11.1.4 Financial Barriers to Health Care Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.
In view of this obligation,

(a) Individual physicians should:

  (i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

  (ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

AMA Principles of Medical Ethics: I,II,VI,VII,IX

Background report(s):

CEJA Report 2-A-09 Financial barriers to health care access

CEJA Report C-I-92 Caring for the poor

CEJA Report C-A-92 Ethics of coinsurance forgiveness

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-09

Subject: Financial Barriers to Health Care Access (Resolution 704, I-07)

Presented by: Regina M. Benjamin, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Daniel W. Van Heeckeren, MD, Chair)

Resolution 704 (I-07), introduced by the Colorado Delegation, and referred by the House of Delegates (HOD), asked our American Medical Association (AMA) to recognize that providing adequate health care is a fundamental societal obligation. The Council on Ethical and Judicial Affairs testified that it was currently considering the issue. The following report presents the results of the Council's analysis and deliberations.

Health care can be viewed as a fundamental human good because it affects "our opportunity to pursue life goals, reduces our pain and suffering, prevents premature loss of life, and provides information needed to plan our lives."[1, 2] AMA's *Principles of Medical Ethics* set out physicians' ethical obligation to support access to medical care for all people (Principle IX),[3] an obligation that physicians share with all who are involved in providing and financing health care, including the medical profession as a whole, health care facilities and payers, and public policymakers. Yet lack of health insurance and inability to pay out of pocket mean that many individuals do not have access to care.

This report examines financial barriers that prevent individuals from getting care and the ethical responsibility that physicians, individually and as a profession, have to ensure that all individuals can access needed care regardless of their economic status. Although financial barriers to access are only one of several factors that affect patients' health and well-being, they are a significant concern and one that physicians and the profession can take steps to address. The Council on Ethical and Judicial Affairs anticipates addressing other barriers to care in future reports.

THE IMPACT OF FINANCIAL BARRIERS TO ACCESS

Since the middle of the 20th century, a variety of steps have been taken to promote greater access to health care, including tying funding for the building and modernization of hospitals under the Hill-Burton Act to provision of charity care, mandating care in emergency situations through the Emergency Medical Treatment and Active Labor Act, and establishing Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP) to provide medical care to potentially vulnerable groups (children, the poor, the elderly, and persons with disabilities). Providing charity

* Reports of the Council on Ethical and Judicial Affairs are assigned to the reference committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.

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care has historically been an important mission of many religious institutions, such as the Catholic Health Association, and recognized as an ethical obligation by the medical profession, for example, through the *Principles of Medical Ethics* as well as public policy initiatives, such as the AMA's "Health Policy Agenda for the American People" in the mid-1980s or current "Campaign for the Uninsured."

Nonetheless, there are still financial barriers to access. In the U.S. today it is estimated that some 47 million Americans lack medical insurance; even within the insured population, 61 percent of adults report being underinsured or having persistent difficulty paying medical bills and out-of-pocket expenses for prescriptions.[4, 5]

Unable to afford basic treatment options, an increasing proportion of Americans must resort to postponing or forgoing required medical treatment and are less likely to receive preventive services or consistent care for chronic conditions.[6] The escalating prices of prescription drugs and the trend for employers to avoid providing medical insurance further exacerbate the situation of those already unable to afford coverage.

These financial barriers to care directly affect patients' well-being. Recent reports by the Urban Institute[7] and the Institute of Medicine[8] indicate that lack of insurance may directly increase the risk of mortality in adults by up to 25 percent, and that deaths attributed to lack of insurance have been rising during the past decade, even when socioeconomic status and lifestyle variables are taken into account. Inadequate access to health insurance carries significant economic and social costs as well, including financial risk for families with uninsured members, financial pressures for health care providers and institutions that serve vulnerable communities, and lost workforce productivity for employers.[9]

Financial obstacles to medical care may also diminish physicians' ability to use their professional knowledge and training to care for their patients. Modern medical care often requires more than a visit with a physician, and a patient without economic means to obtain needed tests, medications, or therapy can receive less than optimal medical care because of this. It is essential that physicians address financial barriers to access. How can physicians—and the medical profession as a whole—best meet the ethical imperative envisioned by the statement, "a physician shall support access to care for all people"?[3]

