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L O Gostin
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The Americans with Disabilities Act (ADA) of 1990 provides a strong weapon in the fight against discrimination by prohibiting the adverse treatment of qualified persons with disabilities. While the law begins to take effect during the summer of 1992, health care professionals do not yet recognize how it will affect the health care system.

In this report I examine three areas of impact the ADA will have on the health care system. First, I show how the act affects the clinical freedom of health care professionals to choose whom they will treat. While the ADA prohibits health care professionals from discriminating against patients with disabilities, it does not guarantee that patients have access to the health care system. Second, I explain how the ADA significantly limits the ability of employers to require medical testing and medical examination. The ADA prevents employers from using medical tests as a basis for invidious discrimination against persons with disabilities, although it does not guarantee that patients have access to the health care system. Third, I explain how the ADA provides an effective review of communicable disease powers. I propose clear criteria for use by public health officials in the exercise of their compulsory powers such as vaccination, screening, and contact tracing.

Phased implementation of the ADA began 1 January 1992. The ADA prohibits discrimination against qualified persons with disabilities in employment, public services, public accommodations, and telecommunications. It does not replace the large body of disability law that already exists, including the federal Rehabilitation Act, Fair Housing Amendments, and Individuals with Disabilities Education Act, as well as state disability statutes. The main change in federal law is that the ADA applies to all covered entities whether or not they receive federal funding. The act states that nothing in the act can be construed so as to apply a lesser standard than is already required under existing law (sec. 501). This means that the case law precedents under existing disability law demarcate the minimum standards required by the ADA.

Although the specific titles to the ADA have slightly different provisions, a finding of discrimination requires adverse treatment of a person with a “disability” who is “qualified,” or who would be qualified if “reasonable accommodations” or modifications were made.

Defining A Disability

Disability is defined broadly to mean “a physical or mental impairment that substantially limits one or more of the major life activities,” a record of such impairment, or being regarded as having such impairment (sec. 3). The definition of disability covers a wide range of medical conditions. Congress and the courts have recognized disabilities of both genetic origin (for example, Down’s syndrome, muscular dystrophy, or cystic fibrosis) and multifactorial origin (for example, heart disease, schizophrenia, or arthritis). Disability includes diseases that are
communicable (such as tuberculosis, hepatitis, or syphilis) and those that are not (such as cerebral palsy or diabetes).\(^4\)

The ADA covers most patients who are not seen as “deserving” by some segments of society, such as persons with the human immunodeficiency virus (HIV), alcoholism, and epilepsy.\(^5\) However, a person who is currently using illegal drugs is not considered disabled but is covered once successfully rehabilitated (sec. 511). Similarly, a range of socially disapproved behavior disorders are excluded from protection, such as most gender identity disorders, pedophilia, exhibitionism, voyeurism, compulsive gambling, kleptomania, pyromania, and psychoactive substance use disorders resulting from illegal drug use (sec. 511).

A person is disabled if he or she has a “record” of or is “regarded” as being disabled, even if there is no actual disability.\(^6\) A “record” indicates that a person has a history of having a disability or has been misclassified as such. This provision protects persons who have recovered from disability or disease, such as cancer survivors.

The term “regarded” includes individuals who do not have disabilities but are treated as if they did. This concept protects people who are discriminated against in the false belief that they are disabled. It would be inequitable for a defendant who intended to discriminate on the basis of disability to successfully raise the defense that the person was not, in fact, disabled. This provision is particularly important for individuals who are perceived to have stigmatized or disfiguring conditions, such as persons with HIV, leprosy, or severe burns.\(^7\)

The fact that a perception of disability is included in the ADA is vitally important in determining whether a pure carrier of disease should be regarded as disabled. Congress expressly signaled its intention to include asymptomatic infection such as HIV, and this has been affirmed by the courts.\(^8\) By similar reasoning, heterozygotes of sickle cell, Tay-Sachs, or cystic fibrosis should be covered by the term “regarded” or perceived to be disabled. Carriers of recessive genetic traits will not develop symptoms but are protected against discrimination that is motivated by the fundamental misconception that they are or will become disabled.

