Seminar on Health Law and Social Policy

This seminar explores the intersections of health care, law, politics, and ethics in the U.S. in the 21st Century. We meet in Furman Hall, Room 316, on Tuesdays, from 4:00 to 6, beginning September 5, 2017. Each discussion will be led by Sylvia A. Law. After the first three weeks, most conversations will also be led by another expert.

We will address four central themes: 1) the consequences that flow from characterizing an issue as social, medical, ethical, economic, scientific, religious or legal, 2) the role of rights, and the complexity of constructing rules and enforcement mechanisms, 3) consideration whether policy is set or money raised at the federal, state, local, professional, family or individual level, and 4) the pervasive influences of class, race and gender.

The seminar is designed to complement other courses offered by NYU Law School. The seminar begins with an introduction to problems of access to health care, costs and quality. These subjects are addressed in greater depth in the basic Health Law course. We will consider issues arising under the Affordable Care Act, but not in the detail offered by the seminar devoted to the ACA in the spring semester. Problems of medical ethics, public health and the regulation of prescription drugs are all presented more comprehensively in courses focused on these subjects. Students with a special interest in health policy and law can take all of these courses.

This is a preliminary listing of topics, readings and leaders. Dates may change to accommodate the schedules of visiting experts and the assigned readings are tentative after September 19.

Hard copy packages of the readings are available a few weeks in advance of each class in Room 414 Vanderbilt Hall.

September 5, 2017. The historic roots of the organization of health care and health care financing in the United States. Why did we make the choices we did?


September 12, 2017. Access and Money. The crisis confronting the uninsured, Medicaid, Medicare, employers, and hospitals.
The U.S. spends more on medical care than any other nation, yet, even after adoption of the Affordable Care Act in 2010, large numbers of people living in the U.S. (citizens and non-citizens) have no health insurance. Since World War II, most private insurance has been based on employment. However, employment based insurance has decreased in recent decades. Common strategies to address this problem include expanding existing sources of health insurance from individuals, employers and state and local governments. Every source of insurance coverage pushes back.

We rely on hospitals to provide care for people in emergent need. The cost of that care is passed on to people with insurance. The cost of insurance goes up, and, as a result, the number of people who can afford insurance decreases. Apart from this vicious circle, access to good quality health care often depends on factors other than insurance coverage. And the high costs of health care are a consequence of factors more complex than service to the uninsured.

The Affordable Care Act, which we will examine later in the semester, addresses some of these issues. But, a core premise of the ACA is to preserve the status quo and it is thus important to understand what that is.


Rosenbaum et al, Note: Hospital Collection Actions, LAW AND THE AMERICAN HEALTH CARE SYSTEM (2012).

September 19, 2017. Quality of Care: The Basics.

The United States has an unparalleled capacity to provide medical care to save lives and promote well-being. However, it is now widely understood that our medical care system often fails to deliver on its potential, and indeed causes preventable injuries. The incidence of common medical procedures varies from area to area, with no demographic explanation. This class explores the complex relationship between medical malpractice litigation and quality of care, reimbursement and care, and approaches tried. What works and why? What has not been tried and why?

*Institute of Medicine, To Err is Human: Building a Safer Health Care System, 1999.*
Lucian L. Leape, Donald M. Berwick, *Five Years After To Err is Human: What Have We Learned?*, 293 JAMA 2384 (2005).

https://ezproxy.library.nyu.edu/login?url=http://jama.ama-assn.org/cgi/content/full/293/19/2384


In 2010 Congress adopted the most comprehensive change in health care financing in the United States since the adoption of Medicaid and Medicare in 1965. This class explores the political process leading to the adoption of the Affordable Care Act, major challenges to the law, and the law’s accomplishments.

A second class, on October 3, examines the implementation of the Act at the state level. It considers the political choices confronting states as they choose whether to embrace or reject the ACA. It examines the negotiations between states and the federal government as states seek federal financial support for programs that do not meet particular federal requirements. Finally, it considers alternatives to the ACA: single payer, Medicare for All, and Medicaid for More.

Disputes over insurance coverage for contraception are an important part of the political debate and will be considered in a later class. The Affordable Care Act is such an important development that NYU offers a course devoted entirely to it.


**Compare Proposals to Replace the Affordable Care Act.**


Co-Leader, Professor Mary Ann Chirba, Boston College of Law. Adjunct Professor, NYU Law, teaching the Affordable Care Act in the spring semester.

State choices and implementation


Alternatives going forward


Co-Leader: Elisabeth Ryden Benjamin, Vice-President, Health Initiatives, Community Service Society of New York


In the early 20th Century, physicians succeeded, to a remarkable degree, in establishing hegemony over the definition and treatment of illness. Nonetheless, patients need panoply of other skilled workers to meet their needs. Nurses are perennially in short supply and many in the nursing profession question whether the organization of medical care limits nurses’ ability to provide quality care and find satisfaction in their work. A later class will address these issues in relation to non-physician providers.

