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REDUCING DISPARITIES THROUGH HEALTH CARE REFORM: DISABILITY AND ACCESSIBLE MEDICAL EQUIPMENT

Elizabeth Pendo *

I. INTRODUCTION

People with disabilities face multiple barriers to adequate health care and report poorer health status than people without disabilities. Although health care institutions, offices, and programs are required to be accessible, people with disabilities are still receiving unequal and, in many cases, inadequate care. The 2009 report by the National Council on Disability, *The Current State of Health Care for People with Disabilities*, reaffirmed some of these findings, concluding that people with disabilities experience significant health disparities and barriers to health care; encounter a lack of coverage for necessary services, medications, equipment, and technologies; and are not included in the federally funded health disparities research.¹ The report also noted the absence of training in disability competence issues for health care practitioners.²

This Article highlights an often overlooked barrier, basic medical equipment that is not accessible to people with disabilities. Twenty years after the passage of the Americans with Disabilities Act of 1990 (ADA),³ many people with mobility impairments cannot get on to examination tables and chairs, be weighed, or use X-ray and other imaging equipment. I introduced this issue into the legal literature in a prior writing focused on the delivery of traditional women's health care services.⁴ However, it is equally relevant to the delivery of basic preventive health care services to millions of men and women with mobility impairments.

Despite the seriousness of the problem, a review of all public and private enforcement activity brought to date reveals relatively few actions challenging inaccessible medical equipment under the ADA. Several recent settlements are

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¹ NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 1 (2009) [hereinafter THE CURRENT STATE OF HEALTH CARE], available at <http://www.ncd.gov/newsroom/publications/2009/pdf/HealthCare.pdf>.

² *Id.*

³ 42 U.S.C. §§ 12101–213 (2006). The ADA was amended in 2008. ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (codified as amended in scattered sections of 29 U.S.C., 42 U.S.C.).

⁴ Elizabeth Pendo, *Disability, Equipment Barriers, and Women's Health: Using the ADA to Provide Meaningful Access*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 15 (2008).

promising, but have not yet generated meaningful and widespread changes in access to and provision of accessible equipment. As I have written previously, inaccessible medical equipment seems like a relatively specific and easily solved issue, but its persistence suggests a deeper, more complex problem for people with disabilities in the health care system.⁵

In my prior writing, I analyzed the possibilities and limits of an ADA-focused litigation approach to the problem of inaccessible medical equipment.⁶ In this Article, I argue that the Patient Protection and Affordable Care Act, as amended (PPACA)⁷ offers a new approach to these pervasive barriers. The provisions of the PPACA focus on expanding coverage, controlling costs, and improving the quality of the health care delivery system.⁸ The PPACA also includes several, lesser-known provisions aimed at improving access to health care for people with disabilities. In particular, the PPACA provides for a standard-setting process for accessible medical equipment, opportunities for disability education and training for medical professionals, and improved data collection on the health and health care of people with disabilities.⁹ This Article brings attention to these lesser-known provisions and offers guidance on how they can be implemented together to most effectively address the problem of accessible medical equipment, as well as some of its underlying causes.

Part II of this Article reviews the health status of people with disabilities in general and examines the necessity of medical equipment such as examination tables, chairs, scales, and X-ray and other imaging equipment to the provision of basic preventive services to men and women with disabilities. Part III summarizes and evaluates the success of the ADA in ameliorating the unequal and inadequate care received by people with disabilities, and considers other proposed doctrinal reforms aimed at setting more specific standards for equipment. Unfortunately, it concludes that doctrinal reforms have not been as successful as hoped.

Part IV introduces a new approach: structural and systemic reform through the PPACA, which includes a standard-setting process for accessible medical equipment, improved data collection based on disability, and opportunities for professional education about caring for patients with disabilities. The reframing of barriers and disparities faced by people with disabilities as an issue of health care access and quality under the PPACA—in addition to an issue of civil rights under the ADA—appears promising.

Part V goes on to highlight a challenge in the development and implementation of equipment standards under the PPACA that has yet to be

⁵ *Id.* at 42–47.

⁶ *Id.* at 28–36, 47–55.

⁷ Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010). The PPACA was amended by the Health Care and Education Affordability Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

⁸ PPACA, 124 Stat. 119; *see also* HENRY J. KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM 1–2, 8–10 (2010), *available at* <http://www.kff.org/healthreform/upload/8061.pdf> (providing a summary of the PPACA).

⁹ *See infra* Part IV.A–B.

addressed. Specifically, in terms of accessible medical equipment in offices and institutions—how much is enough? This part provides guidance on these issues, including suggestions on developing the PPACA’s data collection and provider education and training provisions to inform and reinforce the standard-setting process.

II. THE PROBLEM OF INACCESSIBLE MEDICAL EQUIPMENT

It took a while . . . but I gradually realized that I wasn’t getting the same level of care I had received when I could walk, and get on the scale, and climb up on the examination table.

-John Lonberg, Kaiser Permanente Member¹⁰

Although the data is not complete, there is significant evidence that many people with disabilities are not provided with equal or adequate health care.¹¹ For example, it is well known that people with disabilities face multiple barriers to quality health care services. According to a recent review of the available evidence, people with disabilities use fewer preventive services, have poorer overall health outcomes, experience more preventable emergency room visits, and report more unmet needs and dissatisfaction in the services they do receive.¹² The 2009 report by the National Council on Disability confirms these findings, adding that people with disabilities use health care at a significantly higher rate than people who do not have disabilities, experience a higher prevalence of secondary conditions, and experience more problems accessing health care than other groups.¹³ People with disabilities are less likely to receive basic preventive health care services, such as screening for breast and cervical cancer,¹⁴ screening for

¹⁰ JUNE ISAACSON KAILES & CHRISTIE MAC DONALD, CTR. FOR DISABILITIES ISSUES AND THE HEALTH PROFESSIONS, IMPORTANCE OF ACCESSIBLE EXAMINATION TABLES, CHAIRS, AND WEIGHT SCALES 15 (3d ed. 2009), *available at* http://www.cdihp.org/briefs/1.%20Brief-Exam%20Tables%20and%20Scales-FINAL%20Edition%204_4%208%2009.pdf.

¹¹ Disability activists and policy experts have pointed out the lack of reliable, large-scale population-based studies on the health status, needs, and experiences of people with disabilities. *See generally* THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 12–13; Kristi L. Kirschner et al., *Structural Impairments that Limit Access to Health Care for Patients with Disabilities*, 297 JAMA 1121, 1121 (2007) (“Although no direct evidence currently exists about the population prevalence of these problems nationwide, increasing numbers of legal cases, small studies, and circumstantial evidence point to widespread access barriers for patients with disabilities within U.S. health care settings.”).

¹² Karen Hwang et al., *Access and Coordination of Health Care Service for People with Disabilities*, 20 J. DISABILITY POL’Y STUD. 28, 29–30 (2009) (collecting results of population-based surveys).

¹³ THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 10.

¹⁴ *Id.* at 57–59.

prostate cancer,¹⁵ screening for cardiovascular disease for women,¹⁶ and bone mineral screenings.¹⁷ This is especially troubling as many people with disabilities have a “thinner margin of health.”¹⁸

Inaccessible medical equipment is a fundamental barrier to health care services for people with mobility limitations or impairments.¹⁹ Accordingly, the following examines the necessity of medical equipment in the provision of basic preventive services to men and women with disabilities, including examination tables, examination chairs, weight scales, and X-ray and other imaging equipment.

A. Examination Tables

A health care professional uses examination tables for a wide range of purposes, including routine physical examinations. During a basic physical examination, he or she takes vital signs and perform a general inspection of all the areas of the body.²⁰ He or she may perform a visual examination of the head, neck, and torso, as well as motor skills with the patient seated, while the examination of the thorax, abdomen, and proximal lower extremities should be performed with the patient lying on an examination table.²¹ Examination tables are used to perform routine care such as pelvic exams for adult or sexually active women, and prostate examinations for men.²²

In general, men and women should have at least two physical exams in their twenties, a physical exam every one to five years between the ages of forty and

¹⁵ KRISTINA HANSON ET AL., HENRY J. KAISER FAMILY FOUND., UNDERSTANDING THE HEALTH-CARE NEEDS AND EXPERIENCES OF PEOPLE WITH DISABILITIES: FINDINGS FROM A 2003 SURVEY 9 (2003).

¹⁶ Hwang et al., *supra* note 12, at 29; Thilo Kroll et al., *Barriers and Strategies Affecting the Utilisation of Primary Preventive Services for People with Physical Disabilities: A Qualitative Inquiry*, 14 HEALTH & SOC. CARE IN COMMUNITY 284, 285 (2006).

¹⁷ Ashley Duggan et al., *What Can I Learn from this Interaction: A Qualitative Analysis of Medical Student Self-Reflection and Learning in a Standardized Patient Exercise about Disability*, 14 J. HEALTH COMM. 797, 798 (2009).

¹⁸ Gerben DeJong, *Primary Care for Persons with Disabilities: An Overview of the Problem*, 76 AM. J. PHYSICAL MED. & REHABILITATION, at S2, S3 (Supp. 1997).