OBLIGATIONS TO PROMOTE ACCESS TO CARE FOR INDIVIDUAL PATIENTS

The profession of medicine is grounded in the universal human experience of illness and in the encounter between patients and the physicians who offer them hope of healing.[10] The moral relationship of trust and fidelity between patients and physicians that is central to health care gives rise to special obligations for physicians, including obligations to benefit the patient and to prioritize the task of healing over other interests. In its turn, the obligation of benevolence sustains a professional responsibility to take action to help ensure that patients receive needed care. The obligation of benevolence extends even to forgoing some measure of financial compensation in the interest of supporting a patient's access to needed care.

Medical knowledge is created and transmitted collectively; physicians' knowledge and skills are not solely their own, proprietary goods.[11] As a stakeholder in the creation of knowledge and the education of medical professionals, society has a legitimate claim on physicians' knowledge and

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skills and may reasonably expect them to help ensure access to health care, both as a social good and to meet the needs of individual patients.

There are several actions physicians can take as individual professionals to reduce or eliminate lack of access for their patients who cannot afford to pay for needed care out of pocket. For example, Opinion E-6.12, "Forgiveness or Waiver of Insurance Copayments," (AMA Policy Database) encourages physicians to forgive or waive copayments when these create a financial burden that prevents patients from seeking needed care.[12] Similarly, while preserving their right to choose whom to serve,[11] physicians can opt not to turn away prospective patients who lack insurance coverage and accept new patients regardless of coverage. In recognition of their obligations of fidelity, physicians can continue to see existing patients who lose their insurance. Physicians can further honor the significant societal contribution to their knowledge and training by providing care for indigent patients at reduced or no charge. Additionally, physicians are in a position to provide needed services by ensuring sufficient emergency department coverage. This can be crucial to the extent that many who have insufficient access to care first seek it in the emergency setting.

The Council recognizes that individual physicians and groups are limited in their ability to financially support increased access. Certainly, physicians should not risk the viability of their practices or the quality of care for their patients overall in order to provide greater access to care. As one recent commentary noted, "[i]f physicians do not charge for services, they cannot survive." Yet as the commentary also noted, "If patients cannot afford those services, they cannot survive."[12] When it is not feasible to provide care at no or reduced cost to the patient, individual physicians can still aid patients in other important ways.

For example, physicians can honor their ethical responsibilities to promote access to medical care by acting as advocates to help patients obtain needed care when patients cannot do so by themselves.[13] It will not always be apparent which patients face financial barriers to care—and many patients will be hesitant to raise concerns about cost of care with their physicians. Thus physicians should routinely inquire about patients' financial concerns and assist patients to access public or charitable programs when appropriate. To provide this assistance, physicians should familiarize themselves and their staff with locally available charitable resources, as well as industry- or government-sponsored programs designed to help patients who are unable to purchase medical care or prescription drugs.

Finally, in keeping with Principle IX of the *Principles of Medical Ethics*, it is essential that individual physicians take an active role in public debate about policy solutions to mitigate financial barriers to access, including the expansion of public medical programs and other programs designed to solve many of the problems that lead to financial barriers.[14]

BEYOND INDIVIDUAL PHYSICIANS' RESPONSIBILITIES

Action by individual professionals can help meet the needs of identified patients, but in itself this is not enough. Simply relying on the charity of individual physicians is neither a viable nor a fair way to address financial barriers to care—individual action alone cannot address problematic variations in access to care and risks disproportionately burdening physicians who are in a position to respond voluntarily to the medical needs of the uninsured. Eliminating financial barriers to care requires participation from all stakeholders in health care, including health care facilities, health insurers, and professional medical societies and organizations, to advocate for resources for individuals in need of medical care.