Can a person who is currently healthy but is predicted to become ill be classified as disabled? Law, ethics, and public policy suggest that such a person should receive the same protection as the currently disabled, although the ADA is silent on this point.\(^9\) Those who discriminate because of subjective and uncertain predictions of future impairment foster harmful stereotypes because the person is currently healthy and capable of meeting all job, benefit, or service criteria. The New York Court of Appeals held that obesity is a disability even though the person is not currently impaired: A person cannot be discriminated against “simply because the condition has been detected before it has actually begun to produce deleterious effects.”\(^10\) Another court observed that it would be “ironic and insidious” if current disabilities were protected but the same protection were denied to those who are predisposed to future disability.\(^11\)

The issue of future disability becomes more important as the Human Genome Initiative enhances the ability of physicians to predict diseases such as a genetic propensity for Huntington’s disease. The following proposed amendment to the definition of disability in the ADA would ensure that discrimination against a currently qualified person based upon a future prediction of disease would be prohibited: Disability includes a “genetic or medically identified potential of, or predisposition toward, a physical or mental impairment that substantially limits a major life activity.”\(^12\)

A person is “qualified” if he or she is capable of meeting the essential performance or eligibility criteria for the particular position, service, or benefit. Thus, a person with a disability is not protected unless he or she is otherwise qualified to hold the job or to receive the service or benefit.

Qualification standards can include a requirement that the person with a disability does “not pose a direct threat to the health or safety of others” (sec. 103[b], 302[b][3]). The “direct threat” standard means that persons can be excluded from jobs, public accommodations, or public services if neces-
sary to prevent a “significant risk” to others. The “significant risk” standard originally applied only to persons with infectious disease. However, it was extended by the House Judiciary Committee to all persons with disabilities. To determine, for example, that a person with mental illness poses a significant risk to others, evidence of dangerous behavior must be presented.

The ADA requires reasonable accommodations or modifications for otherwise qualified individuals unless it would pose an undue hardship (secs. 102[b][5], 302[b][2][A][iii]). This requires adaptation of facilities to make them accessible, modification of equipment to make it usable, and job restructuring to provide more flexible schedules for persons who need medical treatment (sec. 101[9]). To accommodate otherwise qualified persons with infectious conditions, the covered entity might have to reduce or eliminate the risk of transmission. Employers, for example, might be required to provide infection control and training to reduce nosocomial or bloodborne infections. An employer, however, is not forced to endure an undue hardship that would alter the fundamental nature of the business or would be disproportionately costly. The Eighth Circuit Court of Appeals, for example, held that a school for persons with mental retardation was not obliged to vaccinate employees to reasonably accommodate a student who was an active carrier of the hepatitis B virus.

**Providers’ Duty To Treat**

The HIV epidemic has revived the recurring question of whether physicians have a duty to provide care within their realm of competence for any patient in need. The question runs deeper than occupational fears of patients with communicable disease. Physicians’ decisions not to treat may be based upon cost (refusing to take uninsured or Medicaid patients), prejudice (shunning drug users), liability concerns (refusing drug abuse treatment for pregnant women), or subtle judgments about which patients deserve scarce health care resources (rejecting an institutionalized person with schizophrenia for a transplant).

In common law, practitioners had no absolute duty to treat patients, but they could not abandon patients already in their care whose health would be jeopardized. The advent of civil rights legislation meant that services had to be rendered without discrimination based upon race, sex, or disability. The duty to provide nondiscriminatory health care services, however, remained problematic: The Rehabilitation Act applied only to federally funded providers; the term “public accommodations” under the act did not expressly include private medical and dental offices; and the line between legitimate clinical judgment and unlawful discrimination was unclear.

The ADA goes a long way toward resolving these questions and toward ensuring that providers do not unreasonably turn away or refer patients with disabilities. The application of the Rehabilitation Act only to federally funded entities was never an insurmountable obstacle because practitioners who received Medicare or Medicaid dollars were covered. Still, the ADA overcomes any limitation in scope through its express application to covered entities whether or not they receive federal funds.

The private nature of medical and dental offices led some to question whether they could be regulated as public accommodations under the Rehabilitation Act and comparable state disability laws. Several courts, however, had already ruled that medical and dental offices as well as clinics, hospitals, and dispensaries are “public accommodations” and that the medical field is not exempt from the requirement not to discriminate on the basis of disability.