¹⁹ THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 49–50; LISA I. IEZZONI & BONNIE L. O’DAY, MORE THAN RAMPS: A GUIDE TO IMPROVING HEALTH CARE QUALITY AND ACCESS FOR PEOPLE WITH DISABILITIES (2006); June Isaacson Kailes, *The Patient’s Perspective on Access to Medical Equipment*, in MEDICAL INSTRUMENTATION: ACCESSIBILITY AND USABILITY CONSIDERATIONS 3 (Jack M. Winters & Molly Follette Story eds., 2007); Kirschner et al., *supra* note 11, at 1121; Pendo, *supra* note 4, at 19–28.

²⁰ CLINICAL METHODS: THE HISTORY, PHYSICAL AND LABORATORY EXAMINATIONS 38 tbl.4.3 (H. Kenneth Walker et al. eds., 3d ed. 1990), available at <http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=cm&part=A245&rendertype=table&id=A253>.

²¹ *Id.*

²² *Id.*

sixty-five, and a yearly physical exam after the age of sixty-five.²³ All women over the age of twenty-one should have a pelvic exam and Pap test every two years.²⁴ Men over the age of fifty should discuss having a prostate exam with their doctor.²⁵

Unfortunately, the literature suggests that people with disabilities receive fewer primary preventive services. For example, studies have found that women with disabilities are less likely to receive pelvic exams within the recommended guidelines,²⁶ and men with disabilities are less likely to receive prostate exams.²⁷

A standard, nonadjustable examination table is typically too high for a safe transfer from a wheelchair to the table surface.²⁸ In addition, tables that lack some form of stabilization or support, such as rails, straps, bolsters, or foot rests, as appropriate, make it difficult for patients with a range of disabilities to stay safely and comfortably on the table surface.²⁹ When a patient cannot safely get or stay on an examination table, a physician cannot perform an appropriate examination. This can result in discomfort, injury, or the delay or denial of treatment.³⁰

B. Examination Chairs

Examination chairs are routinely used for both dental and eye exams. During a dental exam a patient sits in an examination chair while a dental hygienist performs a professional cleaning.³¹ Then a dentist evaluates bone loss and gum inflammation, and examines the patient's face, neck, and mouth for abnormalities.³² The dentist or assistant may also take dental X-rays.³³ Without regular dental exams, plaque may harden into tartar leading to a number of

²³ See generally U.S. Nat'l Library of Med., *Physical Exam Frequency*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/002125.htm> (last updated May 20, 2010) [hereinafter *Physical Exam Frequency*, MEDLINEPLUS] (discussing the different recommendations for medical exam frequency).

²⁴ *Id.*

²⁵ *Id.* However, African American men and those with a family history of prostate cancer should start at age forty-five. *Id.*

²⁶ See Pendo, *supra* note 4, at 23 n.37 (collecting sources).

²⁷ HANSON ET AL., *supra* note 15, at 9. Similarly, a national survey of people with disabilities conducted by the Kaiser Family Foundation in 2003 found that "[l]ess than half of all female respondents reported having a mammogram in the past year and only about a third of all men reported having a prostate exam over the same period." *Id.*

²⁸ Pendo, *supra* note 4, at 24–25.

²⁹ See generally Sandra L. Welner et al., *Practical Considerations in the Performance of Physical Examinations on Women with Disabilities*, 54 OBSTETRICAL & GYNECOLOGICAL SURV. 457, 458 (1999) (discussing the need for proper safety mechanisms when examining a woman with a disability).

³⁰ See, e.g., KAILES & MAC DONALD, *supra* note 10, at 6–7.

³¹ See generally *Dental Exam*, MAYO CLINIC, <http://www.mayoclinic.com/health/dental-exam/MY01097> (last updated Jan. 23, 2010) (discussing what to expect during a dental examination).

³² *Id.*

³³ *Id.*

problems including cavities, gum disease, abscesses, pain, inability to use teeth, and even ligament and bone damage leading to tooth loss.³⁴ Poor dental hygiene is also connected with preterm labor and heart disease.³⁵

An adult over the age of eighteen should have a dental exam and cleaning every year.³⁶ The Surgeon General's 2000 report *Oral Health in America* noted that people with disabilities may face more barriers to dental care than the general population.³⁷ Additionally, the report noted that children with disabilities are "at increased risk for oral infections, delays in tooth eruption, periodontal disease, enamel irregularities, and moderate-to-severe malocclusion."³⁸ The National Institute of Dental and Craniofacial Research has also suggested the existence of similar disparities for people with disabilities, among other groups, while noting the lack of adequate or complete data on the dental health of such groups.³⁹

Examination chairs are also used for eye exams. Regular eye exams are important, as nearly everyone experiences some level of vision loss by the age of fifty.⁴⁰ A regular eye exam, with a patient seated in an examination chair, generally involves a vision test, color-vision tests, as well as other tests to check the muscles and nerves of the eyes and proper dilation.⁴¹ Further, an eye exam will usually include one of several tests for glaucoma, a leading cause of blindness.⁴² Individuals with diabetes may also be tested for diabetic retinopathy, which can

³⁴ See generally U.S. Nat'l Library of Med., *Dental Care-Adult*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/001957.htm> (last updated Feb. 22, 2010) [hereinafter *Dental Care*, MEDLINEPLUS] (discussing the dangers of allowing plaque to remain on teeth).

³⁵ *Id.*

³⁶ See generally *Physical Exam Frequency*, MEDLINEPLUS, *supra* note 23 (discussing the need to have a dental examination every year after the age of eighteen).

³⁷ U.S. DEP'T OF HEALTH AND HUMAN SERVS., ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL 19, 78–79 (2000). The report suggests that although these problems may be due to the underlying congenital anomalies, they may also be due to the inability of individuals with disabilities to receive the personal and professional health care needed to maintain oral health. *Id.* at 79.

³⁸ *Id.* at 253 (citation omitted).

³⁹ NAT'L INST. OF DENTAL AND CRANIOFACIAL RESEARCH, A PLAN TO ELIMINATE CRANIOFACIAL, ORAL, AND DENTAL HEALTH DISPARITIES 3 (2002), available at <http://www.nidcr.nih.gov/NR/rdonlyres/932B8B7D-E114-4491-BE85-ABA6F29663AE/0/hdplan.pdf>. However, the National Institute of Dental and Craniofacial Research notes that "[c]hildren with the most advanced oral disease are primarily found among the poor, American Indians and other minorities, homeless and migrant populations, children with disabilities, and children with HIV infection." *Id.* at 14.

⁴⁰ *Reasons to Get an Eye Examination*, IND. U. SCH. OF OPTOMETRY, http://www.opt.indiana.edu/clinics/pt_educ/iexam/reasons.htm (last visited Nov. 3, 2010).

⁴¹ *Id.*

⁴² See generally U.S. Nat'l Library of Med., *Glaucoma*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/001620.htm> (last updated Aug. 6, 2009) (discussing the causes, symptoms, and treatment for glaucoma).

also lead to blindness.⁴³ The National Institutes of Health (NIH) recommends an eye examination every two years for people with vision problems and an examination every two years after the age of forty whether or not the person has vision problems.⁴⁴ Unfortunately, there is little reliable data upon which to draw a conclusion about access to vision care for people with disabilities.⁴⁵

Like examination tables, a standard, nonadjustable examination chair is typically too high for a safe or comfortable transfer.⁴⁶

C. Weight Scales

According to the NIH, height and weight should be measured at every exam.⁴⁷ Weight gain and obesity are linked to many diseases including reproductive and hormonal problems, cardiovascular disease, high blood pressure, diabetes, and cancer.⁴⁸ Conversely, weight loss can signal several ailments including depression, infection, and cancer.⁴⁹ Monitoring weight gain is also an important aspect of basic prenatal care⁵⁰ and general medication management.⁵¹

Unfortunately, many people with disabilities—mobility disabilities in particular—are not being weighed due to the lack of accessible scales.⁵² In a national survey of people with disabilities, 60% of the respondents who used wheelchairs reported problems being weighed due to the lack of an accessible

⁴³ *Reasons to Get an Eye Examination*, *supra* note 40.

⁴⁴ *Examination Schedule*, IND. U. SCH. OF OPTOMETRY, http://www.opt.indiana.edu/clinics/pt_educ/iexam/examination.htm (last visited Nov. 3, 2010).

⁴⁵ *But see* Lisa I. Iezzoni et al., *Mobility Impairments and Use of Screening and Preventive Services*, 90 AM. J. PUB. HEALTH 955, 960 (2000) (“Among persons 65 years and older, 23.2% of those without mobility problems reported having had vision tests, compared with 21.6% of those with major mobility problems.”). There was also reference to one case in which an individual was denied vision service because he was unable to walk from his wheelchair to the examination chair. *Sterling Visioncare*, DISABILITY RTS. ADVOCS., http://www.drlegal.org/cases/health_insurance/sterling_visioncare.php (last visited Nov. 3, 2010).

⁴⁶ Pendo, *supra* note 4, at 24; *see also* KAILES & MAC DONALD, *supra* note 10, at 3 (“When a physician is unable to perform an appropriate examination because the patient cannot get onto an examination or procedural table and chairs, or be weighed on a standard scale, the patient may receive a lesser quality of health care.”).

⁴⁷ *See generally Physical Exam Frequency*, MEDLINEPLUS, *supra* note 23.

⁴⁸ KAILES & MAC DONALD, *supra* note 10, at 15.