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The Medical Profession

Collectively, the medical profession should work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services by patients who belong to socially, economically, or otherwise medically disadvantaged groups.[14, 15] The profession should participate in the policy development process by supporting proposals that will benefit patients and are consistent with the ethical principles on which the medical profession is established.

Physicians should also recognize that as professionals they share responsibility to help one another address financial obstacles for patients in their individual practices. Declining referrals for patients who have limited insurance coverage or ability to pay adversely affects not only individual patients, but the professional community as well. When physicians cannot rely on consultants to deliver needed services they may feel they must provide the care themselves, which may not be in the best interests of patients or of the medical profession as a whole.

Health Care Facilities & Payers

The entities in the best position to remove financial barriers to access to care may be those that most greatly affect the cost of care: health care facilities and managed care plans or other third party payers. Hospitals account for nearly a third of health spending and insurers, including managed care entities, account for nearly two-thirds of private health expenditures.[17] Although one of the primary duties any corporation holds is to its shareholders, an organization providing or funding health care must also realize how its decisions can affect the health and livelihood of individual patients. Recently, increased scrutiny of the practices of insurers[18] and health facilities[19] has heightened public awareness of the role these entities play in access to health care.

Physicians, even when they are not decision makers in hospitals and insurers, can still exercise their influence as clinical leaders to encourage these organizations to use their resources to improve access to care. Further, those physicians who are employed by or otherwise involved with these entities should remember their ethical obligations regardless of whether they are directly providing medical services.[20] The well-being of patients should always be the foremost obligation of physicians, health facilities, and insurers.

Public Policymakers

For decades, the federal and state governments have assumed large roles in ensuring that individuals' access to care is not inhibited by lack of ability to pay. However, even with Medicare, Medicaid, SCHIP, and other public programs, millions still do not have sufficient access to care. Public programs should fairly distribute available resources to those in need.[21] Specifically, the use of public funds should be appropriately targeted to benefit patients on the basis of medical and financial need.[22] While programs that directly assist individuals in accessing care are certainly appropriate, other programs that can address underlying causes of poverty (such as education, health literacy, discrimination, etc.) are also necessary and should be considered as part of any solution to the problem of access.

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RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted in lieu of Resolution 704 (I-07), and that the remainder of this report be filed:

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation:

(1) Individual physicians should take steps to promote access to care for individual patients, for example—and when possible—accepting new patients regardless of insurance coverage and maintaining patient-physician relationships even after a patient loses health coverage.

(2) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(3) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(4) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(5) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

(New HOD/CEJA Policy)

Fiscal Note: Staff cost estimated at less than $500 to implement.

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CEJA C – I-92
Caring for the Poor

INTRODUCTION

Despite the fact that the United States is the most affluent country in the world, a significant portion of its citizens have inadequate access to medical care.[1] While the barriers to obtaining health care are numerous, perhaps the most difficult hurdle to overcome is the lack of financial resources to pay for it. Although there appears to be a growing consensus that all people should receive basic health care, there is little agreement on how to achieve or finance this goal or even how to define it.[2]

Against that background, this report examines the individual medical practitioner's ethical obligation to treat the poor. Because much of the recent attention has focused upon broader societal obligations and systematic reform, the role of the individual has been overshadowed. The AMA has long recognized an ethic obligation of physicians to assume some individual responsibility for making health care available to the needy. The Association's first code of ethics provided that "to individuals in indigent circumstances, profession services should be cheerfully and freely accorded."[17] More recently, the Association adopted the Council's report, Fundamental Elements of the Patient-Physician Relationship, which called on physicians to "continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care."[6] The Council believes that medical professionals should reaffirm their responsibility for making health care available for the needy. Physicians have a long and proud history of providing such care, perhaps unequaled by any other profession. In reviewing the duty of physicians to provide care for the indigent, the Council does not pretend that individual philanthropy can cure problems that have complex origins and that require more extensive societal solutions. Nevertheless, both physicians and medical societies must continue to take steps to help alleviate the distress and suffering that accompany medical indigency.

