 (U.S. 1776).
but until recently, gay and lesbian couples did not have the legal right to get married.

Eligible Americans have a legal right to obtain health care coverage, but does that mean there is a fundamental, moral right to health care? There are many supporters and opponents of a moral right to health care, and I will present examples of both perspectives in order to further assess that right.

Support for a Right to Health Care

In the US, a significant source of contention in the right to health care debate revolves around the government’s role in providing access to the right. US federal and state governments use taxes to provide services for their citizens, such as police protection, the military, and courts of law. The power of these legislatures to raise funds through taxation and use that money is affirmed in several laws, including the Constitution; however, politicians and citizens interpret the extent of that authority differently. Does the government have the power to use taxpayer money to expand access to health care? Do Americans have a right to access health care? How much health care can they demand as a right? Decisions about whether to expand or restrict access to health care in the US are guided in part by whether or not those in authority believe there is a right to health care. If there is a right to health care, then the PPACA fulfills that right for some, but falls short in providing access for every American. Similarly, the states that did not expand Medicaid would be violating that right by denying coverage to millions of people. In addition, if health care is a right, then ethics

---

187 Beauchamp and Childress, *Principles of Biomedical Ethics* 271.
scholars and legislators need to delineate the extent of that right. Does health insurance coverage provided under the PPACA enable access to health care? If health care is a right, does the PPACA do enough to protect that right? Some persuasive arguments supporting a right to health care are based on human interests, equality, opportunity, and human function.

Kristen Hessler and Allen Buchanan expound on health care as a human right, stating that “being healthy is a universal interest.” They state that human rights are grounded in “basic human interests,” which are universally shared. These interests often require action by others in order for the right to be protected or fulfilled. Hessler and Buchanan claim that the universal interests that justify human rights (which subsequently demand positive duties from others) are founded on the principle of “equal consideration for all persons.” While individuals have a negative duty to refrain from harming another person’s health, governments that have the available resources have a positive duty to ensure that the right to health care is protected. Another egalitarian theorist, Kai Nielsen, maintains that every person has “an equal right to the most extensive total system of equal basic liberties and opportunities...compatible with similar treatment of all.” If “income and wealth...is to

---

189 Ibid., 91.
190 Ibid., 92.
191 Ibid.
192 Ibid., 92.
be so divided that each person will have a right to an equal share,” then health care ought to be distributed equally to every member of society according to need. An egalitarian would argue that the millions of Americans who lack access to appropriate medical care are not being treated as equals and that distribution of the good (health care) is unjust.

Another argument for a right to health care is based on Jefferson and Locke’s concept of a right to life and liberty. William Ruddick argues, “[H]ealth is a prerequisite for life and liberty;” “without at least a certain level of health, one’s life is in danger and one’s liberty of action is restricted or useless.” Ruddick’s perspective cleverly uses the “unalienable rights” expounded in the Declaration of Independence to justify a moral right to health care; however, Ruddick appears to conflate the idea of a negative right to avoid infringements on life and liberty with positive rights that require action from others. The claim that a right to health care based on a right to life and liberty obligates others to provide specific goods or services means that they would be positive rights. I would argue that life and liberty are negative rights, and while ill health might threaten one’s ability to exercise those rights, no person has violated one’s right to life or liberty simply by failing to prevent or treat illness.

Many supporters of a right to health care claim that fairness and equality of opportunity justify that right. Arguments following this line of reasoning are often based on John Rawls’ fundamental principles of justice. Rawls’ first principle states that “each

---

194 Ibid., 212.
195 Ibid., 220.
197 Ibid.
person is to have an equal right to the most extensive scheme of equal basic liberties compatible with a similar scheme of liberties for all.”198 His second principle asserts that “social and economic inequalities are to be arranged so that they are both: (a) to the greatest benefit of the least advantaged, consistent with the just savings principle, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity.”199 The phrase “fair equality of opportunity” can be interpreted several ways, and some have argued that access to health care is necessary to ensure that individuals are not barred from opportunities due to poor health. Ruddick says, “Equality of opportunity would require health care to prevent or compensate for those illnesses and defects which constitute handicaps in the (race)course of life.”200 Ruddick contends that society has a role in mediating the “disparities in health between the fortunate and the unfortunate.”201

Norman Daniels uses a similar argument but instead focuses on preserving opportunity in order to protect “normal functioning.”202 Normal functioning can be maintained through access to health care and allows people to have the ability to take advantage of life’s opportunities. Daniels maintains that access to health care has “special moral importance” in its role of preserving one’s abilities and promoting equal opportunity.203 He separates health care from other aspects of human functioning by

199 Ibid.
201 Ibid.
203 Daniels, Justice, Health, and Health Care, 7 – 8.
stressing the inequalities in access to health care that can have significant consequences for lower-income individuals.\textsuperscript{204} 

In a commentary on Daniels and his application of Rawls’ principles, John Moskop argues that Daniels’ interpretation of Rawls falls short of establishing health care as a universal human right or of specifying the scope of the right to health care.\textsuperscript{205} For example, Daniels fails to specify what he means by “normal” functioning and what opportunities a “reasonable” person should expect. At best, Moskop argues, Daniels’ appeal to fair equality of opportunity grounds claims of access to some level of health care for some people, depending on their capabilities and the resources of their societies.\textsuperscript{206} Moskop suggests that Daniels’ arguments about providing equal opportunity are more relevant when based on virtues such as “beneficence and kindness.”\textsuperscript{207} While arguments for a right to health care to promote equality, opportunity, or human functioning are powerful, many scholars nevertheless argue that there is no fundamental moral right to health care.