⁴⁹ *Id.* at 16.

⁵⁰ *See* OFFICE ON WOMEN’S HEALTH, U.S. DEP’T OF HEALTH AND HUMAN SERVS., PRENATAL CARE: FREQUENTLY ASKED QUESTIONS 3–4 (2006), *available at* <http://www.womenshealth.gov/faq/prenatal-care.pdf>.

⁵¹ Russell H. Jenkins & Allen J. Vaida, *Simple Strategies to Avoid Medication Errors*, 14 FAM. PRAC. MGMT. 41, 42–43 (2007).

⁵² *See, e.g.*, Kroll et al., *supra* note 16, at 288.

scale.⁵³ This is especially problematic as people with disabilities have higher rates of obesity than the general population.⁵⁴

D. X-ray and Other Imaging Equipment

Health care professionals use imaging equipment to take images of structures and activities inside the body to help diagnose a patient's medical condition.⁵⁵ Such equipment includes X-ray equipment, computerized tomography scanners, ultrasound devices, and nuclear scanning equipment.⁵⁶

Nearly half a million patients receive X-ray services each year.⁵⁷ X-rays are used to diagnose a number of health problems, such as severe heart conditions and pneumonia.⁵⁸ X-rays are also used for proper placement of devices within the body, such as breathing tubes.⁵⁹

X-ray examinations require patients to be standing or lying still while images are taken from specific angles.⁶⁰ This presents obvious challenges for people with a variety of disabilities. Although comparative access data based on disability is not readily available for all types of imaging, some information exists on the accessibility of mammography. A screening mammogram is an X-ray of each

⁵³ Kailes, *supra* note 19, at 8.

⁵⁴ See, e.g., THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 35; Allison A. Brown & Carol J. Gill, *Women with Developmental Disabilities: Health and Aging*, 2 CURRENT WOMEN'S HEALTH REP. 219, 219–20 (2002); Evette Weil et al., *Obesity Among Adults with Disabling Conditions*, 288 JAMA 1265 (2002) (finding that obesity is more prevalent in adults with disabilities than the general population). "National Health Interview Survey [NHIS] data from 2002 indicate that 21.4% of women aged 18 and over are obese CROWD data show that 47.6% of a convenience sample of women with physical disabilities report having a BMI of 30 or greater. Another study that used NHIS data for women with functional limitations found that 43.2% of women with three or more limitations were obese." Ctr. for Research on Women with Disabilities, *Health Disparities Between Women with Physical Disabilities and Women in the General Population*, BAYLOR C. OF MED., <http://www.bcm.edu/crowd/?PMID=1331> (last visited Nov. 3, 2010) (citations omitted) (citing various studies).

⁵⁵ Niccie L. McKay, *Industry Effects of Medical Device Regulation: The Case of Diagnostic Imaging Equipment*, 6 J. POL'Y ANALYSIS & MGMT. 35, 37 (1986).

⁵⁶ *Id.*

⁵⁷ Phillip F. Schewe & Ben Stein, *X Rays Were Discovered 100 Years Ago by Wilhelm Roentgen*, AM. INST. OF PHYSICS (Nov. 2, 1995), <http://www.aip.org/pnu/1995/split/pnu247-2.htm>.

⁵⁸ See generally U.S. Nat'l Library of Med., *Chest x-ray*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/003804.htm> (last updated Aug. 8, 2010); *Patient Safety: Radiation Exposure in X-ray and CT Examinations*, RADIOLOGYINFO.ORG, http://www.radiologyinfo.org/en/safety/index.cfm?pg=sfty_xray (last visited Nov. 2, 2010) [hereinafter RADIOLOGYINFO.ORG] (providing an overview of how X-rays work).

⁵⁹ RADIOLOGYINFO.ORG, *supra* note 58.

⁶⁰ See generally U.S. Nat'l Library of Med., *Abdominal Film*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/ency/article/003815.htm> (last updated Feb. 22, 2009).

breast used to detect changes such as tumors and calcium deposits that may indicate cancer.⁶¹ Mammography is used to detect changes that are too small to be felt during a self-exam or a manual exam by a physician.⁶² Typically, a woman stands in front of an X-ray machine, and the technician places her breast between two plates.⁶³ The plates press against the breast to make it flat, generating a more accurate image, and the woman must remain standing and still while several images are taken.⁶⁴

According to the NIH, women over the age of forty should have a screening mammogram every one to two years, depending on risk factors for breast cancer.⁶⁵ However, women with disabilities have less access to breast health services than other groups of women, and inaccessible mammography equipment has been noted as a key barrier.⁶⁶

III. DOCTRINAL APPROACHES

Although the ADA establishes the necessary foundation for ensuring equal and accessible care for people with disabilities, people with disabilities continue to experience significant barriers to care, including basic preventive health services.⁶⁷ With respect to the lack of accessible medical equipment, this could be because detailed standards for medical equipment have not been created by statute or regulation, or by a sufficient body of case law.⁶⁸ The following provides an original summary and examination of the limited success of the ADA in addressing

⁶¹ See, e.g., *Mammograms*, NAT'L CANCER INST., <http://www.cancer.gov/cancertopics/factsheet/Detection/mammograms> (last visited Nov. 3, 2010).

⁶² *Id.*

⁶³ See generally U.S. Nat'l Library of Med., *Mammography*, MEDLINEPLUS, <http://www.nlm.nih.gov/medlineplus/mammography.html> (last visited Nov. 2, 2010).

⁶⁴ *Id.*

⁶⁵ *Physical Exam Frequency*, MEDLINEPLUS, *supra* note 23.

⁶⁶ Kailes, *supra* note 19, at 6 (“Even if women with disabilities schedule mammograms or clinical breast exams, many cannot receive either service when they arrive because of inaccessible health care facilities and medical equipment.” (citation omitted)); M.A. Nosek et al., *National Study of Women with Physical Disabilities: Final Report*, 19 *SEXUALITY & DISABILITY* 5, 34–36 (2001).

⁶⁷ See *supra* Part II.

⁶⁸ As others and I have written elsewhere, the ADA is underenforced, in significant part due to various limitations on private actions. See Samuel R. Bagenstos, *The Perversity of Limited Civil Rights Remedies: The Case of “Abusive” ADA Litigation*, 54 *UCLA L. REV.* 1, 30 (2006) (“The limited remedies have led to massive underenforcement of the ADA’s public accommodations title, and they have left serial litigation as one of the only ways to achieve anything approaching meaningful compliance with the statute.”); Ruth Colker, *ADA Title III: A Fragile Compromise*, 21 *BERKLEY J. EMP. & LAB. L.* 377 *passim* (2000) (discussing the trend of underenforcement of the ADA’s public accommodations provisions); Michael Waterstone, *A New Vision of Public Enforcement*, 92 *MINN. L. REV.* 434, 458, 460–61 (2007) (“There has been a notable lack of systemic and class action litigation under the ADA, particularly with regard to the law’s employment provisions.”).

inaccessible medical equipment as a barrier to care, as well as attempts to develop standards through means other than litigation.

A. Limited Success of the ADA & Rehabilitation Act

The Rehabilitation Act of 1973⁶⁹ requires that hospitals, clinics, and other health care agencies that accept Medicaid funds, Medicare funds, or any other form of federal funding, ensure equal access to programs and services.⁷⁰ Title II of the ADA extends this requirement to public entities, including state and local public health programs, services, and activities, regardless of receipt of federal funding.⁷¹ Title III reaches private offices of health care providers and private hospitals.⁷² I have written previously that this requirement includes an obligation to remove barriers to equal access, including barriers created by inaccessible medical equipment.⁷³ Despite the seriousness of the problem, there have been relatively few private actions brought challenging inaccessible medical equipment under the ADA, as shown in table 1.

⁶⁹ 29 U.S.C. §§ 701–96 (2006).

⁷⁰ *Id.* § 701(a)(1); *id.* § 794(b)(3)(A)(ii). Several courts have found that the receipt of Medicare or Medicaid funds constituted receipt of federal financial assistance within the meaning of the Rehabilitation Act. *See, e.g.,* *Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003) (noting the lack of dispute on point under the Rehabilitation Act and the ADA).

⁷¹ *See* 42 U.S.C. § 12131(1) (2006).

⁷² *See id.* § 12181(7)(F); *id.* § 12182(a); 28 C.F.R. pt. 36 app. B at 696 (2008) (indicating that the office of a health care provider may be included even if it is located in a private home).

⁷³ For a more detailed analysis of the application of the Rehabilitation Act and the ADA, as to the issue of equal access to health care programs and services, see Pendo, *supra* note 4, at 28–36, 47–55.