Until recently, private philanthropy was the primary source for the resources dedicated to meeting the medical needs of the poor.[3,4] Churches, public hospitals, and other charitable organizations took responsibility for delivering health care to the indigent. Physicians often donated their time without charge, and the other costs of care were either covered by donations to the institutions or were shifted to other patients through higher fees for those who could afford to pay for care.[4] With the delivery of the AMA-initiated Flexner report [5] in 1910, substantial change occurred in medical education and, consequently, in the system of caring for the poor. In the following decades, formerly indepndent medical schools became components of universities and also became affiliated with or operated charity hospitals.[4] As a result, care of the poor became a substantial component of the educational process. The passage of the Hill-Burton Act[7] following World War II demonstrated increased government concern with the lack of access to medical care. Under the act, the federal government instituted a loan program that encouraged the building of hospitals in underserved areas. Hospitals could repay their construction loans either in cash or by providing care to the indigent. As a result, the availability of hospital beds in low-income states grew to equal that in high income states, although the greatest gains were observed in middle-income communities rather than poor ones.[33,p350] The responsibilities of providing services nevertheless began being shared by a wider variety of organizations and institutions.

In the 1960s, the federal government undertook a number of health care initiatives. Establishment of Medicare and Medicaid in 1965 had the greatest impact on medical care of all government initiatives of that era. In addition to these programs' numerous other profound consequences and influences, they signified a dramatic shift in responsibility for providing care for the poor from private parties to the national government. Other federal government initiated changes during this time included vastly increased funding for medical research and a significant expansion of the physician population by increasing the number of medical schools as well as their class sizes.[4] As gaps in access to health care

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became apparent, federal programs developed to fill them. The establishment or increased development in the 1960s and 1970s of Community Health Centers, the National Health Service Corps, the Indian Health Service, the Veterans Administration, and public health clinics were responses to meeting visible needs.[31] These federal programs joined systems of state and local public health services that had developed in the late nineteenth and early twentieth century.

Despite worthy aspirations, by the early 1980s the resulting system was badly fragmented wit little communication between its components; such a system could not provide the comprehensive care that it promised.[3,4,31] Additionally, the multitude of administrative programs encouraged the perception that taking care of the less affluent was primarily a responsibility of large government bodies, rather than one belonging to or shared by local organizations and individuals.

EXTENT OF THE PROBLEM TODAY

The problem of lack of access to health care for large segments of our population is well known. According to a recent survey, 17% of Americans had inadequate access to physicians, reflected in such factors as premature death and disability cause by controllable illnesses and high rates of infant and child mortality.[32] Perhaps the largest barrier to obtaining needed care is the lack of financial means to obtain it. Most estimates of the number of citizens who have no health insurance range from 30 to 35 million.[1,8,9] Another 35 to 40 million persons are not covered by major medical policies. Additionally, because major medical policies often do not cover all needed services, the total sum of people who lack potentially needed insurance coverage is substantially greater. The uninsured and the underninsured cannot be stereotyped, for they include many people who are employed, the elderly, children, minorities, persons with handicaps, pregnant women, and other vulnerable populations. Of the 30 to 35 million persons with no health insurance, nearly two thirds ar in families where an adult is employed.

A lack of insurance does not translate in all cases to a lack of access to medical care, but it does have a clear impact upon access to health care. People who are uninsure report up to 47% fewer visits to doctors[12] and fewer hospitalizations than those who have insurance, even though they are in worse health.[3,11] In 1987, roughly one million people were estimated to have attempted to obtain needed medical care but were unsuccessful for economic reasons.[11]

The extent of the problem has steadily increased over the last decade. In 1975, only 63% of those persons with incomes falling below the poverty line were eligible for Medicaid, and by 1985 the percentage had fallen to 46%.[9] Over half of the population living in poverty by the government's own definition, a population consisting disproportionately of women and children, is not even eligible for federal health care assistance. The consequences of growing up without receiving needed medical services can be profound. The lack of access to health care is disproportionately distributed throughout the population in other invidious ways as well. Racial differences in access to and utilization of health care persist.