\textbf{Opposition to a Right to Health Care}

Recognizing health care as a natural or moral right implies that it is universal, regardless of whether it is established as a legal right.\textsuperscript{208} Since just governments should protect the natural rights of their citizens, laws should uphold those rights, including

\textsuperscript{204} Ibid., 8.
\textsuperscript{206} Moskop, “Rawlsian Justice,” 335.
\textsuperscript{207} Ibid.
providing for health care if it is a natural right. The libertarian perspective does not support a right to health care and instead argues that the government’s authority should not infringe on individual rights for the sake of societal entitlements. For example, in the US, libertarians would oppose the redistribution of wealth to pay for publicly-funded health insurance as a violation of individual citizens’ rights to property. Proponents of limited government do not deny that people have a right to seek health care, but rather argue that people are not entitled to those services.

Beauchamp and Childress define a positive right as “a right to receive a particular good or service from others.” While individuals can uphold negative rights of others by simply not interfering in their lives, positive rights place a duty on others to fulfill that right. If a drowning individual has the right to be rescued, then a passerby has a duty to throw a nearby life-ring out into the water. If health care is a positive right, then an individual or a group would be obligated to provide medical services; stating that there is a positive right to health care does not, however, specify who has that duty. Proponents of that right have to identify who has the obligation to provide health care services. Some have argued that governments have the duty to provide health care since governments have the resources and power to establish the system. Others might claim that physicians ought to provide health care since they have the necessary skills to treat patients. Robert Sade argues, “If the right to health care belongs to the patient, he starts out owning the services of a doctor without the necessity of either earning them or receiving them as a gift from the only man who has a right to give them: the doctor.

---

209 Ibid.
210 Beauchamp and Childress, Principles of Biomedical Ethics, 370.
himself.”\textsuperscript{211} While I think proponents of a positive right to health care have failed to provide a satisfactory explanation of who must fulfill the right to health care, Sade also makes a mistake by assuming medical professionals will be the ones that must fulfill that duty.

The American Medical Association’s Principles of Medical Ethics emphasize the fiduciary duty physicians have toward their patients, stating, “A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”\textsuperscript{212} Within their role as health care providers, physicians do assume duties to provide care to patients, but this fiduciary duty stems from the person’s voluntary assumption of the physician’s role and of contractual obligations to provide medical services in a particular practice setting, as well as the patient’s entitlement to those services. The AMA Principles of Medical Ethics also assert that “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”\textsuperscript{213} Thus, according to the AMA Principles, physicians have a duty to treat, but they also have the ability to decide who to accept as a patient. I do not think supporters of health care expansion mean to force physicians to treat patients; rather, the right to health care today usually means a right to health care coverage.

\begin{flushright}
\footnotesize
\textsuperscript{213} “AMA Code of Medical Ethics,” \textit{AMA}.
\end{flushright}
Sade assumes that a right to health care can only be achieved by forcing physician to treat patients, but in modern health care systems, governments enlist the services of physicians and insurers through voluntary contracts to provide greater access to care. Much like lawyers or teachers, physicians are voluntarily hired to provide certain services, and not fulfilling those tasks would violate the physician’s contractual obligations. Physicians do have ethical duties toward patients that are not held by other professionals, but patients cannot rightfully demand treatment from any physician at any place and time. Emergency physicians must treat patients with emergency medical conditions, but that is a legal right established by EMTALA and part of the duties an emergency physician voluntarily assumes. The PPACA expands health care coverage for many Americans but does not guarantee access or legally require physicians to treat certain patients. If there is a right to health care, then some individual or entity must accept the duty to provide those services; however, Sade’s statement that this right will enslave physicians incorrectly assumes that that duty must fall on physicians.

Many assume that if there is a right to health care, then the duty to fulfill that right should fall on governments instead of individual care providers. Countries like Denmark and Canada have a government-run health care coverage system that provides universal access to care for their citizens. The social provision of health care to those who cannot pay for it requires appropriation of the personal property of some citizens to pay for care provided to others who need it. For example, taxes paid to the government support programs that provide services, such as the PPACA’s provision of health insurance coverage or subsidies for millions of Americans. If those who earn
enough money to pay for their own health insurance do not pay those taxes necessary to support government programs, then they face repercussions for tax evasion. The government’s ability to use force through the police to impose laws restricts individual liberty. Sade describes this threat in dramatic terms: “It is a frequently overlooked fact that behind every law is a policeman’s gun or a soldier’s bayonet. When that gun and bayonet are used to initiate violence, to take property or to restrict liberty by force, there are no longer any rights, for the lives of the citizens belong to the state.”

Opponents of a right to health care might argue that the PPACA (and the threat of coercion for a citizen’s noncompliance with tax payments) violates an individual’s right to property.

Engelhardt emphasizes that a positive right to health care conflicts “with the decisions of individuals who may not wish to participate in, and may indeed be morally opposed to, realizing a particular system of health care.” Without the permission of the individual, “to advance such rights is to claim that one may press others into labor or confiscate their property.” Robert Nozick holds that violating an individual’s right for the sake of society’s benefit “does not sufficiently respect and take account of the fact that [the individual] is a separate person.” According to Nozick, individual rights are superior to societal entitlements, and a government ought not violate those rights in order to impose publically-funded programs. Instead of emphasizing individual rights to property and liberty, supporters of a right to health care are more likely to emphasize

214 Sade, “Case as a Right: Refutation,” 1289.
216 Ibid.
the recipient’s need for those resources. While Engelhardt acknowledges that not providing care for others might be viewed as a lack of compassion, this does not justify a violation of individual rights by the state.