The ADA resolves the dispute by defining public accommodations to include 3 professional office of a health care provider, hospital, or other service establishment (sec. 301[7]). The legislation specifies that “no individual shall be discriminated against in the full and equal enjoyment” of services, privileges, or advantages (sec. 302[a]). This requires medical or dental practitioners to provide equivalent services to all patients consistent with their medical needs and irrespective of their disabilities.
The ADA does not completely clarify the distinction between the genuine exercise of clinical judgment and unlawful discrimination. While the act certainly prohibits a refusal to treat based upon prejudice or irrational fear, some medical practices are far more subtle. Practitioners are defending their decisions to not treat or to refer patients with communicable conditions by arguing that this is an exercise of clinical judgment and does not constitute discrimination, and that to restrict the physician’s right to decide whom to treat or when to refer is to dictate the practice of medicine. To be sure, the ADA’s acceptance of selection criteria that are “necessary for the provision of services” (sec. 302[b][2][A][i]) appears to authorize the exercise of legitimate clinical judgment based upon the practitioner’s areas of skill and specialization. Thus, the ADA does not prohibit a practitioner from providing the most appropriate medical treatment in his or her area of skill and specialization. For example, a physician who specializes in treating burn victims could not refuse to treat the burns of a person because that person has tuberculosis; but the physician could refuse to provide other types of medical treatment outside of his or her area of specialty unless the physician provides that treatment to nondisabled individuals.

Such fine distinctions may be hard to make in practice, particularly when the “disability is directly related to the condition being treated.” In U.S. v. University Hospital, the Second Circuit Court held that denial of surgery to correct myelomeningocele was not discrimination when the surgeon believed that there was an extremely high risk that the child would never interact with her environment. Is denial of orthopedic surgery justified when the surgeon claims that the insertion of a pin in an immunocompromised patient infected with HIV would be inadvisable? Would denial of a kidney transplant to a person with advanced terminal cancer deny equal opportunity? The ADA provides no easy answers.

The physician’s exercise of clinical judgment cannot render all treatment refusals or referrals immune from review if there is evidence that they were motivated by prejudice or irrational fear. Primary practitioners such as general internists or dentists cannot claim that they possess insufficient expertise to treat any person with dangerous communicable infections. The courts increasingly are looking beyond the mantle of clinical judgment and are examining patterns of behavior that may be masking prejudice.

Another reason for refusing to treat patients with dangerous infectious conditions is a concern about occupational hazards. Practitioners may be ethically required to endure reasonable risks where the treatment is necessary to save or prolong a life. But some practitioners take a different view when the treatment is elective, even cosmetic. The question then becomes whether one patient should receive treatment different from that of another, not because of clinical differences but because of a perceived occupational risk. The health care professional might conceivably rely on the “direct threat” standard that is contained in Title III of the ADA (sec. 302[3]) and argue that the patient’s infection poses a significant risk of transmission in cases of seriously invasive or particularly bloody procedures. Courts, however, are unlikely to accept occupational risks as a justification for discrimination: The risk is exceedingly low and can be kept low through the “reasonable accommodation” of strict adherence to infection control procedures. Health care professionals will probably be expected to accept some level of risk in carrying out their jobs in the same way that fire fighters or police officers cannot excuse themselves from particularly dangerous assignments.

The act does not guarantee access to health care but merely requires that refusal to provide equal access cannot be based on a person’s disability. A provider’s health care decisions may be based in part on cost. Providing health services of inferior quality or not providing services at all because of a person’s inability to pay may be unethical, but it is not necessarily unlawful. The ADA does not set out to interfere in the purely
financial decisions of providers. Yet a financial decision that has an unfair and unequal impact on persons with disabilities may be challengeable. Would a decision by a hospital to provide chemotherapy for cancer but not antiviral medication for acquired immunodeficiency syndrome (AIDS) be a valid cost decision or pernicious discrimination? Would a state Medicaid rationing plan that refused to cover liver transplants violate the ADA? The courts would be more likely to invalidated such “cost-based” decisions if the plaintiff could demonstrate some underlying animus or improper motive against a group of persons with disabilities.

The Bush administration announced in August 1992 that it was rejecting Oregon’s Medicaid health care rationing plan on the grounds that it violates the ADA. The Oregon program would increase the number of people eligible for Medicaid but would restrict certain medical services. These categories of restriction—such as highly expensive treatments for incurable cancer, the final stages of AIDS, or premature infants with virtually no chance of survival—would present a disproportionate impact on persons with disabilities that potentially could be invalidated under the ADA. The act might prevent the state from denying care simply because the treatment is expensive or because the person’s life is not worth living.

The ADA, then, tears down barriers to access to health services only in a limited sense. It steadfastly refuses to allow a person to be turned away because of the provider’s fears and biases toward the disability. But it remains uncertain to what extent the act can help to ensure access to health care for those who arguably need it most.