Lack of access to health care, particularly primary and preventive care, has pronounced consequences both for the health care system and for society in general. Many observers have noted that when the poor do not have access to medical care in doctors' offices, clinics, or other settings, they ultimately seek care in hosptal emergency rooms.[13,14] This behavior leads to two consequences. First, the many patients who do not need emergency treatment, but who nevertheless go to emergency rooms, add to the costs and strains on an already overloaded system. As one commentator has observed, giving primary care in the emergency setting is "equivalent to tending a rose garden with a bulldozer."[14] Second, those patients who must defer medical care will often present with more severe problems and suffer worse outcomes. Thus, systemic health care costs are increased, scarce resources are misappropriated, and patients' medical outcomes deteriorate.

In short, a significant proportion of our population cannot obtain adequate medical care because they lack the financial resources to obtain it. This problem is not randomly distributed, but disproportionately affects groups who are at other disadvantages. The consequences are numerous and extensive, ranging from the wasting of scarce resources to the raising of philosophical questions about society's moral worth.

THE DUTY TO CARE FOR THE POOR

As discussed above, private philanthropy has been an historical source of care for the poor. The traditional societal expressions of social assistance, such as charity hospitals, were based on the virtues of charity, compassion, and benevolence toward the ill.[16] As the health care system has grown more expensive and more complex, however, theories of the larger society's obligation to provide medical care have shifted away from the traditional virtues. Today, most arguments in support of society's responsibility to provide health services for the poor are more firmly rooted in concepts of equality and justice.[16]

Individual physicians' obligations to care for the poor, however, continue to rest on duties of beneficence and charity. These moral virtues help comprise the ethical foundation of the medical profession.

Definitions of professions are varied, but virtually all encompass the concept of commitment to moral ideals. The objective of the medical profession, in particular, is care for the sick. That simple notion is the essence of the physician: to treat the ill, without concern for who they may be, what their diseases are, or whether they can afford to pay. While reimbursement for treatment may follow, and physicians could not continue to practice without financial support, the pursuit of material gain is not the primary end of the professional. Physicians are more than a special class of businessmen or entrepreneurs; they must continue to embrace elemental moral objectives if they are to maintain the mantle of professional integrity. Speaking of the distinction between tradespeople and professionals, one writer has observed that "[a]lthough this distinction has blurred in modern times, one of the characteristics of a true profession remains its special relationship with the poor."[17] To treat the poor without expectation of payment requires that physicians place others' concerns above their own. Ethicists have identified at least three factors specific to medicine that underlie physicians' obligations of self-effacement of self-interest.[18] The first is the nature of illness:

> The sick person is in a uniquely dependent, anxious, vulnerable, and exploitable state. Patients must bare their weakness, compromise their dignity, and reveal intimacies of body and mind. The predicament forces them to trust the physician in a relationship of relative powerlessness. Moreover, physicians invite that trust when offering to put knowledge at the service of the sick. A medical need in itself constitutes a moral claim on those equipped to help.[19]

Second is the understanding that the practice of medicine is a privilege. Society accords physicians a special status, including access to intimate details of people's lives and bodies as well as social positions of unusual trust and respect. Society additionally invests in medical education and biomedical research because it as an interest in protecting the physical health of its citizens.[16,18] Only through the efforts of prior generations and the support of the broader community are any of society's members able to learn and practice medicine. Once this substantial debt is acknowledged, the responsibility to repay it must be recognized as well. In essence, medical knowledge is not individually owned, but is held in trust for the sick.[19]

Finally, doctors take an oath when they enter the profession. This ceremony constitutes public acknowledgement of one's obligations and a promise to uphold professional duties. One of those sworn responsibilities includes caring for the ill. For example, in the Hippocratic Oath, a physician promises to "keep [the sick] from harm and injustice," and proclaims that "whatever houses I may visit, I will come

for the benefit of the sick." Physicians thus dedicate the selves to their patients' welfare. They do and must hold themselves out as patient advocates.[10]

This traditional view of the profession's unique relationship with the poor is an important distinguishing characteristic of medicine as a profession. It is primarily because medicine is a profession committed to the highest ideals that it retain substantial respect and the power to determine, with our patients, the nature of the medical care we provide.