Engelhardt proposes that “there is no canonical content-full vision of justice to shape secular health care policy.” Many arguments have been made both in support of and in opposition to a right to health care. While theories of justice and rights are valuable in other areas, such as criminal and civil law, perhaps other sources of guidance are necessary to determine the ethics of health care access.

**No Consensus on a Right to Health Care**

In his article “No Theory of Justice Can Ground Health Care Reform,” Griffin Trotter points out that if there are basic disagreements about the justifiability of social welfare programs in general, then it is no surprise that strong controversy exists about how health care should be distributed. He offers three reasons why there is no agreement about distributive justice. First, foundational concepts about each theory of justice, such as egalitarianism or libertarianism, are based on value assumptions that are specific to each theory. When the theories are circular in this way, then it is difficult to find common ground between two separate theories. Second, compromise between two theories is almost impossible unless one already concurs with the central premise(s)

---

218 Ibid., 168.
220 Ibid., 398.
of the competing theory.\footnote{Ibid.} Third, discussions about the theories of justice are abstract; when one attempts to translate the ideas into specific public policies, natural biases surface and the result is an imperfect or altered form of the theory.\footnote{Ibid.} Even James Madison, the “Father of the United States Constitution,” doubted that public policy and conceptions of the general welfare could ever be rooted in a common perception of justice.\footnote{Ibid.} There have always been diverging perspectives about justice and its implementation in US politics. No theory can completely debunk another theory, as each has its own line of reasoning and support. What is just for a libertarian is a gross injustice for an egalitarian, and these contradictions are based on fundamental values that proponents of the different theories are unwilling to compromise. While opinions differ on whether or not there is a right to health care, the disagreement between different theories of justice make a political compromise problematic. If Trotter’s conclusion that no one theory of justice can unequivocally establish whether or not there is a right to health care is correct, we must turn to other sources for guidance about society’s role in the distribution of health care.

**Health Care as a Social Ideal**

Instead of pitting societal entitlements against individual rights, Moskop suggests that health care could be considered a social ideal instead of a right.\footnote{Moskop, “Rawlsian Justice,” 336.} Health care is obviously a valuable social institution that can significantly improve the lives of those in
the community. Engelhardt states, “A secular health care system will need to shoulder the task of fashioning choices about how to invest communal resources in gambling with human suffering and death.”\textsuperscript{226} He suggests that the social distribution of health care might “be created through some form of common and fair negotiation or agreement.”\textsuperscript{227} Even though libertarians usually do not agree with governmental provision of services for individuals, Engelhardt acknowledges that government might have a role in health care. While the extent of that power is constrained by individual rights, there is some support among libertarians for a limited provisions of governmental programs that will benefit society. As Engelhardt proposes, a free society could discuss different ways to promote access to health care and find a system that is favorable to all involved. This discussion would most likely occur among those elected to positions of authority.

Unanimous agreement on a certain form of health care is unlikely, and Engelhardt focuses on fair procedures to establish a health care system. It might be that all citizens entrust a just government or democratic republic to make decisions for a society, or it might be up to volunteer organizations or charities to promote greater access to care. If the citizens of a society voluntarily agree to a system of negotiation for establishing health care, then no one is forced to sacrifice individual rights for the good of society. In addition, I believe that consideration of another recent approach to social justice called the capabilities approach can offer some insight into potential societal values that can guide a health care system.

\textsuperscript{226} Engelhardt, \textit{The Foundations of Bioethics}, 391.
\textsuperscript{227} Ibid.
Martha Nussbaum formulates one account of the capabilities approach through ten “central human capabilities” that emphasize the qualities needed to achieve a life of dignity.\textsuperscript{228} Nussbaum’s “central human capabilities” are: life, bodily health, bodily integrity, senses/imagination/thought, emotions, practical reason, affiliation, relations to other species, play, and control over one’s environment.\textsuperscript{229} According to this theory, humans do not have adequate opportunities or ability to function beneath a certain “threshold level of each capability.”\textsuperscript{230} The goal of societies and governments should be to allow their citizens to achieve and rise above the minimum threshold for each capability.\textsuperscript{231} Nussbaum names “bodily health” as a core capability, which means that life without it falls below a certain level of human functioning.\textsuperscript{232} Like Norman Daniels, Nussbaum argues that humans should exist above a certain threshold of functioning.\textsuperscript{233} Daniels states, “By maintaining normal functioning, health care protects an individual’s fair share of the normal range of opportunities (or plans for life) that reasonable people would choose in a given society.”\textsuperscript{234} As I mentioned earlier, Moskop argues that Daniels’ fair equality of opportunity argument might support a claim to some level of health care, but not necessarily a universal right to health care. Nussbaum claims that dignity is a human right, and since the ten capabilities are based on dignity, they are entitlements that society should provide. Nussbaum attempts to use the capabilities approach “to