**Employment Issues**

In an age when large employers pay as much, or more, for health care as for the raw materials of production, employers have a marked economic incentive to select out employees who will develop medical illness and disease. Payment for medical expenses has become a burdensome cost for employers, often exceeding one-third of total payroll costs. The drive to stay competitive requires employers to invest heavily in worker selection at a time when the use of medical, biological, and drug tests is booming and when the use of genetic predictive tests is no longer a remote, futuristic possibility. Most large firms require preemployment medical examinations. Although prior regulations under section 504 of the Rehabilitation Act prohibited medical examinations before the offer of a job, most private employers, including federal contractors, were not covered by the regulations. The ADA presents a potentially irreconcilable paradox for employers: Medical benefit costs make it fiscally imperative to consider current and future disease and disability, while Congress requires employers not to discriminate against qualified workers with potentially costly disabilities.

The ADA’s prohibition against discrimination includes medical examinations and inquiries (sec. 102[c]). An employer is not permitted to conduct a medical examination before offering a job or to ask a job applicant whether he or she has a disability, or about the nature or seriousness of the disability. Such inquiries must be limited to assessing the applicant’s ability to perform job-related functions, not the future health costs to the employer. The ADA permits an employer to require medical examinations only after an offer of employment is made, provided that all entering employees are subjected to the same examination and the medical information is kept confidential. The employer cannot withdraw the job offer to a qualified person based upon a disability detected in the examination. Employers are also limited in their right to conduct medical examinations or inquiries of their employees. Medical testing or examination of existing employees is permitted only if job related and consistent with business necessity (sec. 102[c][3]).

Congress, in enacting the ADA, recognized that “an inquiry or medical examination that is not job-related serves no legitimate employer purpose, but simply serves to stigmatize persons with a disability.” The ADA will significantly impede the growing use of medical testing and information gath-
ering by employers across America, thus transforming the way the business community makes employment decisions.

Health Insurance Coverage

Employers caught in the clash between economic competitiveness and antidiscrimination principles will undoubtedly search for ways to limit their health benefit costs, and they are likely to do so by greatly limiting coverage. Congress intended to afford insurers, employers, hospitals, health maintenance organizations (HMOs), and other providers the same opportunities to design and administer insurance and benefit plans in a manner that is consistent with the basic principles of underwriting, classifying, and administering risks they would enjoy in the absence of the ADA (sec. 501[c]). Insurers may sell to and underwrite individuals applying for health coverage; and employers and their agents may establish and observe the terms of employee benefit plans based upon sound actuarial data.

The ADA, therefore, does not restrict insurers, self-insurers, or other benefit plan administrators from structuring a health benefit package and carrying on their normal underwriting activities. This includes using preexisting condition clauses in health benefit contracts, placing caps or other limits on coverage for certain procedures or treatments, excluding coverage for certain conditions or treatments, or charging a higher premium or copayment to persons with higher risks.

The ADA’s major limitation on employers and insurers is to prevent them from using underwriting as a subterfuge for invidious discrimination (sec. 501[c]). Congress intended a liberal construction of the word “subterfuge,” so that any evasion of the principles of antidiscrimination, whether malicious, purposeful, or inadvertent, will be unlawful. Thus, employers cannot deny a qualified applicant a job either because the employer’s insurance plan does not cover a disability or because of the increased cost. The sharp distinction drawn by the ADA is that any discrimination in health coverage for disabled job applicants must be justified on the basis of actuarial data demonstrating a heightened risk of future illness.

Critically important issues emerge to be decided by the courts. A plan administrator may lawfully tailor a benefits package to, say, exclude coverage after five days in the hospital. But could the administrator exclude coverage for treatment of HIV disease, rehabilitative treatment, or wheelchairs? To be sure, the administrator would have to present sound actuarial data, but could disabled employees prove that such actions are a subterfuge for discrimination?

Whether one regards the ADA’s exemption of underwriting as reasonable or not depends upon how the insurance industry and employers offering insurance benefits are viewed. If the industry is regarded strictly as a business, it is difficult to question the ability to discriminate on the basis of sound actuarial data. The sharp distinction drawn by the ADA is that any discrimination in health coverage for disabled job applicants must be justified on the basis of actuarial data demonstrating a heightened risk of future illness.

The ADA may stifle the prevalent practice of employee screening and medical examination and prevent futuristic em-
ployee selection through genetic and biological tests. But the act will do little to solve the deeper underlying problem of who pays health care costs and how.