Table 1: Private Actions Challenging Inaccessible Medical Equipment

<i>Filed</i>	<i>Case Name</i>	<i>Settled</i>
2000	Metzler v. Kaiser Foundation Health Plan (Cal. Super. Court, Alameda County) ⁷⁴	2001
2003	Equal Rights Center v. Washington Hospital Center (D.D.C.) ⁷⁵	2005
2008	Olson v. Sutter Health (Cal. Super. Court, Alameda County) ⁷⁶	2008
N/A	Longo and UCSF Medical Center (structured settlement) ⁷⁷	2008

The first and largest private action was *Metzler v. Kaiser*, filed by Disability Rights Advocates on behalf of its California members with disabilities. The action alleged discriminatory care on the part of Kaiser Foundation Health Plan, the nation's largest nonprofit health maintenance organization, including inaccessible equipment such as examination tables, scales, and mammography machines:⁷⁸

The three named plaintiffs are all Kaiser members who use wheelchairs. One of them, John Metzler, had pressure sores on his buttocks for a year,

⁷⁴ Settlement Agreement, Metzler v. Kaiser Found. Health Plan, Inc., No. 829265-2 (Cal. Super. Ct., Mar. 26, 2001) [hereinafter Metzler v. Kaiser Settlement], available at <http://www.dralegal.org/downloads/cases/metzler/settlement.pdf>.

⁷⁵ Settlement Agreement Among the United States of America and Washington Hospital Center, Complaint No. 202-16-120 (Dep't of Justice Nov. 2, 2005) [hereinafter Washington Hospital Center Settlement], available at <http://www.ada.gov/whc.htm>.

⁷⁶ See [Proposed] Order Certifying a Settlement Class and Finally Approving Class Action Settlement, Olson v. Sutter Health, No. RG06-302354 (Cal. Super. Ct., July 11, 2008) [hereinafter Olson v. Sutter Health Settlement], available at http://www.dralegal.org/downloads/cases/sutter/order_7-11-08.pdf.

⁷⁷ See *USCF Medical Center Settlement Agreement*, LAW OFFICES OF LAINEY FEINGOLD, <http://llegal.com/2008/09/ucsf-settlement-agreement> (last visited Nov. 1, 2010) [hereinafter UCSF Medical Center Settlement Agreement].

⁷⁸ See Metzler v. Kaiser Settlement, *supra* note 74. There was a similar case in 1988 in which a plaintiff alleged that she was denied assistance to help her transfer from her wheelchair to an examination table for a gynecological exam in Georgetown University Hospital's Obstetrics and Gynecology Clinic. See Settlement Agreement Between the United States of America and Georgetown University, Under the Americans with Disabilities Act, Complaint No. 202-16-92 (Dep't of Justice Oct. 31, 2001), available at <http://www.ada.gov/gtownhos.htm#anchor262953>. The Clinic did have an adjustable examination table, but it was inoperable at the time of plaintiff's visit. *Id.* para. 6.

but his doctors had not visually examined them because the examination table was inaccessible. Another, Johnnie Lacy, had not had a gynecological examination in more than 15 years because of the same problem[.] The third, John Lonberg, was not weighed for 15 years because there was no scale accessible to a wheelchair at his Kaiser doctors' office.⁷⁹

A settlement was reached in 2001, pursuant to which Kaiser Foundation Health Plan agreed to a range of remedial measures addressing inaccessible medical equipment, architectural barriers, and certain policies and procedures throughout its California hospitals and medical offices.⁸⁰

The second case was filed in 2003 by the Equal Rights Center against Washington Hospital Center (WHC), the largest private acute-care hospital in the Washington D.C. area, alleging that patients with disabilities had been denied equal access to treatment because of the inaccessibility of WHC's medical facilities, including examination tables and equipment, as well as policies and procedures that left patients with disabilities without adequate assistance to eat, drink, and care for themselves.⁸¹ An agreement was reached in 2005 that provided in part that WHC would make at least thirty-five patient rooms accessible, remove architectural barriers based on expert recommendations, purchase at least one accessible exam table in each department, and make other changes of policies, practices, and procedures to ensure that people with disabilities receive equal and high quality care.⁸²

The third action was filed in 2008 as a California state court class action against the California hospital chain Sutter Health and alleged, among other things, that Sutter Health failed to provide accessible medical equipment, "including, but not limited to, examination tables, examination chairs, lift equipment, scales, diagnostic equipment (e.g., x-ray, mammography and MRI equipment), dental chairs, [and] ophthalmology equipment."⁸³ A settlement was reached pursuant to which Sutter Health agreed to assess and address a range of issues, including

⁷⁹ Tamar Lewin, *Disabled Patients Win Sweeping Changes from H.M.O.*, N.Y. TIMES, Apr. 13, 2001, at A14.

⁸⁰ Metzler v. Kaiser Settlement, *supra* note 74, at 3.

⁸¹ Washington Hospital Center Settlement, *supra* note 75, at 16.

⁸² Neil Adler, *Washington Hospital Center Settles Lawsuit, Agrees to Changes*, WASH. BUS. J. (Nov. 3, 2005, 2:46 PM EST), <http://washington.bizjournals.com/washington/stories/2005/10/31/daily38.html>; Press Release, Wash. Lawyers' Comm. for Civil Rights & Urban Affairs, Washington Hospital Center Agrees to Landmark Settlement to Improve Access for Patients with Disabilities (Nov. 2, 2005), *available at* http://www.equalrightscenter.org/site/PageServer?pagename=pr_05_11_02.

⁸³ Class Action Consent Decree at 4, *Olson v. Sutter Health*, No. RG06-302354 (Cal. Super. Ct. July 11, 2008).

architectural barriers, inaccessible medical equipment, and policies and procedures for all of its hospitals.⁸⁴

Also in 2008, an agreement was reached through a structured settlement between August Longo and the University of California San Francisco Medical Center (USCF).⁸⁵ Longo, a disability rights advocate, was admitted to a hospital room at USCF without an accessible bathroom and was told that there were no patient rooms with accessible bathrooms.⁸⁶ USCF entered negotiations, and reached an agreement in which it agreed to a range of remedial measures, including removal of barriers; modification of policies, procedures, and training programs to improve patient care services to persons with disabilities; and installation and use of accessible medical equipment.⁸⁷

Although it is difficult to draw a conclusion from four settlements, all were settled within the last ten years and two were settled in 2008. This may suggest an increase in private enforcement of the ADA's requirement of equal access for people with disabilities overall, and of the accessible medical equipment requirement in particular. In addition, in 2009, a group of advocates, nonprofit organizations, legal service providers, and lawyers joined together to form the Barrier Free Healthcare Initiative, a group dedicated to "eliminat[ing] the physical and programmatic barriers that people with disabilities face in obtaining healthcare."⁸⁸

There is some evidence of a similar increase in public enforcement, as the Department of Justice was involved in a small but increasing number of cases during the past two decades. Between 1994 and September 2009, the Department was involved in fifty-five actions involving architectural barriers in a health care setting, and twelve actions involving inaccessible medical equipment, as shown in table 2.

⁸⁴ See *Olson v. Sutter Health Agreement*, *supra* note 76; News Release, Sutter Health, Sutter Health Adopts Sweeping Plans for Improved Access under ADA: Agreement with Disability Rights Advocates Puts Sutter in the Lead in Hospital Access (Apr. 18, 2008), available at http://www.sutterhealth.org/about/news/news08_disabilityaccess.html.

⁸⁵ See USCF Medical Center Settlement Agreement, *supra* note 77.

⁸⁶ *August Longo: Advocate for Accessible Health Care through Structured Negotiations*, LAW OFFICE OF LAINEY FEINGOLD (Apr. 7, 2010), available at <http://llegal.com/2010/04/august-longo>.

⁸⁷ See USCF Medical Center Settlement Agreement, *supra* note 77.

⁸⁸ Press Release, Barrier Free Healthcare Initiative, Hospitals Join Disability Community to Launch Initiative to Improve Access and Care for People with Disabilities (June 26, 2009), available at http://thebarrierfreehealthcareinitiative.org/?page_id=47.

Table 2: DOJ Involvement in Actions in a Health Care Setting⁸⁹

	<i>Architectural Barriers</i>	<i>Inaccessible Equipment</i>
Litigation	0	0
Consent Decree	2	0
Formal Settlements	5	7
Other Settlements	19	3
Mediation	26	2
Amicus Brief	3	0
TOTALS	55	12

Since September 2009, the Department of Justice reached a settlement with Beth Israel Deaconess Medical Center (Beth Israel),⁹⁰ a teaching hospital affiliated with Harvard University. The agreement provides, among other things, that Beth Israel will ensure that accessible patient rooms and medical equipment are available for each of its clinical services. Specifically, it requires that “at least 10% of examination and treatment equipment purchased or leased after the effective date of this Agreement, but no fewer than one of each type in each clinical service, will be accessible to and usable by individuals with disabilities.”⁹¹ Beth Israel also agreed to survey existing facilities and equipment, including patient beds, exam tables, patient lifts, and radiologic and diagnostic equipment, for compliance with ADA standards, and agreed to implement a system to ensure the purchase of accessible equipment where available.⁹²

⁸⁹ The table is based on a review of quarterly ADA status reports which cover selected ADA activities of the Department, including the removal of architectural and equipment barriers. *ADA Enforcement*, U.S. DEP’T OF JUST., <http://www.ada.gov/enforce.htm> (follow “Status Reports” hyperlink) (last visited Nov. 1, 2010). A few of the cases were difficult to classify, particularly when they involved both architectural and equipment barriers. For example, the “Other Settlements” section of the July-December 2008 status report had a case that involved both “an accessible exterior door” (an architectural barrier) and “an accessible exam and x-ray room” (an equipment barrier). *Id.*

⁹⁰ Settlement Agreement Between the United States of America and the Beth Israel Deaconess Medical Center Under Title III of the Americans with Disabilities Act, DJ No. 202-36-195 (Dep’t of Justice Oct. 1, 2009) [hereinafter *Beth Israel Deaconess Settlement*], available at <http://www.ada.gov/bidmsa.htm>. Two other Harvard-affiliated teaching institutions, Massachusetts General Hospital and Brigham and Women’s Hospital, reached agreements earlier the same year, and will use part of the estimated \$12 million for improvements to purchase accessible exam tables, mammography units, X ray machines, and scales. Stephen Smith, *Two Flagship Hospitals to Upgrade Accessibility*, BOS. GLOBE, June 26, 2009, at B1.