\textsuperscript{228} Martha Nussbaum. \textit{Frontiers of Justice: Disability, Nationality, Species Membership} (Cambridge, MA: Harvard University Press, 2006), 70.
\textsuperscript{229} Ibid., 76-77.
\textsuperscript{230} Ibid., 71.
\textsuperscript{231} Ibid.
\textsuperscript{232} Ibid., 76-77.
\textsuperscript{233} Ibid., 71.
\textsuperscript{234} Daniels, “Justice, Health, and Health Care,” 7
provide the philosophical underpinning for an account of core human entitlements that should be respected and implemented by the governments of all nations, as a bare minimum of what respect for human dignity requires.”235 Not only can it be argued that dignity is not a universal right (although it is desirable), but Nussbaum also fails to specify what the threshold level for the capabilities entails or whether and how societies can implement programs that provide health care and support all of the other human capabilities she identifies. Falling short of supporting health care as a universal right, I think Nussbaum and Daniels’ arguments support the more moderate perspective that views health care as a social ideal.

If the capability to achieve bodily health is a goal toward which society should strive, then health care could be justified as a social ideal. Each society and country works to achieve different objectives, and the perception of “social ideal” is relative, depending on the community’s values. Societies secure the resources that are most important to them and their way of life. For example, the first capability of “life” is more important than “play,” since the former is necessary to achieve the latter but the opposite is not true. People in poorer countries face more pressing threats to their opportunities, like acquiring healthy food and clean water, which need to be addressed before needs that are not as basic. Countries could continuously work to achieve the capabilities threshold and to establish the ten capabilities as social entitlements.

Perhaps, as Moskop proposes, society can begin to establish a distribution of health care

235 Nussbaum, *Frontiers of Justice*, 70.
resources that is grounded in “its history, culture, affluence, and special needs or goals.”236

Moskop states that a social ideal “may inspire the creation of specific legal rights.”237 In the US, EMTALA and the PPACA have granted new or different legal rights to patients and thus imposed legal duties on institutions, companies, and physicians. Both laws have significantly changed the US health care system and how patients interact with it. I think that the expanded access to health care under these laws is an encouraging change. Greater access to care can improve the health of individuals, which can positively affect the lives of those individuals, their families and friends, and society as a whole. As more people gain health insurance coverage, individuals and families will be both more financially secure and better able to seek treatment. In addition, increased access to care can lead to more treatment of illnesses and management of chronic diseases, which decreases pain and suffering. It should be noted that there is also a significant issue of patient responsibility in health care. Do patients have a duty to take care of their own health? It seems that each individual might have a responsibility for his or her own health, but the scope and limits of that responsibility are complex and controversial topics. I believe that patients do bear some responsibility for their own health and health care, but cannot pursue that difficult topic further within the length limits of this thesis.

If health care is indeed a social ideal, then we ought to work constantly toward improving the quality and efficiency of the system in order to provide the greatest

237 Ibid.
benefit for patients and families. While Americans might not necessarily have a right to health care, our society ought to work toward supporting citizens’ capability to be healthy. The implementation of Medicaid, Medicare, and the PPACA indicate that Americans do indeed believe that health care is an important aspect of society. EDs are vital components of emergency care, and ideally, patients with emergent or urgent illness would not have to wait to be seen by a physician. Strengthening the primary care foundation would not eliminate ED visits, but it might improve the overall health of the US population.

There are innumerable improvements to the US health care system that could be made, and I contend that primary care is a worthy starting point. A more robust foundation in primary care is linked to better population health and fewer socioeconomic inequalities in Europe.\(^{238}\) Investment in primary care now might not only save money in the future, but also improve the long-term health of Americans. US states with a higher proportion of primary care physicians had lower health spending and higher rates of use of effective care, which may be due to better preventive services and continuity of care.\(^{239, 240}\) In addition, a literature review paper found that primary care can alleviate inequalities due to health care maldistribution and is associated with better health.\(^{241}\)

\(^{238}\) Kringos, “Europe’s Strong Primary Care Systems,” 692.
\(^{240}\) Katherine Baicker and Amitabh Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” *Health Affairs*, Supplemental Web Exclusives, (2004): W4-193.
\(^{241}\) Starfield, “Contribution of Primary Care,” 459, 461.
The US is moving toward more comprehensive insurance coverage, but there are still many other changes that could be made that might promote the health and wellbeing of Americans. Reform that bolsters primary care will not improve every problem that patients and providers in the US health care system face, but it is a step toward higher-quality patient care. If primary care can be strengthened, then numerous illnesses and hospitalizations can be avoided. While many ill patients need specialty care, both sick and healthy people can take advantage of primary care. The availability of primary care affects health outcomes as well as the efficiency of the rest of the system, which makes it a good area to address. In the next chapter, I will recommend changes that need to be made in order to improve access to health care in the US.
Despite its high overall and per capita costs, the US health care system fails to provide optimal care for many Americans. Identification of areas needing improvement is an essential step to reform, and in Chapter 2 of this thesis, I described some of the problems related to lack of access to primary care and increased use of EDs. The evidence I reviewed suggests that increasing access to primary care could promote better patient health and a more efficient health care system. If accessible preventive measures and continuity of care can improve patient health, then fewer patients will need to seek care in the ED. Ideally, the ED would not have to function as safety-net care if patients were treated in more appropriate settings for their ambulatory care sensitive conditions.