The United States is exceptional in in demanding long, costly physician training, and assuming that individual students/doctors bear much of these costs. U.S. doctors earn more than those other nations. Our patterns of medical education and compensation produce more surgical specialists, and fewer primary care doctors than other countries. This, in turn, undermines quality of care and increases costs. We depend on foreign medical graduates to staff essential, but less attractive, forms of care.

In 2014, expert opinion is divided on whether the U.S. needs more doctors or rather needs to encourage new doctors to do the primary care work generated by the Affordable Care Act and an aging population. There is broad agreement that we produce more medical school graduates than positions in residency programs. Even though Medicare provides a substantial portion of the funding for graduate medical education, it is unclear that those funds promote sensible workforce policy or how these patterns might be changed.

NOTE, Sylvia A. Law, Physician Supply and Funding for Graduate Medical Education, (2014). **Hard copy package.**


Miriam J. Laugesen, Roy Wada, Eric M Chen. *In Setting Doctors’ Medicare Fees, CMS Almost Always Accepts The Relative Value Update Panel’s Advice on Work Values*, HEALTH AFFAIRS, May 2012, [https://mail.google.com/mail/u/0/#inbox/15e6d725b12112f5?projector=1](https://mail.google.com/mail/u/0/#inbox/15e6d725b12112f5?projector=1).


For the most part, the U.S. assumption is that the provision and financing of health care and the education of health care professionals is a non-governmental function, controlled by professional norms, market competition, and governmental regulation, state or federal. Why has the U.S. rejected the assumption that the organization and financing of health care should be a public function? "Public health" represents an exception to this generalization. What defines the appropriate sphere of public health? How has the concept of public health changed over time? This class explores these questions in the concrete context of drug resistant TB, Zika, and opioid abuse. Our focus is on New York City, and on the work of our guest, Professor James Colgrove. Copies of his books EPIDEMIC CITY: THE POLITICS OF PUBLIC HEALTH IN NEW YORK (2001) and STATE OF IMMUNITY: THE POLITICS OF VACCINATION IN 20TH CENTURY AMERICA. (2006) are on reserve for you in the library.

Public Health


Drug Resistant TB


Zika


Hilary D Martson, Considerations for Developing a Zika Virus Vaccine, 375 N. ENG. J. MED. 1209 (2016).


Opioid Abuse

CDC, Drug Overdose deaths in the United States continue to increase in 2015. https://www.cdc.gov/drugoverdose/epidemic/


**Co-leader:** Prof. James Colgrove, Mailman School of Public Health

**October 24, 2017. Abortion. Political and Constitutional Limits on state authority to restrict women’s access to abortion.**


Note, Constitutional application of Whole Women’s Health in the lower federal courts


In 1997, a unanimous Supreme Court rejected a constitutional claim that liberty and privacy protect the rights of competent, terminally ill people who seek physician assistance in hastening death. Since 1997, experience under Oregon’s Death with Dignity Act has been reassuring and a large majority of Americans support patient choice in these circumstances. Washington, Vermont, Colorado, and California adopted similar laws, and Montana did so by judicial decision. This conversation will address the complex issues of choice at the end of life, including palliative care.

NOTE. The common law rights of competent people to refuse medical treatment. Quinlan. Cruzan.

End of Life Choice and Care


Pain and palliative care.

Institute of Medicine, RELIEVING PAIN IN AMERICA: A BLUEPRINT FOR TRANSFORMING PREVENTION, CARE, EDUCATION AND RESEARCH. June, 2011.

N.Y. Palliative Care Information Act 2010.

Physician hastened death.


https://ezproxy.library.nyu.edu/login?url=http://content.nejm.org/cgi/content/full/357/4/321

https://ezproxy.library.nyu.edu/login?url=http://content.nejm.org/cgi/content/full/352/16/163


Many recent studies document that women and racial minorities receive less medical care and less favorable outcomes for a variety of common conditions including heart disease, cancer and pain. The U.S. health care system seeks to serve people from diverse cultures, many of whom do not speak English. How do we address this phenomenon as advocates, administrators, medical educators, and public health officials?

Non-citizens are commonly denied health insurance coverage and the Affordable Care Act makes little change in that policy. Nonetheless, hospitals are required to provide essential health services based on medical need. How can these seemingly inconsistent policies be reconciled?

**Race and Language**


http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30569-X/fulltext

**Immigrants.**


**Co-Leaders:** Max Hadler and Claudia Calhoon, New York Immigration Coalition


**November 14, 2017. Nurses and other non-physician health professionals: supply, education, compensation and the organization of work.**

In the early 20th Century, physicians succeeded, to a remarkable degree, in establishing hegemony over the definition and treatment of illness. Nonetheless, patients need panoply of other skilled workers to meet their needs. Nurses are perennially in short supply and many in the nursing profession question whether the organization of medical care limits nurses’ ability to provide quality care and find satisfaction in their work.