⁹¹ *Beth Israel Deaconess Settlement*, *supra* note 90, ¶ 29.

⁹² *Id.* ¶¶ 23, 28.

In addition, in July 2010, the Department of Justice and the Department of Health and Human Services published a guidance document addressing access to medical care for individuals with mobility disabilities, including accessible medical equipment, which may suggest an increased commitment to ensuring equal access to health care for people with disabilities.⁹³

Although the recent private and public enforcement activity described above appears promising, ADA litigation has yet to generate meaningful and widespread changes in access to and provision of accessible equipment. As I have written previously, “[t]he law confers the right to nondiscriminatory access to health care, and to be meaningful, this right must be enforced.”⁹⁴ This means that civil rights litigation, or the credible threat of litigation, has a role to play in the continued protection and promotion of the rights of patients with disabilities.

B. Proposed Reform: The Promoting Wellness for People with Disabilities Act

Although the ADA requires equal access to health care, which includes a duty to acquire or redesign equipment, it does not require health care institutions or providers to have any specific type or types of equipment.⁹⁵ Compare this with the specific requirements regarding the removal of architectural barriers: new facilities must meet the numerous and detailed requirements for fixed features of buildings and structures, such as entryways, doorways, stairs, elevators, floor surfaces, restrooms, parking areas, and curbs established by the ADA Accessibility Guidelines for Buildings and Facilities (ADAAG),⁹⁶ and existing facilities must remove architectural barriers in accordance with these requirements where “readily achievable.”⁹⁷ More specific requirements for furnishings and equipment, which

⁹³ U.S. DEP’T OF JUSTICE & U.S. DEP’T OF HEALTH AND HUMAN SERVS., AMERICANS WITH DISABILITIES ACT: ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES (2010) [hereinafter ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES], available at http://www.ada.gov/medcare_mobility_ta/medcare_ta.pdf.

⁹⁴ Pendo, *supra* note 4, at 47.

⁹⁵ *Id.* at 34, 37.

⁹⁶ See 28 C.F.R. pts. 35–36. On July 23, 2010, the Attorney General signed final regulations adopting the updated ADA Standards for Accessible Design. *Revised ADA Regulations Implementing Title II and Title III*, DEP’T OF JUSTICE, <http://www.ada.gov/regs2010/ADAregs2010.htm> (last updated Oct. 12, 2010). The official text was published in the Federal Register on September 15, 2010. *Id.* The revised regulations amend the Department’s Title II regulation and Title III regulation. *Id.* Appendix B to the Title III regulation discusses major changes in the ADA Standards for Accessible Design. *Id.* These final rules will take effect March 15, 2011, but compliance with the 2010 Standards for Accessible Design is not required until March 15, 2012. *Id.*

⁹⁷ 42 U.S.C. § 12182(b)(2)(A)(iv) (2006) (requiring that public facilities “remove architectural barriers, and communication barriers that are structural in nature, in existing facilities, and transportation barriers in existing vehicles and rail passenger cars used by an establishment for transporting individuals (not including barriers that can only be removed through the retrofitting of vehicles or rail passenger cars by the installation of a hydraulic

would include medical equipment, have been contemplated by the Department of Justice at least twice—in 1991 and again in 2008—but both times the Department declined to set such standards.⁹⁸

The Promoting Wellness for Individuals with Disabilities Act (Promoting Wellness Act), introduced in 2006 by Senator Tom Harkin,⁹⁹ was an attempt to fill this gap. The Promoting Wellness Act called for the rapid development of standards for accessible medical equipment, a wellness grant program, and additional education and training for doctors.¹⁰⁰ Specifically, it called for the Architectural and Transportation Barriers Compliance Board (Access Board) to develop and publish a detailed set of standards for medical and diagnostic

or other lift), where such removal is readily achievable”). In the regulations, “readily achievable” is defined as “easily accomplishable and able to be carried out without much difficulty or expense.” *Id.* § 12181(9). Factors to be considered include (1) the nature and cost of the action to be taken; (2) the financial resources of the place of public accommodation, and the effect of the action on its expenses and resources; and (3) the type of operations of the place of public accommodation, and the impact of the action on its operations. *Id.*; *see also* 28 C.F.R. § 35.151(b)(1) (2010) (requiring that “[e]ach facility or part of a facility altered by, on behalf of, or for the use of a public entity in a manner that affects or could affect the usability of the facility or part of the facility shall, to the maximum extent feasible, be altered in such [a] manner that the altered portion of the facility is readily accessible to and usable by individuals with disabilities, if the alteration was commenced after January 26, 1992”).

⁹⁸ In 1991, the Department proposed a regulation under Title III requiring that all newly purchased furniture or equipment be accessible to the extent such equipment is available. 28 C.F.R. pt. 36 app. B at 735–36 (Proposed Section 36.309: Purchase of Furniture and Equipment). The Department omitted that section from the final rule, asserting that such requirements “are more properly addressed under other sections” (though such sections were left unspecified), because “there are currently no appropriate accessibility standards addressing many types of furniture and equipment.” *Id.* In 2008, the Department again explicitly declined to include regulatory guidance with respect to the acquisition and use of free-standing equipment or furnishings used by covered entities to provide services under Title II and Title III, which would include medical equipment. Nondiscrimination on the Basis of Disability in State and Local Government Services, 73 Fed. Reg. 34,466, 34,474–75 (June 17, 2008) (to be codified at 28 C.F.R. pt. 35); *see also* Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 73 Fed. Reg. 34,508, 34,516–17 (June 17, 2008) (to be codified at 28 C.F.R. pt. 36). The Department did state its intent to analyze the economic impact of future regulations governing specific types of free-standing equipment, which would include medical and diagnostic equipment. Nondiscrimination on the Basis of Disability in State and Local Government Services, 73 Fed. Reg. at 34,474–75; *see also* Nondiscrimination on the Basis of Disability by Public Accommodations and in Commercial Facilities, 73 Fed. Reg. at 34,516–17.

⁹⁹ S. 3717, 109th Cong. (2006). The Promoting Wellness Act was also introduced in the House and its purpose was to amend the Rehabilitation Act of 1973 and the Public Health Service Act. H.R. 3294, 110th Cong. (2007).

¹⁰⁰ H.R. 3294.

equipment within nine months.¹⁰¹ It also set interim standards to be used immediately for all purchases of such equipment, including: examination tables that are “height-adjustable between a range of at least 18 inches to 37 inches”;¹⁰² weight scales “capable of weighing individuals who remain seated in a wheelchair or other personal mobility aid”;¹⁰³ and “mammography machines and equipment . . . capable of being used by individuals in a standing, seated, or recumbent position, including individuals seated in a wheelchair.”¹⁰⁴

The Promoting Wellness Act also sought to provide grants to public and non-profit entities for programs to promote good health, disease prevention, and wellness for individuals with disabilities, and to prevent secondary conditions.¹⁰⁵ It sought to revise applicable grant and Medicare funding requirements to oblige institutions to include training to improve competency and clinical skills in providing health care to, and communicating with, patients with disabilities.¹⁰⁶

The Promoting Wellness Act did not make it out of committee in 2006 or 2007.¹⁰⁷ It was introduced again in 2009, but was not enacted.¹⁰⁸

IV. NEW APPROACH: HEALTH CARE REFORM

Although there have been attempts to address the problem of inaccessible medical equipment through existing civil rights law such as the ADA, as well as other doctrinal reforms, significant barriers to the health and health care of people with disabilities remain.¹⁰⁹ The Patient Protection and Affordable Care Act, as amended (PPACA), signed into law on March 23, 2010, offers a new approach to these pervasive barriers.¹¹⁰ The provisions of the PPACA focus on expanding coverage, controlling costs, and improving the quality of the health care delivery system.¹¹¹ The PPACA also includes several provisions aimed at improving access to health care for people with disabilities. In particular, the PPACA provides for a standard-setting process for accessible medical equipment, improved data collection on the health and health care of people with disabilities, and opportunities for disability education and training for medical professionals.

¹⁰¹ *Id.* § 2.

¹⁰² *Id.* § 2(c)(1).

¹⁰³ *Id.* § 2(c)(2).

¹⁰⁴ *Id.* § 2(c)(3).

¹⁰⁵ *Id.* § 3.

¹⁰⁶ *Id.* § 4.

¹⁰⁷ The Library of Congress, THOMAS, <http://www.thomas.gov> (search for “S. 3717, 109th Cong.” and for “H.R. 3294, 110th Cong.” in advanced search) (last visited Nov. 20, 2010).

¹⁰⁸ H.R. 1938, 111th Cong. (2009).

¹⁰⁹ See discussion *supra* Part II.

¹¹⁰ Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified as amended in scattered sections of 42 U.S.C.).

