Opinion

Insurance cost contributes to mortality rate

Chris Hood
Guest Writer

Unaffordable malpractice insurance keeps 85 percent of North Carolina's qualified family physicians from offering pre-natal and birth services. Obstetricians, specialists who treat only pregnant women, are also affected. They cannot locate where lower physician incomes make insurance too expensive, and rural practice pays much less than urban practice. So, in 25 or so rural N.C. counties, doctors cannot afford to deliver babies. Called the malpractice insurance problem, having physicians trained for but not providing obstetric medicine contributes to the state's abysmal infant death rate.

The problem extends to urban areas, too, where the family physician's income, the lowest of doctors in all types of practice, is not enough to purchase insurance needed to offer obstetric care.

That pregnant women in rural counties are forced to choose between long-distance medicine or none at all is not questioned. Neither is the overburdened market for obstetric medicine, often too expensive for poor families, nor the combined effect of the problem. North Carolina ranks 50th nationwide in infant mortality, and solutions range from the N.C. Institute of Medicine's recent call for mandatory health insurance to Gov. Jim Martin's $16 million prenatal care proposal for teenage mothers.

But not addressed by either Gov. Martin or the Institute of Medicine is the role of malpractice insurance. Statewide, family physicians have been forced out of the baby business, and obstetricians can't fill the gap. Physician-provided care is thus completely absent from the fight against infant mortality in one-fourth of our state, those 25 or so rural counties.

Although the infant mortality problem does not solely rest in rural counties, N.C. Insurance Commissioner Jim Long proposed in 1988 an insurance subsidy for doctors willing to practice in rural counties lacking adequate health care. Long said that his proposal would help those doctors pay malpractice insurance costs that have increased six-fold over the last six years. The result? "Prenatal care and hospital facilities," said Mr. Long, for women currently without.

In justifying his proposal, Mr. Long also stated that North Carolina suffers in a way not reported by infant death statistics. He said that complications of pregnancy resulting in post-natal health problems go untreated due to a lack of nearby medical care. That situation hurts more than just the babies and their parents. Long explained, for babies with problems that could have been avoided burden public and private health insurance systems, many for the rest of their lives. Gov. Martin also made that point in his recent proposal, but he referred to the problem in its statewide context, not just in rural areas.

Despite the attraction of Long's proposal and the need for physician services on a statewide basis, lobbyists approach state officials with an alternative solution to the problem. A statewide doctors' group calls for tort reform, claiming that rewriting the law governing malpractice suits will guarantee full-service medicine in rural counties. Tort reform, that view goes, would lower malpractice insurance costs for all doctors by capping the amount of money available to those who sue.

Commissioner Long's position on tort reform is that it is unnecessary. "We are a good state to write insurance coverages in," he said in 1988. And he gave the reason: "We are not as litigious as other states. Jury awards are very conservative in North Carolina."

Still, the doctors' lobbying effort is understandable. Malpractice suits threaten all of them, not just family physicians trained in obstetric care or obstetricians who might locate in rural counties. Even adding the family physician in non-rural practice who could be covered by a subsidy, Long's proposal would aid only a portion of state doctors.

For pregnant women and their families, though, tort reform advocacy stalls a direct solution for providing needed doctor services. Why? Urging new laws over who can sue and how much they can win encounters powerful resistance from lawyers, who promise a colossal battle. Tort reform thus diverts support from a subsidy by subordinating it to a pending political brawl.

Avoiding that high-stakes conflict, Long proposed a practical way to alleviate the crisis. And if the following statement is valid, much less prophetic, then time has run out: "The tough situation is down the line two or three years," said a spokesman for the N.C. Medical Society in 1988, "when this (the malpractice insurance problem) has an effect on infant mortality."

Supporting the call for a subsidy is an additional fact of the infant mortality problem, one related to Gov. Martin's proposal for extending Medicaid coverage to teens. Dr. Bret Williams, author of the definitive study of N.C.'s infant death rate, recently stated: "It doesn't matter if a pregnant teenager has insurance, if she has no place to go." The market for obstetric treatment is overburdened throughout the state, and a subsidy for family physicians statewide would provide access to those who even with Medicaid cannot find care. It would also lower costs for other pregnant women who choose the family physician's services, for obstetricians are more expensive.

Finally, the cost for a comprehensive subsidy compares favorably to Gov. Martin's $16 million Medicaid-based plan. Based upon rates published by Mr. Long's office in 1988, counties currently lacking services added to the cost of covering as many as three family physicians in the remaining 75 counties amounts to less than $10 million, less than two-thirds the price of the governor's plan. Moreover, a subsidy, whether rural-only or statewide, would be light years away from the cost in public and private dollars required by the N.C. Institute of Medicine's mandatory insurance plan.

Taxpayers spend an ocean of dollars on both patient insurance such as Medicaid and physician training at state medical schools, so why not a relatively inexpensive plan to make available the urgently needed services that doctors provide?

Chris Hood is a senior interdisciplinary studies major from Southern Pines.

A neglected vision for UNC

Brien Lewis
Guest Writer

Chancellor Paul Hardin, in his University Day address Oct. 12, outlined his vision for the University. The chancellor painted noble, broad strokes on his canvas, depicting the missions of a "complete university": to learn, to teach, to serve. Hardin chose not to use the opportunity to address a vision for the needs of the University and, particularly, the student body. He did call on each student to consider teaching as a career — a valuable message. The future of education depends upon a strengthened and attentive generation of teachers at all levels of the system. But as important as this call was, it didn't even scratch the surface of what UNC needs to address in the '90s.