**Communicable Disease Powers**

Public health departments have long had the power to order vaccination, testing, treatment, contact tracing, and isolation for communicable and sexually transmitted diseases, with few constraints. While these powers are exercised in the name of public health, they deprive individuals of the human rights of autonomy, privacy, and even freedom. Courts have often been deferential to public health departments, provided that their powers were not exercised in an “arbitrary, oppressive or unreasonable” manner. Certainly, modern constitutional law requires a more compelling justification when rights such as liberty are affected. Yet the courts have not developed a cogent standard of review for public health powers.

The ADA promises to provide an effective review of the exercise of public health powers. Any decision to compulsorily test, vaccinate, treat, trace sexual contacts, or isolate will have to comply with the standards provided under the ADA. The ADA may appear to be an unlikely source of law with which to regulate public health. To all appearances, disability law is concerned with “pure discrimination”—the inequitable treatment of persons with disabilities because of bigotry or stereotype, disregarding the person’s qualifications, skills, and experience. Regulation of communicable disease does not fit comfortably into the ADA’s rubric of pure discrimination. Yet Title II of the ADA applies to all public services that are defined to include all actions by state and local governments, including those of public health departments. I believe that the courts may require public health departments to operate under the standard of “significant risk,” that is, the department must demonstrate that the subject poses a significant risk of transmitting disease before it can exercise compulsory powers. Here I propose systematic criteria for the future of communicable disease regulation, founded on the Supreme Court’s decision in *Arline* and subsequent case law, as well as the rich legislative history of the ADA, and subsequent regulations promulgated by the Department of Justice.

First, the determination of significant risk is solely a public health inquiry guided by disciplines such as virology, bacteriology, and epidemiology. The ADA has been thoughtfully crafted to replace reflexive actions based upon irrational fears, speculation, and pernicious mythologies with carefully reasoned judgments based upon well-established scientific information. Second, significant risk must be determined case by case and not under a blanket rule, generalization about a class of disabled people, or assumption about the nature of the disease. This requires a fact-specific, individualized inquiry resulting in a well-formed judgment grounded in a careful and open-minded weighing of risks and alternatives. Third, the risk must be “significant,” not speculative, theoretical, or remote, and not even an “elevated” risk. The ADA sets a “clear, defined standard” that requires actual proof of significant risk to others. In the employment context, the Equal Employment Opportunity Commission specified that “direct threat” means a “significant risk of substantial harm” to the person or to others.

The following factors should be used in determining significant risk. (1) Mode of transmission: A significant risk should be based upon a primary mode of transmission, not a mode that is unestablished or highly inefficient. A bloodborne disease could theoretically be transmitted through a bite, through rough play among children, or by bleeding into food. Yet the “significant risk” test would not be met if personal restrictions were based upon such speculative mechanisms of transmission. Excluding HIV-infected children from school or a food handler from his or her job, for example, would not be allowed under this standard.

(2) Duration of risk: A person can be subjected to compulsory public health powers only for the period of time of contagiousness. The subject must continue to be infectious and conditions or activities exist for
spreading infection. Discrimination against a teacher with noninfectious tuberculosis, for example, would not be tolerated, because the period of danger has passed.48

(3) Probability of risk: The authority of the public health department to impose restrictions grows as the probability of the risk of transmission increases. Substantial probabilities of transmission based upon firm scientific calculations provide the best justification for the exercise of public health powers. Exclusion of children with lice or measles from school, for example, would be permitted, because transmission is likely. But exclusion of a child with the hepatitis B virus would not be permitted, because the risk of transmission is low.49 If the hepatitis-infected child exhibited highly aggressive behavior, the decision would be more difficult, requiring an assessment of risk.50

(4) Severity of harm: As the seriousness of potential harm to the community rises, the level of risk needed to justify the public health power decreases. The level of risk, then, can be roughly calculated through an inverse correlation between the seriousness of harm and the probability of its occurrence. Minor or inconsequential infections require a higher probability of transmission than lethal infections require.