However, it is also very clear that a variety of forces are at play which, by design or otherwise, conflict with the treatment of physicians as professionals and discourage professional behavior, in particular, the extraordinary burden of government regulation and oversight, and the economic pressures of third party payers.

Notwithstanding these obstacles, the Council believes that the profession's understanding of medical practice must continue to include the recognition that individual physicians have an obligation to help care for the indigent. That responsibility is based in the very concept of the meaning of professionalism, including its pursuit of moral ideals such as justice and beneficence, and its acknowledgement of society's broad and substantial support. For

[w]ithout charity, something essential goes out of medicine, something vital disappears from the life of its practitioners. Recall the words of the medieval hospitaler, "I cannot sell mercy for gold. " The disappearance of charity care...means the disappearance of mercy as a quality of medical care and as a characteristic of the life of practitioners. This is an inestimable loss.[34]

PHYSICIANS' CURRENT CONTRIBUTIONS

Physicians in the past were aided in their efforts to serve the poor through their ability to shift costs to patients who could afford to pay for medical care. The health care system today makes such underwriting practices much less viable. As government has tried to decrease the costs of its programs, it has adopted a number of restrictive payment mechanisms, such as prospective payment systems for hospital care and limitations on balance billing, that reduce available funds.[9] Other third party payers have instituted their own systems of oversight and cost containment. Consequently, it is much more difficult to share the burden of indigent care with private parties.

Despite these developments, physicians continue to provide substantial levels of care for the poor. According to one survey, 77% of physicians in fee-for-service practice provided free or reduced rate care in 1982.[15] This translated into approximately $9.2 billion of bad debt and charity care for that year.[14] In a more recent survey, nearly two-thirds of physicians reported providing free or reduced-fee care to patients during the previous week.[20] A 1991 study of group practices in Wisconsin revealed that physicians reported uncompensate and discounted care amounting to 7.6% of their total billings.[21] The total was distributed as 1.6% charity care, 3.0% bad debt, and 3.0% discounted Medicaid care. Physicians apparently responded to increased needs: as the percentage of uninsured patients increased from 1986-1991, group practices reported an increase in the amount of charity care provided over the same time period. Unfortunately, the contributions were not equally shared among practices. A disproportionate share of uncompensated care was provide by those practices which already had relatively high levels of Medicaid patients.

While physicians have maintained substantial levels of charity care, hospitals have also borne large and increasing proportion of the burden as well. The American Hospital Association reports that, at the beginning of the decade, hospitals provided $3.9 billion in uncompensated care; by 1989 that amount had nearly tripled to $11.1 billion.[14] The problems of drug abuse, AIDS, and violence place tremendous

strains on the hospital system and it is unlikely that such increases in uncompensated care can continue. Other institutions have developed to provide care for the indigent, but some have reported problems recruiting physicians.

Although no other learned profession provides as much charity as the medical profession, improvement can and should occur. While the majority of physicians do provide free or reduced-fee care within their practices, as high as one quarter to one third of practitioners may fail to direct services to the poor. There appear to be additional problems with respect to biases against certain patient populations and inadequate respect for physicians who spend the majority of their efforts meeting the needs of the indigent. The medical demands of the poor have also increased more quickly than physicians have been able to respond.

PROPOSALS

There are many proposals today for legislative solutions for the problem of access to medical care including the AMA's Health Access America. The policies of the House of Delegates have made improved access to health care the association's clear priority, and a joint report of the Councils on Medical Service and Medical Education at this meeting recommend a number of important measures to improve health care access for the inner-city poor. There should be no question today that the Association supports change and expanded government resources to care for those who need it. But, as discussed above, the duty to care for the poor is not only that of society or the medical profession as a whole, but of each individual physician as well.[3]

The editors of the *Journal of the American Medical Association* and the *ABA Journal, The Lawyer's Magazine* jointly write yearly editorials calling upon both physicians and attorneys to give fifty hours of uncompensated services a year to the poor. The American Bar Association (ABA) believes that "[i]t is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services without fee or at a substantially reduced fee..."[17] Additionally, some voluntary county bar associations, such as the Orange County Bar Association in Orlando, Florida, ask their members to provide a specified amount of legal care for the indigent as a condition of membership.[22]

Setting aside a percentage of one's practice for the indigent is a traditional method of service. Physicians are diverse in their practices and income levels. Many physicians have relatively modest incomes and practices directed at patients with modest incomes.

