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The Bioterrorist Threat and Access to Health Care

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The intentional dispersal of anthrax spores in the United States demonstrates the need for preparedness for bioterrorism and naturally occurring infectious diseases capable of causing mass civilian casualties. In the event of a bioterror attack, medical-care professionals and institutions will be called on to help in the rapid identification of health threats, to help prevent the spread of disease in the population, and to care for and treat infected patients. Many barriers to accomplishing these tasks, like improved training of health-care practitioners, funding for facilities improvements and pharmaceutical stockpiles, and coordination of information and reporting systems, are being explored and addressed (*1*). However, one additional issue might prove to be among the most formidable barriers to the effective handling of a bioterror attack in America.

Recognizing the importance of early detection, the U.S. government has devoted considerable attention to expanding the national public health system's capacity to detect outbreaks (*1*). These detection systems rely largely on reports from the medical-care system; after all, persons with symptoms will likely present first in physicians' offices, clinics, or hospital emergency departments.

But consider this: what if the first individual infected with a transmissible illness chooses not to be evaluated within the medical-care system? Such an individual's illness, left undetected, might spread to family, neighbors, and other contacts. If these secondarily infected individuals also face barriers to care, the illness will spread further. In this way, a large-scale outbreak could be well under way before the medical community has an opportunity to make the first diagnosis. Once an outbreak occurs on a large scale, today's travel and work patterns could lead very rapidly to nationwide, or worldwide, dissemination.

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There are many potential reasons why an infected patient might not present for evaluation by the medical-care system. Some, like individual stoicism and bravado in the face of illness, are less amenable to intervention by the medical-care system. However, more than 40 million U.S. citizens have no health insurance, a problem not faced by any other advanced industrialized nation. Their lack of insurance is a known risk to their own health (*2*), but it must now also be recognized as a risk to the nation's health (*3*).

The Federal Welfare Reform Act of 1996 exacerbated the problem by virtually prohibiting federally funded medical clinics from providing most services to illegal immigrants (*4*). Publicity surrounding this law and its enforcement has been most damaging. For instance, although the act has specific exceptions for emergency treatment and for testing and treatment of symptoms of communicable diseases, Texas's state attorney general, John Cornyn, issued an opinion on 10 July 2001 stating that the Act precluded public clinics and hospitals in Texas from providing most services to illegal immigrants. An argument by Texas's public hospitals that early entry into the health-care system is cost-effective and necessary to protect the public's health did not sway the state from pursuing a strict interpretation of the Act. Indeed, before September 11, a lawsuit against the hospitals was being considered [(*5*), the suit is now "in limbo" (*6*)]. Adding to these concerns may be immigrants' and health-care professionals' memories of California's Proposition 187, which called on practitioners to refuse to treat illegal immigrants and to report them to immigration authorities (*7*). Passed in 1994, this proposition was never fully implemented and its health-care provisions were turned back in 1999 during mediation by the Settlement Program of the 9th Circuit Court of Appeals, but it has undoubtedly contributed to mistrust of the medical-care system among immigrants (*8*).

In the aftermath of the attacks on the World Trade Center buildings, attempts have been made locally to remove barriers to access. The Governor of New York issued Executive Orders 113 and 54, declaring a state disaster and, in the words of New York's Health Commissioner Antonio Novello, ordering medical-care providers, "Thou shalt not ask who will pay for this" before providing care for potential victims of the attacks (*9*). Over the next 4 months, New York's Disaster Relief Medicaid program enrolled almost 400,000 people (*10*). Doing so involved obtaining additional funding from the state pool for the uninsured and a dramatic streamlining of the application process for Medicaid (*9*). In our view, a similar lowering of barriers to access is in order for everyone living within U.S. borders.

In particular, two steps should be taken immediately to facilitate detection and reporting of infectious diseases. First, a homeland defense directive should go out, stating that individuals with symptoms that suggest infection with a contagious illness should present for evaluation and that those who do so will be treated without prejudice. Second, patients and physicians should be assured that no adverse consequences will result from reports to public health departments. An effective national defense against bioterrorism requires that all potentially infected patients can be at least evaluated without fear of deportation or other significant social or economic losses. Although additional funds will be required to evaluate uninsured patients, the investment in detection is the right thing to do—and it might even save money in the long run, as treatable and preventable illnesses are detected earlier and contained.

References and Notes

1. Public health emergency preparedness and response; available at www.bt.cdc.gov, accessed 5/15/02
2. T. Halstead, M. Lind, *USA Today*, 12 November 2001, p. A17.
3. Committee on the Consequences of Uninsurance, Board on Health Care Services, *Care Without Coverage: Too Little, Too Late* (Institute of Medicine, National Academy Press, Washington, DC, in press), 212 pp.
4. Personal Responsibility and Work Opportunity and Reconciliation Act of 1996, The Welfare Reform Act, Pub. L. No. 104-93, 110 Stat. 2105 (1996); 8 U.S.C. Section 1611(b).
5. J. Yardley, *New York Times*, 12 August 2001, p. A18.
6. S. Brewer, *Houston Chronicle*, 11 December 2001, p. A1.
7. T. A. Ziv, B. Lo, *N. Engl. J. Med.* **332**, 1095 (1995).
8. League of United Latin American Citizens *et al.* v. Wilson, 997 F Supp. 1244 (C.D. Cal. 1997).
9. A. Novello, American Public Health Association, 129th Annual Meeting and Exposition, Executive Board Special Session: APHA Response to Acts of Terrorism. Session 3099.1; Atlanta, 22 October 2001.
10. D. Janison, K. Hetter, *Newsday*, 7 March 2002, p. A5.
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