Many factors influence whether nurses and other non-physician health care professionals can practice to the full extent of their training and capacity: scope of practice laws, availability and extent of insurance reimbursement, ability to prescribe drugs or to make referrals, availability of malpractice insurance, and more. All of these issues are controversial.

**Nurses.**
Review, PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE, pp. 220 to 225 (physician control of other necessary professionals).


Current State of Unionization Among Nurses


Other health professionals.

American Psychological Association, Iowa Becomes Fourth State to Allow Psychologists to Prescribe Medications, May 27, 2016.  


Optional reading. Rebecca Grant, The U.S. is running out of Nurses, The Atlantic, Feb. 6, 2016,  
http://content.healthaffairs.org/content/29/5/893.full.pdf+html.

Co-Leaders: Professor Susan Apold, Clinical Professor of Nursing and Professor Caroline Dorsen, Assistant Professor of Nursing, NYU School of Nursing.


Susan Jaffe, Seeking Dental Care for Older Americans 35 HEALTH AFFAIRS 2164 (2016).  http://ezproxy.library.nyu.edu:2403/content/35/12/2164.full


November 28, 2017.  Religion, Health Care, and Reproductive Choice

Religious beliefs often inform health care decision making.  Religions offer diverse teachings on many health services including contraception, abortion, sterilization, the right to refuse life-saving treatment, blood transfusions, and vaccinations.  In a pluralistic society different people have conflicting religious views.  Patients, doctors, nurses, other workers, hospitals, insurers, and the employers and tax payers who pay for insurance have diverse, religiously based views of medical care.  Whose religion controls?

These general issues are now debated in two concrete contexts.  The Catholic Church now controls the hospitals that admit forty percent of patients in the U.S., and that proportion is increasing.  The Church often seeks to impose strict concepts of morally acceptable medical care on both doctors and patients.  These conflicts take many forms.  Whose religious beliefs control?

In response to the Affordable Care Act, many employers assert a religious based right to refuse to contribute to insurance coverage for contraception or some forms of contraception.  Other assert a religious based right to refuse to complete a simple form declining the coverage to which they object.  In implementing the Act, the administration has drawn distinctions among religious organizations that employ and serve people of the same faith, religious organizations
that employ and serve a larger community, and secular organizations. Are these distinctions sustainable? In 2014 the Supreme Court held that some profit making corporations may assert religious belief to refuse insurance coverage for some forms of contraception. In 2017 this principle was extended to all corporations and to moral as well as religious objections. What are the limits of this principle?


Hospitals and health care providers.

Christine Khaikin and Lois Uttley, State Oversight of Hospital Consolidation: Inadequate to Protect Patients’ Rights and Community Access to Care, 18 AMA J. ETHICS 272 (2016). HTTP://JOURNALOFETHICS.AMA-ASSN.ORG/2016/03/PFOR3-1603.HTML


The Ethical and Religious Directives for Catholic Health Care Services.

Catholics for Choice memo, April 2011.


The Contraception Mandate and the ACA

AMERICAN HEALTH CARE SYSTEM, 2017 UPDATE, IMPLEMENTATION OF THE AFFORDABLE CARE ACT. (HOBBY LOBBY).


December 5, 2017. Community Health Centers and Medical-Legal Partnerships.
The community health center program is a bright spot in the health care landscape, providing high quality care at reasonable cost, reducing racial and linguistic disparities, and responding to community needs. Do these programs provide a model for health care for a broader segment of the population? Why are these programs so often marginal to acute care medicine? How does the organization of medical education promote or undermine these forms of service?

More recently, Medical-Legal Partnership programs have brought lawyers into primary health care, both in hospitals and community health centers. Lawyers assist health care professionals in addressing patient problems that require legal, rather than medical, approaches.

**Community Health Centers**


NYC, Community Health Networks, 2017.


**Medical Legal Partnerships**

PBS NewsHour, September 2015, Why Doctors Are Prescribing Legal Aid for Patients in Need.
Tina Rosenberg, When Poverty Makes You Sick, A Lawyer Can be the Cure, N.Y. TIMES (July 17, 2014).  

Brian Glick, Neighborhood Legal Services as House Counsel to Community-Based Efforts to Achieve Economic Justice: The East Brooklyn Experience, 23 NYU REV. OF L. & SOC. CHANGE 105 (1997).  
Medical Legal Partnerships, Joel Teitelbaum, Obligation and opportunity: medical-legal partnership in the age of health reform. 35 J LEG MED. 7 (2014). 

Co-Leaders: Robert M. Hayes, President and CEO, Community Healthcare Network; Mallory Cair Curran, Chair of the Board, National Center for Medical-Legal Partnership, Director, Mental Health Law Project, MFY Legal Service.