¹¹¹ *Id.*; HENRY J. KAISER FAMILY FOUND., *supra* note 8, at 1–2, 8–10.

A. Developing Standards for Accessible Medical Equipment

With respect to medical equipment, the PPACA amends the Rehabilitation Act to include a requirement that the Access Board (an independent federal agency), in consultation with the Food and Drug Administration Commissioner, promulgate regulations establishing “minimum technical criteria for medical diagnostic equipment used in (or in conjunction with) physician’s offices, clinics, emergency rooms, hospitals, and other medical settings.”¹¹² The criteria must ensure “independent entry to, use of, and exit from the equipment” by people with disabilities.¹¹³ Medical equipment includes examination tables, examination chairs (including dental and eye examination chairs), weight scales, and mammography and other imaging equipment.¹¹⁴

The Access Board is an independent federal agency created in 1973 to ensure accessibility for individuals with disabilities.¹¹⁵ It is comprised of members from various federal agencies and departments and from the public—a majority of whom must have a disability.¹¹⁶ It has several responsibilities including developing, updating, and providing training on accessibility requirements for the built environment, transportation vehicles, electronic and information technology, telecommunications equipment, and most recently, medical and diagnostic equipment.¹¹⁷

The Access Board allows for considerable collaboration in its rule-making process, and encourages comments from private interest groups, designers, related industry, and the community at large in the formation of proposed guidelines.¹¹⁸ By bringing together stakeholders with relevant experience and knowledge, the Access Board process provides an opportunity to develop an informed and comprehensive set of guidelines. This approach is more efficient than individual actions litigated institution by institution, or office by office, whether public or private. The detailed standards for buildings and facilities subject to Title II and Title III contained in the ADAAG¹¹⁹ and the specific standards for public rights-of-way such as sidewalks, street crossings, and curbs, contained in the draft Public

¹¹² PPACA, sec. 4203, §510(a); OFFICE OF THE LEGISLATIVE COUNSEL, COMPILATION OF PATIENT PROTECTION AND AFFORDABLE CARE ACT 496 (2010), *available at* <http://docs.house.gov/energycommerce/ppacacon.pdf>.

¹¹³ PPACA, sec. 4203, §510(a) (to be codified at 42 U.S.C. § 794f).

¹¹⁴ *Id.* sec. 4203, § 510(b) (to be codified at 42 U.S.C. § 794f).

¹¹⁵ *About the U.S. Access Board*, U.S. ACCESS BOARD, <http://www.access-board.gov/about.htm> (last visited Nov. 1, 2010).

¹¹⁶ *Id.*

¹¹⁷ *Board Rulemaking*, U.S. ACCESS BOARD, <http://www.access-board.gov/about/rulemaking.htm> (last visited Nov. 1, 2010).

¹¹⁸ *Id.*

¹¹⁹ For the full text of the 2004 ADAAG, see Americans with Disabilities Act (ADA): Accessibility Guidelines for Buildings and Facilities, 36 C.F.R. pt. 1191 app. A (2004), *available at* <http://www.access-board.gov/adaag/ADAAG.pdf>.

Rights-of-Way Accessibility Guidelines (PROWAG)¹²⁰ are examples of the process.

A similar process has begun for medical equipment, as the Access Board conducted a public information meeting on the new medical equipment accessibility standards on July 29, 2010.¹²¹ This first meeting was designed to provide information to and seek input from interested parties, including experts and researchers in accessible medical diagnostic equipment, industry representatives, advocacy and civil rights specialists, liaisons from various federal agencies, and members of the public.¹²²

Going forward, the Access Board will likely review the various emerging standards for accessible medical equipment, including the interim standards from the proposed Promoting Wellness Act,¹²³ standards suggested by the Disability Rights Education and Defense Fund (DREDF) in connection with the Department of Justice's rule-making activity in 2008,¹²⁴ and the Department of Justice's 2010

¹²⁰ Americans with Disabilities Act (ADA) Guidelines for Buildings and Facilities; Architectural Barriers Act (ABA) Accessibility Guidelines; Public Rights-of-Way, 70 Fed. Reg. 70,734, 70,734 (Nov. 23, 2005) (to be codified at 36 C.F.R. pts. 1190–91) [hereinafter PROWAG], available at <http://www.access-board.gov/prowac/noa.pdf>. Once adopted by the Department of Justice, the PROWAG will become the new minimum design standards under the ADA for both new construction and alterations of public rights-of-way. See 42 U.S.C. § 12204(a) (2006) (requiring the Architectural and Transportation Barriers Compliance Board to issue supplementary minimum guidelines). In the meantime, the Department of Transportation has recognized the PROWAG as “the current best practice in accessible pedestrian design under the Federal Highway Administration’s Federal-aid (504) regulation.” PUB. RIGHTS-OF-WAY ACCESS ADVISORY COMM., SPECIAL REPORT: ACCESSIBLE PUBLIC RIGHT-OF-WAY: PLANNING AND DESIGNING FOR ALTERATIONS 3 (2007) [hereinafter PROWAAC], available at <http://www.access-board.gov/prowac/alterations/guide.pdf>.

¹²¹ *Board Holds Forum on Medical Diagnostic Equipment*, U.S. ACCESS BOARD (July 31, 2010), <http://www.access-board.gov/news/mde-meeting.htm>.

¹²² The meeting opened with an overview of the rulemaking process, the legislative background, and a proposed timetable, and proceeded into presentations by experts and researchers in accessible medical diagnostic equipment, industry representatives, advocacy and civil rights specialists, and liaisons from Federal Agencies. *Id.*

¹²³ See *supra* text accompanying notes 102–104.

¹²⁴ DREDF recommended that the Department adopt minimum standards for “high-priority” medical equipment, including:

Examination tables (height adjustable, with a minimum height of 15” from the floor, extra-wide top[s] and higher weight capacities, adjustable hand rails, and adjustable foot/leg supports), weight scales with accessible features, diagnostic and imaging equipment (including mammogram machines) with accessible features, [and] medical chairs (including dental chairs) with accessible features

guidance on access to medical care for individuals with mobility disabilities.¹²⁵ Hopefully, the Board will also develop more information on the comparative cost of different types of accessible medical equipment with various features, which to date has been difficult to find.¹²⁶

B. Collecting Needed Data

Disability activists and policy makers have called for the study of people with disabilities as a health disparities population.¹²⁷ As suggested by Sidney Watson:

[D]isparity issues are complex and may be deeply embedded in providers' actions and patients' decisions, as well as in institutional policies and practices. Given this genesis, many disparities are unlikely to be suitable to the approach required by civil rights laws. The adoption of systems reform, which moves disparity-reduction efforts from the civil rights arena into the world of health care quality regulation, may ease this limitation.¹²⁸

Although her comments were in the context of addressing racial disparities in health care, they apply to disability-based disparities as well.

“Health disparity” is a fluid term meaning many things to different agencies. The Minority Health and Health Disparities Research and Education Act of 2000, for example, defines a health disparity population as one in which there is a significant disparity in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates as compared to the general population.¹²⁹ Initially, both

See Summary of Proposed Regulation on Medical Care Facilities, DISABILITY RIGHTS EDUC. & DEF. FUND, http://www.dredf.org/DOJ_NPRM/medical_facilities.shtml (last visited Nov. 1, 2010).

¹²⁵ ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES, *supra* note 93, at 9 (2010) (“[A]n accessible exam table or chair should have at least the following: ability to lower to the height of the wheelchair seat, 17–19 inches, or lower, from the floor; and elements to stabilize and support a person during transfer and while on the table, such as rails, straps, stabilization cushions, wedges, or rolled up towels.”).

¹²⁶ Pendo, *supra* note 4, at 53–54 (indicating the current lack of data and need for future studies to identify the impact that accessible medical equipment has on the medical care of persons with disabilities).

¹²⁷ THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 127–28; Letter from Mary Lou Breslin et al., Senior Policy Advisor, Disability Rights Educ. and Def., to HRSA Regulations Officer, Health Res. and Servs. Admin. (June 9, 2010), *available at* <http://www.dredf.org/healthcare/FINAL-DREDF-HRSA-letter-6-09-10.pdf>.

¹²⁸ Sidney D. Watson, *Equity Measures and Systems Reform as Tools for Reducing Racial and Ethnic Disparities in Health Care*, COMMONWEALTH FUND, Aug. 2005 (pub. no. 776), at 3.

¹²⁹ 42 U.S.C. § 287c-31(d)(1) (2006). The Office on Minority Health, for example, defines health disparities as significant differences between one population and another. *What are Health Disparities?*, THE OFFICE OF MINORITY HEALTH,

the definition of health disparity population and the focus of government dollars were on ethnic minority populations.¹³⁰ Over time, there have been calls for the study of additional populations, including residents of rural areas, women, children, the elderly, and persons with disabilities.¹³¹ Still, persons with disabilities were not included in major federal health disparities research.¹³²

This appears to have changed with the passage of the PPACA.¹³³ One of the goals of the Act is to reduce health disparities across populations.¹³⁴ The PPACA provides for additional research monies aimed at increasing the “development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health proficiency, reducing health disparities, and aptitude for working with individuals with disabilities.”¹³⁵ In terms of access, the PPACA requires that all reporting from the secretary of the Department of Health and Human Services on federally conducted or supported health care or public health programs include separate “data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants.”¹³⁶ Although the section does not specifically provide that individuals with disabilities will be recognized as a health disparity population, this provision does include “disability status” among the previously recognized disparity populations and affords the same research benefits to this population.¹³⁷

As discussed above, a lack of reliable, population-based data on the health status and experiences of people with disabilities is part of the problem for people

<http://minorityhealth.hhs.gov/templates/content.aspx?ID=3559> (last modified Nov. 2005). The NIH Working Group defines health disparities as “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.” Press Release, Nat’l Inst. of Health, NIH Announces Institute on Minority Health and Health Disparities (Sept. 27, 2010), available at <http://www.nih.gov/news/health/sep2010/nimhd-27.htm>.