While there are multiple ways that the US health care system could be reformed, I will propose some recommendations and solutions applicable to primary care and the ED that I believe would be the most effective changes for those two health care settings. These proposed changes would cost a significant amount of money, but investment in a strong primary care foundation now could contain costs and decrease spending in the long-term. In addition, focusing on primary care might decrease the amount of health care spending currently seen in hospital and specialty care. Other countries with highly developed primary care systems, such as the Netherlands and Denmark, have shown that it is possible to spend less on health care than the US and still have better health
outcomes. While implementation of all of my recommendations may not be feasible, focusing on a few could drastically improve the efficiency of the US health care system. There are many provisions in the PPACA that affect primary care, and I will analyze the value of several of these measures. I will also discuss further changes that could increase the number of primary care physicians and bolster the role of physician extenders in primary care. Finally, I will offer recommendations for improving the effectiveness and efficiency of care in hospital EDs.

**PPACA Provisions and Recommendations**

If universal access to health care should be a social ideal, then efforts ought to be made to ensure the health care system addresses the needs of society. The US health care system provides adequate care for many people, but others are not able to access those same resources. The PPACA attempts to expand access to health care, and measures to increase availability of primary care are a vital aspect of that goal. Primary care provisions in the Act focus on reimbursement rates, funding of primary care sites, availability of preventive care, and increasing the primary care workforce. The effectiveness of many PPACA provisions cannot be evaluated definitively after such a short time since implementation and will become more apparent over the coming years. I will, however, offer some provisional assessment of major primary care provisions of the Act.

Low reimbursement rates from public insurance programs dissuade primary care providers from accepting these patients.\textsuperscript{243} The PPACA addressed this issue by increasing Medicaid reimbursement levels to those of Medicare for two years (2013 – 2014)\textsuperscript{244} and providing a 10% bonus for providers treating Medicare patients for five years (2011 – 2015).\textsuperscript{245} While this measure helped physicians and practices to provide care for many publicly insured individuals, both changes were temporary. The Medicaid reimbursement changes were federally funded while in effect, and afterward the states were given the option to continue the higher reimbursement rate levels. Twenty-three states reverted to the pre-PPACA Medicaid rates.\textsuperscript{246} Continuity of care with a primary care physician would ideally last longer than two and even five years; these provisions might not have been enough to encourage physicians to accept new Medicaid and Medicare enrollees if they would still be patients beyond the two or five year period of the PPACA’s increased reimbursement provisions. For example, a primary care physician might accept a new Medicaid patient in 2013 and be paid at Medicare rates; however, at the start of 2015, the reimbursement rate would decrease if his or her state opted not to continue the pay bump. The PPACA also established a new Center for Medicare and Medicaid Innovation (CMMI), with a charge of analyzing different payment options and methods; perhaps CMMI can remedy the issues in primary care reimbursement in the coming years.\textsuperscript{247}

\textsuperscript{243} Ubel, “Physicians Reluctant to see Medicaid Patients,” \textit{Forbes}.
\textsuperscript{244} Davis, “How the ACA Will Strengthen Primary Care,” 1201.
\textsuperscript{245} “Summary of the ACA,” \textit{Kaiser Family Foundation}.
\textsuperscript{246} “15 States Continue Bump in Medicaid”
\textsuperscript{247} Davis, “How the ACA Will Strengthen Primary Care,” 1202.
The PPACA provided states with additional federal funding for “health homes” for two years starting at the beginning of 2011. Health homes are designed to provide access to primary care services for chronically ill Medicaid patients. Health homes are based on the model of patient-centered medical homes (PCMH), which have been shown to reduce the use of ED services in certain areas. A patient’s health home will have a primary care provider who works with a team to coordinate care, transition patients between in-patient stays and primary care, refer patients to community or social services, and promote the health of the patient. States have the option to allow Medicaid patients with chronic illnesses or certain other medical conditions to choose a primary care site as a health home. Each state can create its own reimbursement method for the health home and institute protocols for referring eligible Medicaid patients from the ED to their health home. By April of 2016, health home models were established in 21 states and the District of Columbia (D.C.). While their full effect on patient care and access to services is not obvious yet, health homes have potential to be excellent sources of care for chronically ill Medicaid patients.

The PPACA requires all health insurance plans that started after September 2010 to cover certain preventive services without the patient having to pay a co-insurance,

---

248 “Summary of the ACA,” Kaiser Family Foundation.
250 Ibid.
253 “Summary of the ACA,” Kaiser Family Foundation.
254 Davis, “How the ACA Will Strengthen Primary Care,” 1202.
co-payment, or meet a deductible. These preventive services include some standard immunizations for children, folic acid supplements for pregnant women, cholesterol screening for adults, and diet counseling for high risk adults. The Act also covers encourages elderly patients to seek continuing care by covering co-insurance, deductibles and co-payments for preventive measures and annual wellness checks from primary care providers. While these measures may prompt patients to increase their use of preventive services, patients would still face a barrier if access to timely primary care is not expanded.