Many physicians also give in extraordinary ways in time and commitment to their existing patients and have little opportunity to actively seek out charity care. It is not fair to those physicians who do donate time and services that others do not share in the collective burden. Caring for the poor is not a practice reserved for those who lack the skills to be more gainfully employed, but is reflective of the purpose of the healing arts.

In setting individual goals, a distinction can be drawn between charity care and bad debt. Forgiveness of debt occurs after service has been rendered for which payment is expected, when the patient becomes unable to make the payment. The act is one primarily of justice rather than charity. Donation of one's services without advance expectation of payment is an act based in altruism and demonstrates a purposeful affirmative recognition of one's professional obligations. The line may at times be blurred. For example, although some may not characterize the decision to accept Medicaid patients as true charity, it can be appropriately viewed as reduced-fee care that is undertaken from the beginning with no expectation of full reimbursement. Medicare patients may increasingly fall into this category as well.

Both forgiveness of debt and charity care are important contributions to serving the poor. Nevertheless, the distinction between the two is important, not only because of the contrast in intention, but because

there may be a meaningful difference in the populations reached. Because those without insurance visit physicians significantly less frequently than those who can afford treatment,[3,11,12] a system of charity care that depends primarily upon forgiveness of debt will miss a large proportion of the most needy people. Those physicians who seek out the poor not only provide a forceful example of the principle of beneficence, but also make a more meaningful contribution to increasing access to care.

Alternatives to caring for indigent patients in the office exist, but they need to be made more accessible and more visible. For example, physicians can volunteer at freest ding clinics or hospital clinics that attempt to reach the poor. A number of such opportunities exist, and these clinics are often overburdened. In Chicago in late 1990, pregnant women seeking care at a public clinic had to wait 125 days for an appointment with a physician.[14] Other possibilities include organizing a weekend clinic to offer care to the poor and volunteering services at local shelters for battered women or the homeless.[10,36] More specialized physicians can help ensure appropriate staffing for hospitals by agreeing to be placed on back-up call schedules. Opportunities are available to volunteer for a week or two for the Indian Health Service or the National Health Service Corps. Direct care may be the best sort of medical service to provide,[8] but physicians can additionally become political advocates for the medically indigent in their communities. Acts in this regard include meeting with government officials, giving presentations and requesting funding at local government budget meetings, and working with local health care institutions to expand services for the indigent.[24]

Physicians should not hesitate to treat the medically indigent for fear of malpractice suits. Some states provide special malpractice protection for charity care, and the belief that the poor are more likely to sue may not be supported by the facts.[25,26] Because the poor have low future earning potential, many private attorneys will not often represent them in such cases. While the poor may be more likely to suffer bad medical outcomes because of their general ill health or because they have less continuity of care, these unfortunate results do not appear to be reflected in malpractice suits.

The Council recognizes that other circumstances may nevertheless make it difficult for physicians to work with the poor. Even the most ardent advocates for placing the indigent in private practices recognize the existence of other barriers:

> Most of us come from a different culture and do not understand, for instance, that the very poor are often so overwhelmed by the emotional, social, and financial stresses in their lives that they simply cannot comply with our evaluation or treatment We who are used to the efficiency and power of conventional doctoring find this new work very demanding emotionally.[23]