¹³⁰ See 42 U.S.C. § 287c-31 (“The term ‘minority group’ has the meaning given the term ‘racial and ethnic minority group’ . . .”).

¹³¹ U.S. DEP’T OF HEALTH AND HUMAN SERVS., HEALTHY PEOPLE 2010: UNDERSTANDING AND IMPROVING HEALTH AND OBJECTIVES FOR IMPROVING HEALTH 11–16 (2000).

¹³² See generally THE CURRENT STATE OF HEALTH CARE, *supra* note 1, at 12–13, 127–28; Margaret A. Nosek & Darrell K. Simmons, *People with Disabilities as a Health Disparities Population: The Case of Sexual and Reproductive Health Disparities*, 5 CAL. J. HEALTH PROMOTION 68, 68–81 (2007).

¹³³ Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, sec. 4302, § 3101, 124 Stat. 119, 578 (2010) (to be codified at 42 U.S.C. § 300kk).

¹³⁴ *Id.* sec. 3011, § 399HH (to be codified at 42 U.S.C. § 280j).

¹³⁵ *Id.* sec. 5307(a) (to be codified at 42 U.S.C. § 293(e)).

¹³⁶ *Id.* sec. 4302, § 3101 (to be codified at 42 U.S.C. § 300kk) (providing in the section entitled “Understanding Health Disparities: Data Collection and Analysis” that the Public Health Service Act be amended to include “Title XXXI: Data, Collection, Analysis and Quality”).

¹³⁷ *Id.*

with disabilities in the health care system.¹³⁸ For example, although the available studies and legal actions are suggestive, we do not know where people with disabilities are accessing health care, and whether, where, and how much accessible medical equipment is available at those offices and facilities.

In terms of accessible medical equipment, the PPACA requires that the secretary of the Department of Health and Human Services identifies locations where individuals with disabilities access “primary, acute (including intensive), and long-term care,” determine “the number of providers with accessible facilities and equipment,” and the number of employees “trained in disability awareness and patient care of individuals with disabilities.”¹³⁹ Notably, several of the settlements discussed above called for similar surveys or evaluations of accessibility, including the availability of accessible medical equipment.¹⁴⁰

C. Provider Education and Training

The continuing problem of inaccessible medical equipment suggests deeper issues, including stereotypes, assumptions, and a lack of training and education in disability-related issues in the health care context.¹⁴¹ Education and training are critical because studies have consistently demonstrated that the attitudes of physicians and other health care professionals toward people with disabilities are as negative, if not more negative, than the general public.¹⁴² As one study found, “health professionals significantly underestimate the quality of life of persons with disabilities compared with the actual assessments made by people with disabilities themselves. In fact, the gap between health professionals and people with disabilities in evaluating life with disability is consistent and stunning.”¹⁴³ Other studies have found similar results for students in the health care professions.¹⁴⁴

¹³⁸ See *supra* Part II.

¹³⁹ PPACA, sec. 4302, § 3101(a)(2)(D)(i)–(iii) (to be codified at 42 U.S.C. § 300kk).

¹⁴⁰ Metzler v. Kaiser Settlement, *supra* note 74; USCF Medical Center Settlement Agreement, *supra* note 77.

¹⁴¹ Pendo, *supra* note 4, at 42–47. Classic works on stigma and disability in the health care context include Adrienne Asch, *Distracted by Disability*, 7 CAMBRIDGE Q. HEALTHCARE ETHICS 77 (1998); Paul K. Longmore, *Medical Decision Making and People with Disabilities: A Clash of Cultures*, 23 J.L. MED. & ETHICS 82 (1995).

¹⁴² Carol J. Gill, *Health Professionals, Disability, and Assisted Suicide: An Examination of Relevant Empirical Evidence and Reply to Batavia* (2000), 6 PSYCHOL. PUB. POL’Y & L. 526, 530 (2000).

¹⁴³ *Id.*

¹⁴⁴ See, e.g., Raymond C. Tervo et al., *Health Professional Student Attitudes Towards People with Disability*, 18 CLINICAL REHABILITATION 908, 913–14 (2004) (finding that nursing, medicine, and allied health students held less positive attitudes than the norm, as measured on the Scale of Attitudes Toward Disabled Persons (SADP)); Raymond C. Tervo et al., *Medical Students’ Attitudes Toward Persons with Disability: A Comparative Study*, 83 ARCHIVES PHYSICAL MED. REHABILITATION 1537, 1539 (2002) (finding that first-year medical students held less positive attitudes than SADP norms).

Physicians report discomfort, reluctance, and limited experience in caring for patients with disabilities, and attribute these reactions to limited training.¹⁴⁵ Not surprisingly, patients with disabilities also report concerns regarding both physician attitudes and physician competence about disability issues.¹⁴⁶ A growing number of policy experts have found that health care providers, including primary care providers, lack basic training in disability issues.¹⁴⁷ Indeed, the Institute of Medicine suggests the lack of provider education and disability awareness is one of the most significant barriers to care, and states that providing more education to providers is critical to counter disability stereotypes and misconceptions.¹⁴⁸

There have been efforts to increase education and training for health care providers. Physicians and others involved with medical education have called for increased education and training on disability issues.¹⁴⁹ Others have recognized familiarity with disability issues as a key element of cultural competence for providers,¹⁵⁰ and as a cornerstone of patient-centered care.¹⁵¹ As noted above, in terms of accessible medical equipment, the PPACA calls for identification of locations where people with disabilities are seeking care as well as the physical, equipment, and attitudinal barriers they may face there, which could also inform the development of training and education programs for providers. The PPACA

¹⁴⁵ Duggan, *supra* note 17, at 799 (citing M. Aulagnier et al., *General Practitioners' Attitudes Towards Patients with Disabilities: The Need for Training and Support*, 27 *DISABILITY & REHABILITATION* 1343–52 (2005)); Sweetey Jain, *Care of Patients with Disabilities: An Important and Often Ignored Aspect of Family Medicine Teaching*, 38 *FAM. MED.* 13, 13 (2006) (describing proper etiquette and the connection to patient-centered care). Jain further explains, “[f]amily medicine residents and medical students are often uncomfortable when treating patients with disabilities. One reason for this discomfort is the lack of training they receive about this important aspect of medicine.”

¹⁴⁶ Pendo, *supra* note 4, at 43.

¹⁴⁷ See *INST. OF MED., THE FUTURE OF DISABILITY IN AMERICA* 153 (2007); *THE CURRENT STATE OF HEALTH CARE*, *supra* note 1, at 304–05; U.S. DEPT. OF HEALTH AND HUMAN SERVS., *THE SURGEON GENERAL'S CALL TO ACTION TO IMPROVE THE HEALTH AND WELLNESS OF PERSONS WITH DISABILITIES* 22–24 (2005).

¹⁴⁸ *INST. OF MEDICINE*, *supra* note 147, at 156–58.

¹⁴⁹ Paula M. Minihan et al., *Teaching about Disability: Involving Patients with Disabilities as Medical Educators*, 24 *DISABILITY STUD. Q.* 2–3 (2004) (collecting literature).

¹⁵⁰ See, e.g., Gary E. Eddey & Kenneth L. Robey, *Consider the Culture of Disability in Cultural Competence Education*, 80 *ACAD. MED.* 706, 706 (2005).

¹⁵¹ Duggan, *supra* note 17, at 799. There is also a growing body of information about communicating with patients with disabilities in the disability and medical literature. See generally Lisa I. Iezzoni et al., *Communicating about Health Care: Observations from Persons Who Are Deaf or Hard of Hearing*, 140 *ANNALS INTERNAL MED.* 356 (2004); Lisa I. Iezzoni et al., *Teaching Medical Students about Communicating with Patients with Major Mental Illness*, 21 *J. GEN. INTERNAL MED.* 1112 (2006); Lisa I. Iezzoni et al., *Teaching Medical Students about Communicating with Patients Who Have Sensory or Physical Disabilities*, *DISABILITY STUD. Q.* (Winter 2005), <http://www.dsq-sds.org/article/view/527/704> (online journal Vol. 25, no. 1).

also provides support for grants and incentives to institutions for additional training in caring for “vulnerable populations” and in cultural competency, which could include people with disabilities.¹⁵²

V. A CHALLENGE AND SOME RECOMMENDATIONS

The reframing of barriers and disparities faced by people with disabilities as an issue of health care access and quality under the PPACA—in addition to an issue of civil rights under the ADA—appears promising. The provisions identified above are necessary and significant on their own, and can be mutually informing and reinforcing if taken together. In this vein, this part highlights a challenge in the development and implementation of medical equipment standards that has yet to be addressed, and offers a few recommendations to guide the process.