Medicaid patients face numerous barriers to primary care, but after National Federation of Independent Business v. Sebelius, many low-income inhabitants of states opting not to expand Medicaid are left without any insurance coverage. Thirty-one states and the District of Columbia have expanded Medicaid, but 19 states have not. Subsidies to purchase health care coverage are available to those earning slightly above the PPACA Medicaid threshold; these subsidies gradually decrease as a family’s household income increases. According to the PPACA, those below the Medicaid income threshold are not eligible to purchase subsidized health insurance through federal or state insurance exchanges, due to the lawmakers’ assumption that the Medicaid provision would cover that population. This means those with an income slightly above 133% of the Federal Poverty Level (FPL) have to pay almost nothing for

---

257 Davis, “How the ACA Will Strengthen Primary Care,” 1203.
259 Ibid.
260 Davis, “How the ACA Will Strengthen Primary Care,” 1203.
coverage, but there is no assistance in those states that chose not to expand their Medicaid programs for non-disabled, childless adults who earn less than 133% of the FPL. Uninsured, low-income Americans are not as likely as insured patients to seek preventive or long-term care from a primary care provider, and most private-practice providers are unwilling to accept uninsured patients if they cannot pay the costs in full. The high cost of health care in the US makes insurance coverage a virtual prerequisite to access for most non-emergency care, since treatment can be financially devastating to individuals and families. Although those with Medicaid often do not have easy access to primary care, they do have some amount of insurance coverage that may enable them to secure access to some primary care services in some areas. Thus, states ought to expand Medicaid coverage under the PPACA to enable patients to seek and find primary care services instead of going to the ED.

Several provisions in the PPACA are meant to increase the number of primary care providers in the hope that this will expand access to care. One approach in the Act was to invest $1.5 billion in the National Health Service Corps (NHSC), which funds scholarships and loan forgiveness for physicians, nurse practitioners, and physician assistants who serve as primary care providers for a designated period of time in underserved areas. A 2012 HHS report found that ten years after fulfilling their commitment, over half of NHSC providers still practice in medically underserved

---


areas. In 2013, there were 8,900 primary care providers practicing in the NHSC, and there was an almost 2.5 fold increase in the number of NHSC clinicians since 2008. Between 2009 and 2013, federal funding has helped the NHSC financially support 14,000 providers who provide care in underserved areas. While these NHSC financial incentives encourage students to enter primary care fields, this provision was only in effect from 2011 to 2015. I recommend an extended investment in the NHSC and other loan repayment programs in order to encourage a stable influx of new primary care providers.

Measures also focus on promoting growth within the workforce of advanced practice providers. The PPACA includes grants and loan forgiveness for nurse practitioners (NPs) and physician assistants (PAs). The shortage in NPs is also addressed by expanding education capacity, supporting training programs, and developing a career track. NPs and PAs play a large and increasing role in the provision of primary care, and their contribution should not be understated. In the following section, I will recommend further changes to support their roles as primary care providers and thereby increase access to primary care. While the medical and legal issues related to reliance on NPs and PAs are complex, I will evaluate those options in the next section.

267 Ibid.
269 “Summary of the ACA,” Kaiser Family Foundation.
Physicians are a vital part of the primary care workforce, but availability of residency slots has been identified as a bottleneck in medical education that impedes the training of new primary care physicians.\textsuperscript{270} Beginning in 2011, the PPACA has redistributed unused residency slots to other hospitals, emphasizing primary care and general surgery training for medically underserved areas.\textsuperscript{271} While this redistribution might seem useful, it did not do enough to bolster Graduate Medical Education (GME) in the primary care specialties. The PPACA takes a similar approach as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that redistributed residency openings in 2005.\textsuperscript{272} After its implementation, there was a rise in primary care training, but it was only half as large as the increase in non-primary-care training.\textsuperscript{273} I believe that the flow of medical school graduates into primary care residencies should be a central point of reform in order to increase the number of primary care physicians. The PPACA does offer some changes, but more extensive measures need to be implemented to relieve the shortage of primary care physicians.

\textbf{Addressing the Primary Care Workforce Shortage}

Elimination of the GME bottleneck could potentially reverse a significant portion of the primary care physician shortage through a growth in residency position funding.

In 2006, the Association of American Medical Colleges (AAMC) called for an expansion in


\textsuperscript{271} Candice Chen et al., “The Redistribution of Graduate Medical Education Positions in 2005 Failed to Boost Primary Care or Rural Training,” \textit{Health Affairs} 32, no. 1 (2013): 103.

\textsuperscript{272} Chen, “Redistribution of GME in 2005,” 103.

\textsuperscript{273} Ibid., 106.
medical schools to accommodate 30% more students.274 The increase is expected to be only 0.8% shy of that goal for incoming medical students in 2019;275 however, there has only been an 8% growth in the number of residency, or GME, positions since 2002.276 The Balanced Budget Act of 1997 capped the number of federally funded GME positions, and that cap is still in effect today.277 While there are several different approaches to accelerating the slow growth in residency training slots, there is a general consensus that a GME reform or overhaul needs to take place.278,279,280 For example, the AAMC recommends that Congress raise the cap on how many residency slots Medicare will fund and that the number of residency positions should increase by 4,000 every year over the next decade.281 The Alliance of Academic Internal Medicine (AAIM) and the American College of Physicians (ACP) have made several recommendations, including more transparency in how funds are invested in training and encouraging primary care training in ambulatory settings for internal medicine residents.282 Policymakers and medical institutions should work together to find solutions that are

276 “AAMC Physician Workforce Policy,” AAMC.
277 Ibid.
278 Ibid.
281 “AAMC Physician Workforce Policy,” AAMC.
both effective and cost-efficient in order to increase the number of medical school graduates training to be primary care physicians.

