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# Making "Meaningful Access" Meaningful: Equitable Healthcare for Divisive Times

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# Making “Meaningful Access” Meaningful: Equitable Healthcare for Divisive Times

May 27, 2018 Leslie Francis [Beyond Disadvantage: Disability, Law and Bioethics](#), [Disability](#), [Health Law Policy](#), [Leslie Francis](#)

By **Leslie Francis**

Another anniversary of President Bush’s [signing](#) of the Americans with Disabilities Act (ADA) is coming up in late July, yet the nation remains far from offering even a semblance of equitable societal opportunity to most individuals with disabilities.

For them, full social participation is dismissed as merely an idealistic dream. With its focus on restoration of full functioning for patients, the health care delivery system might be supposed an exception, but a closer look shows the opposite is true.

Physicians’ offices, clinics, and hospitals too often have not been made accessible. Too frequently, these facilities have diagnostic or treatment equipment that some people, due to disability, cannot use. Health care provider staff are not trained to interact with or assess disabled individuals, and may be swayed by implicit biases that target disability, just as are non-medical personnel or laypersons in the population.



Photo by The Leadership Conference on Civil and Human Rights/Flickr

As for the courts, the Supreme Court's decision over thirty years ago in *Alexander v. Choate* continues to reassure states in their efforts to curtail access to their Medicaid programs in ways that disproportionately affect people with disabilities. In fact, over the years since enactment of the ADA, the courts—and the US Supreme Court most notably—have been especially frustrating crafters of barriers to disability civil rights, so much so that the usually divided Congress came together across the aisles to pass the ADA Amendments Act (ADAAA) in 2008.

In creating the ADAAA, the Congress responded most forcefully, and almost unanimously, to the Court's determinations that people do not count as disabled unless they are virtually unable to do any of the ordinary activities of daily living—so direly impaired, that is, that even with accommodation to their disabilities or modifications to expunge physical, sensory, intellectual or emotional barriers, they cannot make use of societal opportunity or execute any socially useful role.

The ADAAA addressed the problem of *who* is disabled, but not the more basic problem of *what* disability civil rights require.

Since enactment of the ADAAA, people seeking to use that statute to enforce their civil rights have been far less likely to find their claims dismissed on the ground that they fall outside of the group of people the statute was designed to protect. But they now find their claims dismissed without trial on the grounds that they were not qualified or eligible for what they sought, or that their exclusion was not on the basis of their disability. The ADAAA addressed the problem of *who* is disabled, but not the more basic problem of *what* disability civil rights require.

In our contribution to the upcoming Petrie-Flom Center symposium **Beyond Disadvantage: Disability, Law, and Bioethics**, Anita Silvers and I develop an account of disability civil rights in access to health care. Our account explicates the concept of “meaningful access” put forth in *Alexander v. Choate* but ever since applied in a way that has proved misleading. In that decision—upholding Tennessee’s cutback in hospital stays for Medicaid patients to fourteen days annually against a challenge that it disparately impacted the disabled—the Court said that the Rehabilitation Act required federally funded programs to give meaningful access to their benefits to the disabled and non-disabled alike. But the Court also said that because people with disabilities and people without disabilities each had access to the fourteen days, the standard of meaningful access was met, even if due to their disabilities some people could not access adequate treatment in that short time.

That flawed reasoning resulted from the Court’s failure to take into account a critical difference between two ways of responding to difference: accommodation and modification. Here’s what the difference is, and why it matters: “Accommodations” make adjustments for individual differences, so that people with disabilities can perform jobs, participate in activities, or receive services.

“Modifications” change practices or policies or reconstruct the built environment; their effects extend beyond particular individuals. Accommodations are justified by and require evidence of individual needs and abilities. Modifications are subject to different challenges: that they are inconvenient, expensive, inefficient, or distributively unjust. Modifications may also be inclusive in ways that extend beyond disabilities, as curb cuts famously do by facilitating pushing strollers and baby carriages in crossing streets.

If a request for a modifying policy change is seen as an individual accommodation, or a request for an individual accommodation is confused with a demand for policy change, the results for disability civil rights can be dire—and that’s exactly what happened as the Court interpreted the Rehabilitation Act, and ultimately the ADA.

The first major case interpreting the Rehabilitation Act, *Southeastern Community College v. Davis* created exactly this confusion. Here the Court failed to deal critically with the College’s shift in the terms of analysis from accommodation for a student nurse to modification of an entire nursing curriculum, and thus failed to address whether the College’s outright refusal to consider any accommodation or weigh Davis’s potential with accommodation for a useful nursing career, was unreasonable.

The Court’s initial mistake in *Davis* was compounded in *Alexander v. Choate*. The disabled plaintiffs in Tennessee sought a modification of Tennessee’s length of stay policy for Medicaid recipients. Instead, they were perceived by the Court as seeking unreasonable accommodations for themselves. The Court construed them as asserting “affirmative action” in the form of maximally effective treatment, a demand that was easy to re-imagine in terms of unfair advantage. Instead, the Court should have examined whether Tennessee’s outright refusal to consider even the possibility of reasonable modification of the policy so that disabled people’s access to medical care might be meaningful discriminated against the disabled.

In our contribution to the symposium, we explore how this distinction

between accommodations and modifications can facilitate understanding meaningful access to health care.

Sometimes, all that is required is accommodation to enable a person with a disability to receive a benefit that is equitable. But sometimes, policies, practices, and environments must be modified, in which case health care providers should consider offering access to care in ways that offer more inclusive and meaningful participation for all.