Physicians need to be aware of the potential frustrations of caring for the poor and to be prepared for the recognition of their own professional limitations. Physicians need not face their duty to provide care for the indigent as unsupported individuals; organized medicine has contributions to make as well. Many doc ors may want to be involved more actively in their communities but do no have the time or knowledge to investigate or establish opportunities. Local and state medical societies are well-situated to establish programs that can direct and coordinate physicians who want to offer their services. The New York County Medical Society, for example, has organized a Physician Community Services program that refers doctors to opportunities to provide care at clinics, help with disease prevention drives, serve as health consultants, and teach. In Washington, D.C., the Archdioces of Washington coordinates more than 200 private consultants to serve as a referral network for indigent patients.[23] The AMA also recognizes that national medical specialty societies can take leadership roles in this area, as exemplified by the American Academy of Ophthalmology National Eye Care Project.[35] By effectively communicating with available facilities and providing a centralized outlet or creative energies, organized medicine can make significant contribution to the treatment of the needy by lowering obstacles to physician participation. Attached is a catalogue of a portion of such programs. The AMA is working now with the Pharmaceutical

Manufacturer's Association to assist in he implementation of its program to provide pharmaceuticals free of charge to the needy.

There should be n illusion that the voluntary charity of the medical profession can cure the problem of lack of access to health care.[13,27,28] The problem is simply too large and too complex. The need for care is far greater than the capacity for philanthropy.[1] Additionally, barriers to care besides lack of financial resources prevent many from obtaining needed services.[29] An improved system of access to care, as proposed by the AMA or others, would provide patients more options, reduce any stigma associated with charity,[13] and be more effective.[30]

However, the need for charity care exists today, and probably always will. This report recognizes that so long as the poor have unmet medical needs, it is incumbent upon each physician and upon the medical profession as a whole to try to alleviate some of that distress.

RECOMMENDATIONS

For the reasons described in this report, the Council on Ethical and Judicial Affairs recommends that the following guidelines be adopted and that the remainder of the report be filed:

1. Each physician as an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstance such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients.

In the poorest communities, it may not be possible to meet the needs of the indigent for physicians' services by relying solely on local physicians. The local physicians should be able to turn for assistance to their colleagues in prosperous communities, particularly those in close proximity.
Physicians are meeting their obligation, and are encouraged to continue to do so, in a number of ways such as: by seeing indigent patients in their offices at no cost or at reduced cost, by serving at freestanding or hospital clinics that treat the poor, and by participating in government programs that deliver health care to the poor. Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless.

In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor .

2. State, local, and specialty medical societies should help physicians meet their obligations to provide care to the indigent. By working together through their professional organizations, physicians can provide more effective services and reach more patients. Many societies have developed innovative programs and clinics to coordinate care for the indigent by physicians. These efforts can serve as a model for other societies as they assist their members in responding to the needs of the poor.

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As a final note, physicians should not fail to report a suspected adverse event or reaction because they cannot prove a causal link. Ethical constraints may prohibit rechallenging the patient, and some information on causation may result from the accumulation of many individual reports. The FDA requests that all suspicions of serious events be reported, a policy that accords with the goal of protecting the public health.

(References pertaining to Report B of the Council on Ethical and Judicial Affairs are available from the Office of the General Counsel.)

C. ETHICS OF COINSURANCE FORGIVENESS (RESOLUTION 7, I-91)

HOUSE ACTION: FILED

Resolution 7 (I-91) calls for the American Medical Association to "monitor evolving legal and regulatory standards regarding forgiveness of coinsurance payments and disseminate this information to physicians." Resolution 7, which was referred, also calls for the Association to "develop more specific ethical guidelines on the issue of coinsurance payments forgiveness."

In response to Resolution 7, the Council has developed the following opinion:

OPINION 6.13: FORGIVENESS OR WAIVER OF INSURANCE COPAYMENTS

Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through copayments. By imposing copayments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a copayment for the care. Physicians commonly forgive or waive copayments to facilitate patient access to needed medical care. When a copayment is a barrier to needed care because of financial hardship, physicians should forgive or waive the copayment.

A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the copayment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates Opinion 2.19 and is unethical.

Physicians should be aware that forgiveness or waiver of copayments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of copayments may constitute fraud under state and federal law. Physicians should ensure that their policies on copayments are consistent with applicable law and with the requirements of their agreements with insurers.

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