In addition to GME barriers, growth in primary care is stunted by medical school culture. A career in primary care does not seem to garner much respect among medical students, and negative views about those specialties are common in medical training.283 A 2012 study found that students were often influenced by experiences before becoming medical students and by the attitudes of society toward primary care.284 Students of all years had this negative perception of primary care specialties, which suggests that medical school does not deflate this attitude and might strengthen it.285 Study participants perceived primary care more negatively than subspecialty care, and shadowing or working with primary care physicians did not seem to change that perspective. If students do not have a positive view of a certain specialty, it is unlikely that they will voluntarily enter residency training in that specialty. To counteract this negative view, educators should emphasize the rewards of primary care practice and the value of primary care in the health care system, rather than furthering negative views that might discourage potential primary care physicians. For example, medical schools could give their students opportunities to work with primary care physicians who find their specialty fulfilling.

In addition to improving training programs for residents, students can be supported through financial incentives. As mentioned earlier, greater steps should be

284 Ibid., 11.
285 Ibid.
taken to support the NHSC to encourage premedical and medical students to pursue primary care in medically underserved areas. If newly insured Americans are concentrated in underserved areas, then this measure could bolster the workforce in those areas.\textsuperscript{286} A 2014 study showed that more than half of medical school graduates had greater than $50,000 in student debt, and public medical school graduates with significant debt are less likely to choose primary care specialties.\textsuperscript{287} Loan forgiveness and scholarships could provide a significant incentive to prospective physicians to pursue primary care specialties. Physicians are an essential component of a solid primary care foundation, which in turn is essential to a strong health care system.

In addition to physicians, NPs and PAs serve a vital role in primary care and can fill the gap left by the physician shortage. Changes to improve access to primary care should focus on increasing the overall number of providers rather than only increasing the number of physicians. Although the role of physicians should not be underestimated, patients need more access to primary care, and more NPs and/or PAs could narrow that gap. Both NPs and PAs are well educated clinicians and must pass a state board exam to be certified.\textsuperscript{288} The Agency for Healthcare Research and Quality reported that about 56,000 NPs and 30,000 PAs worked in primary care settings in 2010.\textsuperscript{289} NPs and PAs can provide many of the same primary care services as physicians,

\textsuperscript{286} Petterson, “Projecting Primary Care Workforce,” 508.
\textsuperscript{287} Julie P. Phillips et al., “A Retrospective Analysis of the Relationship between Medical Student Debt and Primary Care Practice in the United States,” \textit{Annals of Family Medicine} 12, no. 6 (2012): 547.
\textsuperscript{289} “The Number of Nurse Practitioners and Physicians Assistants Practicing Primary Care in the United States,” \textit{U.S. Department of Health and Human Services: Agency for Healthcare Research and Quality},
and evidence shows that they provide appropriate patient care, comparable to that of a
physician.\textsuperscript{290,291,292} Measures to improve access to primary care might focus on
increasing the number of NPs and PAs who can supplement a primary care physician.
PAs practice under a physician and can perform services that are both delegated by the
physician and within the physician’s scope-of-practice.\textsuperscript{293} On the other hand, NPs are
limited by the scope-of-practice standards set by state laws, which vary widely.\textsuperscript{294} A
2010 Institute of Medicine (IOM) report listed its first recommendation as “Remove
scope-of-practice barriers” for NPs so that they can “practice to the full extent of their
education and training.”\textsuperscript{295} Laws restricting PA and NP practice should balance patient
safety and access to care. In addition, more funding could be allocated toward the
education and training of these practitioners. The PPACA provision that funded the
NHSC from 2011 through 2015 for physicians also included financial incentives for PAs
and NPs. Again, I propose that this and similar measures in the PPACA should be
extended into more permanent funding. In addition, legislation should ensure PAs and
NPs are reimbursed at the same rate as physicians when performing the same task.\textsuperscript{296}
More PAs and NPs could reduce ED crowding and improve access to primary care
appointments, so future policies should increase their role in the primary care setting.

\textsuperscript{290} Paradise, “Improving Access to Adult Primary Care.”
\textsuperscript{291} Miranda Laurant et al., “The impact of Nonphysician Clinicians: Do They Improve the Quality and Cost-
Effectiveness of Health Care Services?,” \textit{Medical Care Research and Review} 66, no. 6 (2009): 365 – 89 S.
\textsuperscript{292} Ira B. Wilson et al., “Quality of HIV Care Provided by Nurse Practitioners, Physician Assistants, and
\textsuperscript{293} Paradise, “Improving Access to Adult Primary Care.”
\textsuperscript{294} Ibid.
Press, 2011), 278.
\textsuperscript{296} Paradise, “Improving Access to Adult Primary Care.”
Emergency Department Recommendations

In addition to primary care, PAs and NPs are being used in “fast track” areas in the ED to help ease the burden of crowded waiting rooms.\textsuperscript{297} Fast track areas of the ED are units that assess and treat patients with minor conditions who can be released quickly,\textsuperscript{298} they have been shown to decrease patient wait times.\textsuperscript{299} A hospital ED in Louisiana incorporated an NP in a fast-track area while measuring quality markers. Although the number of visits increased, the door-to-provider time was almost halved after a year.\textsuperscript{300} In addition, the length of stay in the ED decreased and the number of patients who left without being treated declined.\textsuperscript{301} Another option might be for EDs to have 24/7 urgent or primary care centers on the hospital campus or next to the ED. These centers could be staffed by PAs, NPs, and hospital-based physicians in order to provide more timely and cost-effective treatment for patients with non-urgent ACSCs.