Central to the understanding of “significant risk” is the fact that even the most serious harm will not justify public health regulation in the absence of a reasonable probability that it will occur. The court in Leckelt misunderstood the relationship between probability and severity of risk. The court held that even if the probability of HIV transmission from a nurse to a patient were “extremely low . . . there is no cure for HIV . . . and the potential for harm is extremely high.”51 If the seriousness of harm were the conclusive consideration in all cases, it would require the courts to uphold almost any restriction on a person with a potentially lethal contagious disease, even if the risk of transmission were very low. The court in Glover recognized this in finding a violation of disability law when staff in a mental retardation facility were required to be tested for HIV. Although the potential harm from HIV infection is serious, its chance of occurring “approaches zero.”52

(5) Human rights burdens: While human rights burdens are often missing from public health calculations, they are of central importance. The efficacy of the public health power must be weighed against the burdens on human freedom, autonomy, and privacy. Courts must balance the significance of risk and the efficacy of the intervention (will the public health power reduce a serious health threat?) with the burdens (at what human, social, and economic cost will the public health benefit be achieved?). Wherever possible, public health officials should use the least-restrictive or invasive power capable of achieving the public health goal.

These standards of review should provide an adequate tool to evaluate whether public health departments have gone too far in restricting human rights in the name of public health. Yet hard cases will arise that will push this analytic tool to its limits. How will the courts, for example, decide whether dismissal of a surgeon or dentist infected with HIV or hepatitis B constitutes discrimination against a person with a disability? The probability of transmission is remote, and the impact on the professional’s career is dire. But the duration of risk is long term, posing a cumulative risk to patients, and the severity of harm for persons infected is sobering.53 The ADA does not solve such taxing public policy questions but forces society to justify why discrimination against persons with disability is clearly necessary for the health of the public.

Conclusion

The ADA emerges as an effective, albeit still developing, method of examining health care, health benefit, and public health decisions. The reason for the more focused review is that the ADA recasts the fundamental question that society must ask when a clinician refuses to treat a patient; an employer fires a person who has or is predicted to develop a costly disease; or a public health official requires a subject to submit to testing, vaccination, or another compulsory power. Before the advent of dis-
ability law, few legal tools existed to combat such discrimination. The primary question asked was whether the physician, employer, or public health official had the power to make the decision. This way of conceptualizing the problem is most favorable to the person exercising the power.

Now, the question must be asked, Is the public health official, clinician, or employer denying persons with disabilities equal opportunities under the law? This views the problem from the perspective of the person who is subject to discrimination. Once the issue is framed as coming within the principles of antidiscrimination and civil rights, a new way of thinking about health care law becomes possible.

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NOTES
2. The general effective date for public services and public accommodations titles was 26 January 1992; the general effective date for entities with twenty-five or more employees was 26 July 1992; and the general effective date for entities with fifteen to twenty-four employees is 26 July 1994. J.W. Parry, “The Americans with Disabilities Act: Effective Dates in Each Title,” Mental and Physical Disability Law Reporter 15 (1991): 13–16.
9. Letter from Rep. Steny Hoyer (D-MD) to the National Biomedical Ethics Advisory Committee, 1 August 1990.
24. 729 F.2d 144 (2d Cir. 1984).
II. RESPONSE

Americans With Disabilities Act: Lessons For The Future

by William L. Roper

With the possible exception of the Omnibus Budget Reconciliation Act (OBRA) of 1989, which legislated Medicare physician payment reform and created a new federal agency for health care research, the Americans with Disabilities Act (ADA) is the most important federal health legislation of the past three years. But it has received little notice relative to its important implications for American life.

This is surprising for many reasons. One of the major factors is the imperfect manner by which we track current events. The ADA was accomplished with little rancor. Controversy, not importance, generally defines prominence in current events. Because there was no long battle between Congress and the president, no struggles between rival administration camps, and no active efforts by proponents or opponents to highlight the law’s profound ramifications, the act became law with scant media attention, hardly proportionate to its importance.

The ADA was little noticed, but it will be long remembered. It stands as the largest expansion of the coverage of U.S. civil rights Law since the Civil Rights Act of 1964. It has led and will further lead to changes in the design of buildings and the delivery of many services, especially health care. It puts the force of law and legal remedies on the side of those who are discriminated against because of their disability. It promises to open up all aspects of American life to individuals with disabilities: employment opportunities, government services, public accommodations, transportation, and telecommunications. I am pleased to have played a part in the enactment of this new law. During 1989 and early 1990 I led the White House negotiating team in discussions with Congress about the scope and provisions of the ADA.

Larry Gostin’s thoughtful paper, which

William Roper is director of the Centers for Disease Control in Atlanta. During development of the ADA, he was director of the White House Office of Policy Development.

36. Ibid.
51. Leckelt v. Board of Commissioners of Hospital District no. 1,909 F.2d 620 (5th Cir. 1990).