As noted above, the first question will likely be what standards should be required for each individual type of medical equipment.¹⁵³ The more difficult question will be how much of the medical equipment meeting the new specifications will be required, and when. In other words, in terms of medical equipment in offices and institutions—how much is enough?

There is no generally accepted answer to that question. The Promoting Wellness Act, for example, called for a phased-in approach—all new equipment purchased was to meet the interim or final standards for accessibility, perhaps until all medical equipment met the standards.¹⁵⁴ However, the Department of Justice’s July 2010 guidance suggests that the answer is something less than “all,” but does not provide numbers or percentages, stating only that “the number of accessible exam tables needed by the medical care provider depends on [several factors],” as illustrated by the following:

Q: In a doctor’s office or clinic with multiple exam rooms, must every examination room have an accessible exam table and sufficient clear floor space next to the exam table?

Probably not. The medical care provider must be able to provide its services in an accessible manner to individuals with disabilities. In order to do so, accessible equipment is usually necessary. However, the number of accessible exam tables needed by the medical care provider depends on the size of the practice, the patient population, and other

¹⁵² See generally Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, sec. 5307, 124 Stat. 119, 628–29 (2010).

¹⁵³ See *supra* Part II.

¹⁵⁴ Promoting Wellness for Individuals with Disabilities Act of 2009, H.R. 1938, 111th Cong. § 2 (2009). However, Section 1 implies that all medical equipment would be subject to the standards issued by the Access Board not just those newly purchased. *Id.* § 1.

factors. One accessible exam table may be sufficient in a small doctor's practice, while more will be likely necessary in a large clinic.¹⁵⁵

The Department of Justice's guidance is in line with judicial interpretation of the ADA's accessibility requirement for public programs under Title II, which has generally not required that each facility or office must be accessible. In *Alexander v. Choate*, the Supreme Court held that the nondiscrimination mandate of Section 504 of the Rehabilitation Act is met when people with disabilities are provided "meaningful access" to such programs.¹⁵⁶ Although "meaningful access" has been interpreted in different ways,¹⁵⁷ it has not meant that every facility or office must be accessible and usable by individuals with disabilities, but rather that each service, program, or activity, when viewed in its entirety, is readily accessible to and usable by individuals with disabilities.¹⁵⁸ Unfortunately, no more specific standards have emerged through statute, regulation, or published case law.

I would like to suggest a few places the Access Board could turn to for further guidance. The recent private and public settlement agreements discussed above provide support for setting both minimum requirements and percentage goals for accessible medical equipment.¹⁵⁹ For example, the 2009 Beth Israel settlement provided that at least 10% of examination and treatment equipment (including examination tables and chairs, lifts, radiologic equipment, and scales) purchased or leased after the settlement date, but no fewer than one of each type in each clinical service, will be accessible to and usable by individuals with disabilities.¹⁶⁰ This appears consistent with the approaches reached in previous settlements over time,¹⁶¹ as well as analogous to the percentages used to define architectural accessibility of general patient rooms in settlements and in the ADAAG.¹⁶²

¹⁵⁵ ACCESS TO MEDICAL CARE FOR INDIVIDUALS WITH MOBILITY DISABILITIES, *supra* note 93, at 3.

¹⁵⁶ *Alexander v. Choate*, 469 U.S. 287, 301, 304 (1985).

¹⁵⁷ For a discussion of "meaningful access" in the context of health care, see generally Leslie Pickering Francis & Anita Silvers, *Debilitating Alexander v. Choate: "Meaningful Access" to Health Care for People with Disabilities*, 35 FORDHAM URB. L.J. 447 (2008).

¹⁵⁸ See *Anderson v. Dep't of Pub. Welfare*, 1 F. Supp. 2d 456, 464 (E.D. Pa. 1998).

¹⁵⁹ See *supra* text accompanying notes 74–93.

¹⁶⁰ *Beth Israel Deaconess Settlement*, *supra* note 90, ¶ 29. Similarly, Beth Israel agreed to ensure that at least 10% of its patient rooms are accessible, and that accessible rooms "are dispersed throughout [its] facilities and clinical services to the greatest extent possible." *Id.* ¶ 26.

¹⁶¹ For example, WHC agreed to purchase at least one accessible exam table in each department, and that all future purchases of examination tables would meet agreed-upon standards for accessibility. Washington Hospital Center Settlement, *supra* note 75, §§ IV.B.1–B.2 ("WHC hereby agrees to purchase and place one accessible examination table or examination chair . . . as appropriate to the Department, in each Department that utilizes examination tables or chairs and which does not already have such an examination table or chair. . . . All height-adjustable equipment that patients must transfer to for examination or treatment purposes (excluding operating tables and hospital beds) that

I would also suggest that the Access Board look to the data collection provisions of the PPACA to inform the standard setting process throughout the two-year development period.¹⁶³ In an earlier writing, I suggested that in the context of a Medicaid program, meaningful access should be defined in relation to the health care demographics of the state or region, specifically the number or percentage of women with disabilities enrolled in that state or region, as well as the extent to which inaccessible medical equipment presents a barrier to women's health care for the class.¹⁶⁴ I also suggested some starting points for gathering national and state-specific data on the number of women with disabilities affected, as well as the use of surveys or other tools to discover the percentage of participating institutions and offices with accessible equipment.¹⁶⁵ Pursuant to the PPACA's data collection provisions, similar types of demographic data for people with disabilities and people with impairments or mobility limitations that may also be affected, generally, would be helpful in determining how much equipment is available, and how much is needed. As a starting point, it would be helpful to discover the number, percentage, and location of offices and institutions with various types of accessible equipment. Geographic distribution information would also be useful because, as suggested by the ADAAG, medical facilities could consider other means of providing access, including providing equivalent services at an accessible site in the medical center, delivering services to persons with disabilities in their own homes, or transporting people with disabilities from their homes to an accessible facility where they can receive equivalent services.¹⁶⁶ Making this information available in a searchable database could be helpful for people seeking care, as well as for providers who need to make appropriate referrals for testing or treatment.

It would also be helpful to know what types of services people with disabilities are attempting to access at those offices and facilities, the extent to

WHC purchases after the Effective Date of this Agreement shall be accessible . . . to individuals with disabilities.”).

¹⁶² For example, the ADAAG requires that all public and common use areas of a medical facility be accessible, and sets the following standards for patient rooms: “In general purpose hospitals, and in psychiatric and detoxification facilities, 10 percent of patient bedrooms and toilets must be accessible. The required percentage is 100 percent for special facilities treating conditions that affect mobility, and 50 percent for long-term facilities and nursing homes.” *Americans with Disabilities Act ADA Title III Technical Assistance Manual Covering Public Accommodations and Commercial Facilities*, U.S. DEP'T OF JUSTICE AMERICANS WITH DISABILITIES ACT, § III-7.8300, <http://www.ada.gov/taman3.html> (last visited Nov. 3, 2009) [hereinafter *Dep't of Justice Technical Assistance Manual*].

¹⁶³ The PPACA requires promulgation of standards within two-years of enactment, rather than within the nine-months envisions by the Promoting Wellness Act. In addition, the PPACA does not require any interim standards. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, sec. 4203(a), 124 Stat. 119, 570 (2010).

¹⁶⁴ Pendo, *supra* note 4, at 53–54.

¹⁶⁵ *Id.*

¹⁶⁶ *Dep't of Justice Technical Assistance Manual*, *supra* note 162, § III-4.5100.

which inaccessible equipment is a barrier, and any denial or delay of care or other negative outcome that resulted. Identifying other populations that would be served by the acquisition of accessible equipment, such as the elderly, people who are obese, or the temporarily injured, could also inform the standard-setting process.

To be clear, action can and should be taken now to ensure access to health care for people with disabilities, including the development and implementation of standards for accessible medical equipment. As the analysis above suggests, the type and quantity of accessible equipment needed in various locations and types of practices is likely to be a moving target, as it should be responsive to significant shifts in the health care demographics. Therefore, as a matter of policy, collection and monitoring of information in any or all of the categories described above—by federal agencies, insurers offering qualified health insurance plans, provider networks, or all of these—would be helpful in ensuring equal access to care on an ongoing basis.

VI. CONCLUSION

Although civil rights law requires that health care institutions, offices, and programs be accessible, the available evidence shows that people with disabilities are receiving unequal, and in many cases inadequate, care. For example, twenty years after passage of the ADA, many people with mobility impairments cannot get on examination tables and chairs, cannot be weighed, and cannot use X-ray and other imaging equipment. Despite attempts to address this problem through ADA enforcement and doctrinal reforms, significant barriers remain.

Although the right to nondiscriminatory access to health care can and should be protected, health care reform offers a new and complementary approach. Specifically, the PPACA includes several provisions aimed at improving access to health care for people with disabilities, including a survey of and standard-setting process for accessible medical equipment, as well as improved data collection based on disability, and disability education and training opportunities for health care providers. Addressing the health and health care of people with disabilities as part of the larger national project of health care reform suggests a systems reform approach that could benefit people with disabilities. It could also provide an opportunity to think about the problem more broadly and to connect any solution to a deeper and more informed understanding of disability rights and health care reform, generally.