It has been suggested that the PPACA might be a catalyst to redefining the role of the ED in the health care system beyond the provision of emergent care.\textsuperscript{302} Given the continuing lack of access to primary care, the ED might integrate more holistic approaches to health rather than focusing on episodic care.\textsuperscript{303} For example, the IMPACT DC Asthma Clinic was established to provide education and follow-up care to children.

\textsuperscript{298} Ibid.
\textsuperscript{301} Ibid.
\textsuperscript{303} Ibid.
with asthma in the familiar ED setting. The Clinic aimed at children who rely on episodic ED care in order to transition them into medical home continuing care. The typical 90-minute visit focused on working closely with the families to develop unique plans for management of each patient’s illness. This intervention was successful in improving patient quality of life and managing symptoms. Other EDs could take similar measures to ensure that chronically ill patients are fully informed about their diseases and how to manage them.

Similar to the IMPACT Clinic’s efforts to communicate better with families, other measures could focus on increasing patients’ knowledge and understanding of their diseases and the health care system as a whole. One study showed that patients weigh several factors when deciding where to seek care but do not necessarily know all the options that are available. Hospitals with EDs might attempt to increase public knowledge about other primary care options, including where to go and when, as well as payment information. Another option practiced by the Ochsner Health System in Louisiana involves having a triage nurse on-call to advise patients over the telephone on where to seek care. If the patient ought to go to an urgent care or primary care clinic,

---

305 Ibid., 119.
306 Ibid., 117.
307 Ibid., 119.
then the nurse can schedule an appointment while on the phone with the patient.\textsuperscript{310} “Ochsner On Call” estimates that only about 20% of the calls warrant a visit to the ED, and the majority either get appointments or advice on at-home treatment.\textsuperscript{311} Other educational measures might focus on helping patients understand what constitutes an emergency and when is an appropriate time to schedule a primary care appointment.

Care coordination is also emerging as a means to improve patient care. Some have suggested that improved coordination between ED physicians and primary care providers might improve patient outcomes, although more research is needed to test that theory.\textsuperscript{312} For example, better communication methods could ensure that primary care physicians know what happened to the patient in the ED and might increase the chances that the patient will have a follow-up visit with the primary care physician.\textsuperscript{313} In addition, the measures that focus on illness prevention or chronic disease management might be financially advantageous for institutions if high-cost ED visits for uninsured or underinsured could be decreased.

\begin{itemize}
\item \textsuperscript{310} Ibid.
\item \textsuperscript{311} Ibid.
\end{itemize}
CONCLUSION

The US health care system is flawed, and I have recommended several changes that I believe would increase both the efficacy and the efficiency of the system. There are innumerable ways to improve and revamp the system, and I have only suggested a few measures that might have a positive impact on primary care and the ED.

The ED and primary care are crucial aspects of the US health care system, and it is important that those two branches of the system work as effectively as possible. I believe health care is a social ideal and improving the current system for patient health should be a goal for both citizens and legislators. More and more people are seeking treatment in the ED, and EDs are busy and overcrowded. EMTALA establishes a limited legal right to health care for emergency medical conditions, and for many that is their only access to treatment. The US is moving toward providing a broader set of health care services for US citizens and residents, and the PPACA is attempting to expand access to health care. While I agree with the goals of these laws, I do not claim there is a human right to health care, as do many supporters of the PPACA. Rather, I think access to health care should be considered a social ideal, which we can afford in a country with as many resources as the US.

The PPACA has increased health insurance coverage, but many Americans still cannot schedule primary care appointments or be treated for ACSCs in a timely manner. This lack of access endangers patients’ health and is a symptom of an inefficient health care system. The identification of problems that affect both the ED and primary care is the first step toward reform. I have suggested several modifications to the PPACA,
recommendations for primary care, and changes to the ED that could begin to improve patient care and the system as a whole. Implementation of the PPACA continues to unfold, and its effect on coverage, cost, and access will become more apparent over the next few years. As the US health care system evolves, we must continually strive to implement changes that promote the health of patients and society.
REFERENCES


Baicker, Katherine, and Amitabh Chandra, “Medicare Spending, the Physician Workforce, and Beneficiaries’ Quality of Care,” Health Affairs, Supplemental Web Exclusives, (2004): W4-184 – W4-197.


The Declaration of Independence para. 2 (U.S. 1776).

DeLia, Derek, Joel C. Cantor, Susan Brownlee, Jose Nova, and Dorothy Gaboda, “Patient Preference for Emergency Care: Can and Should It Be Changed,” *Medical Care and Research Review* 69, no. 3 (2012): 277 – 293.


Laurant, Miranda, Mirjam Harmsen, Hub Wollersheim, Richard Grol, Marjan Faber, and Bonne Sibbald, “The impact of Nonphysician Clinicians: Do They Improve the Quality and Cost-Effectiveness of Health Care Services?,” *Medical Care Research and Review* 66, no. 6 (2009): 36S – 89S.


Yarnell, Kimberly S. H., Truls Østbye, Katrina M. Krause, Kathryn I. Pallak, Margaret Gradison, and J. Lloyd Michener, “Physicians as Team Leaders: ‘Time’ to Share the Care,” *Preventing Chronic Disease* 6, no. 2 (2009).

CURRICULUM VITAE

Personal Information
Cornelia (Nella) W. Hendley

Education
Bachelor of Science, Biology
   Wake Forest University, 2015

Honors
Phi Beta Kappa