This week's headlines have confirmed the dire financial straits UNC is in. Cutbacks and hiring freezes do far more than prevent a photocopy from being made or a position from being filled — they cause frustration and damage morale. UNC cannot afford a sagging morale with its weaknesses in faculty and staff salaries and benefits. There are no easy fixes to budgetary woes which face the state, but Hardin i on target in his requests for financial flexibility. My vision of Carolina is of a proud, accountable servant of the state and an institution that is the master of its own house.

Even as sectors of our university community struggle to get by on a yearly basis, it seems at times that there are buckets of money to be had around here. More than $30 million was raised for a basketball shrine, $12 million for an alumni playpen and the equivalent of 15 full Morehead scholarships was used to buy out a football coach. Surely there are more pressing uses for these easily-generated funds. There are graduate students scraping by to stay in school so that they can fill the thinning professorial ranks. Thousands of undergraduates are accumulating substantial loan burdens. Buildings are overdue for major repairs. Parking and child care are lacking or non-existent. Why is money so hard to come by for these projects? Somehow I think UNC would have survived without a Dean Dome and a Hole-In-The-Woods. Will we remain the admirable institution we long to be if we cannot retain graduate students and staff? My vision of Carolina is of a progressive university that utilizes its friends and alumni to protect and enhance its valued resources.

I could write exhaustively of specific needs and desires for UNC in the '90s: a Black Cultural Center to educate all and bring our community together on a new cultural and interpersonal level; an academic minor to complement a strengthened curriculum; a food service where the only mandatory component is an excellent product; a barrier-free campus for handicapped citizens; a library that is flourishing instead of wounded; a clean, green campus that is safe any time, day or night; textbooks that aren't the price of a used car and a tuition policy that isn't treated like a breakable piggy bank.

The student body is a transitory entity. We lack the historical perspective of a faculty member and we are not faced with the pressures of an administration. But because we lack those things we have freshness and a special brand of optimistic enthusiasm. We are not yet mired in place. For students are not simply another interest group at UNC. We are told repeatedly by other segments of the University community that we are the future. We must take up that mantle and wear it prominently and proudly. My vision for UNC is of a university unafraid of being rejuvenated and challenged by its students and willing to respond to their ideas.

For too long our mission has been divided: students are here "to learn," faculty "to teach" and the institution's resources "to serve." UNC needs a renewed commitment and a united mission, with all of us serving and teaching and learning from each other.

Brien Lewis, a senior political science major from Toronto, Canada, is the student body president.

View toward diseases requires change

Don Taylor
Guest Writer

The people of the developing world today face many health problems which are virtually nonexistent in the industrialized world. I propose that to improve the health status of these people there must first be a fundamental change in the accepted explanations of disease causation. Specifically, the individualistic explanations which are held by the majority today must give way to more accurate structural explanations if we are to effectively combat many health problems in the developing world.

Individualistic explanations of public health problems focus on what makes the people suffering from a disease different from those people not suffering from it. They compare the groups and define the causes of the problem as the differences between the groups alone. This seems logical on the surface, but this type of explanation is flawed. Let's look at cholera to illustrate my point.

Cholera is an infectious diarrheal disease which continues to be endemic in many developing countries. The causal agent is the Vibrio Cholerae bacterium. But, is it also the true cause of cholera?

Individualistic explanations for the persistence of cholerafocus on the differences between us and the people suffering from the problem: They are dirty and ignorant, they don't boil their drinking water, they don't have or use toilets, etc. By focusing only on the differences between the people affected by cholera and those not affected, we absolve ourselves from any responsibility for the problem.

I purport that structural explanations are more accurate in illustrating the primary causes of cholera, focusing on inherent qualities of the systems in which people live. Poor water supply, exploitative economic conditions and lack of governmental infrastructure in the developing world are related structural explanations for continued cholera infection. The net transfer of wealth from developing nations to the West, coupled with the fact that basic sanitation is not a high priority, leaves most citizens of developing nations without clean drinking water and waste disposal. The lack of basic services should not be underestimated as an explanation. It was not vaccines or boiling water which precipitated the biggest drop in deaths from infectious diseased in the United States but the provision of safe water and better living conditions. The world's economic, political and societal institutions not only make possible but *ensure* that some of our global society will continue to die from cholera.

The real tragedy in the general acceptance of individualistic explanations of disease is the ineffectiveness of the prevention measures which follow this view. Boiling of water, use of a basically ineffective vaccine and "education" about cholera are typical prevention strategies produced from individualistic explanations. They focus on the individual's actions and attempt to get him to act to protect himself. But how does one keep boiled water for a household of 15 when they have only one three-gallon pot? And why should they have to take special actions when we are protected by turning the faucet?

Truly effective prevention measures only come from structural explanations of disease. If tube wells or proper pipe water systems are provided to the people now suffering from cholera, then the rate of the disease will drop dramatically. This type of prevention is so effective because it alters the structural environment which now allows cholera to exist and does not rely on individual action to provide protection from disease. But this type of prevention calls for major capital outlays and intuitively a shift in the responsibility for the eradication of the disease. It challenges the status quo.

Changing the way we think of disease causation is a radical change. It causes us to look at overall structures operating in the world. Continuation in our present way of thinking makes it inevitable that certain members of society will contract diseases eradicated in the West. Structural causation theory will not allow us to simply blame those suffering for the fact the problem exists, but calls us to accept some of the responsibility for ending much of the world's unnecessary suffering.

I am not trying to say that people have no individual responsibility for their own health, nor do all health problems fit this conceptual framework as nicely as cholera. I simply think that in order for us to translate genuine concern into positive, tangible results, we must re-examine the way we think of disease causation. We must realize that blaming individuals for a health problem without even considering the institutions and structures in which the problem exists, is shortsighted. Until we address the structural causes of disease and implement the politically tough prevention measures which are called for by these explanations, cholera and other "ancient" diseases will continue to silently kill thousands of our fellow global citizens.

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