Prostitution and the American Health Care System:
Denying Access to a Group of Women in Need

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I. INTRODUCTION

Disability is, in one sense, a matter of social construction. Society allows certain "sick" or "disabled" people to be exempt from normal social responsibilities and given special access to public resources.1 Whether an individual is considered disabled is often determined by social attitudes toward particular groups.

This phenomenon is illustrated vividly in the area of prostitutes' access to health care.2 Due in part to the nature of their work and in part to their

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2 This article focuses on female prostitution. Male prostitution has received recent attention due to the often myopic focus on homosexual activity and the spread of HIV. See, e.g., NEW S.F. AIDS Campaign Aims At Polk Gulch's Male Hustlers, S.F. CHRON., May 31, 1993, at A17; David Braaten, 'Call Boy' Clients Warned of AIDS, WASH. TIMES, May 15, 1990, at A1. However, the vast majority of prostitutes in this country are women. See JOHN F. DICKER, PROSTITUTION: REGULATION AND CONTROL 16-17 (1979). In addition, the economic, social, and legal barriers that combine to deny health care to female prostitutes do not affect male prostitutes in the same way. Some of these differences may be attributed to the historical subordination of women, the continuing devaluation of women's contribution to the work force, and the unique racial and economic mix of female prostitutes. Others may be attributed to the physiology of women's health. While some of the issues addressed in this article may apply to male prostitutes, female prostitutes endure their cumulative effect.
socio-economic status,3 prostitutes' health care needs exceed those of most other women. However, the amount and quality of health care available to many prostitutes is woefully inadequate. In addition, health care insurance options are unavailable to most prostitutes. Recently, courts have begun to construe the Social Security Administration's definition of "disability" such that a prostitute's medical impairment may become irrelevant in determining her eligibility for public disability benefits.4

The Social Security Act defines disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months, or . . . blindness."5 Disability has been so narrowly defined to ensure that finite resources are distributed only to those who are most "deserving," that is, those who truly cannot work. Because the first part of the Social Security disability definition hinges on employability, the type of work one does has special significance.

Prostitution does not fit easily into the Social Security disability framework because this type of "work" is considered socially unacceptable. Thus, a tension arises between the belief that disabled persons are entitled to public support, and the judgment that certain types of "work" should be discouraged.

Disabled women who engage in prostitution are finding themselves in the middle of this tension as the result of a recent line of cases construing "substantial gainful activity," that is, "work," to include illegal activity. First, people who "worked" at drug-dealing6 or theft7 were disqualified from receiving federal disability benefits. Soon, federal district courts in California8 and Illinois9 extended the definition of "substantial gainful activity" to include prostitution. Because most prostitutes have limited access to health care services and virtually no access to health care insurance, this definition may have a devastating impact on many socially and politically marginalized women.

This article explores barriers to health care for prostitutes, focusing on the recent elimination of disability benefits and Medicaid coverage for many of these women. After briefly describing current demographics of

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3 This article focuses primarily on prostitutes of lower socio-economic status. See infra part I.A.
4 See Speaks v. Secretary of Health and Human Servs., 855 F. Supp. 1108, 1112 (C.D. Cal. 1994) (holding that claimant's drug addiction and other medical impairments were irrelevant since she was capable of making at least $600 per month as a prostitute). See also Love v. Sullivan, No. 91C7863, 1992 WL 86193, at *3 (N.D. Ill. Apr. 22, 1992) (holding that claimant was engaged in "substantial gainful activity," since she had "three to four customers each day" and earned "between forty-five and eighty dollars" per day).
7 See, e.g., Dotson v. Shalala, 1 F.3d 571 (7th Cir. 1993). But see Corrao v. Shalala, 20 F.3d 943 (9th Cir. 1994).
8 Speaks, 855 F. Supp. at 1113.
prostitution and various ideological approaches to sex work, this article evaluates the special health care needs of prostitutes. It then addresses current availability and quality of health care for prostitutes, and their lack of health care insurance options. After analyzing the decisions in Speaks v. Secretary of Health and Human Services\textsuperscript{10} and Love v. Sullivan,\textsuperscript{11} as well as their many adverse consequences, this article concludes by offering several possible solutions.

A. Demographics of Prostitution

Because prostitutes are socially and legally required to conceal the nature of their activities, determining the number of American women who engage in "the oldest profession" is not a simple task. While most calculations range between 230,000 and 350,000,\textsuperscript{12} numbers as high as 1,300,000 have been estimated.\textsuperscript{13} In any event, a significant number of American women currently engage in various forms of prostitution on a full or part-time basis.

Although by definition all prostitutes engage in sex for money, they are not a homogeneous class of women. Indeed, social, economic, and philosophical differences among prostitutes seem to outnumber any similarities generated by the nature of their work. Recognition of these differences is extremely important in evaluating public policy that targets or otherwise affects prostitutes.

A somewhat static class system, mirroring the economic and racial stratification of the larger society, divides prostitutes into several categories. Streetwalkers—those who openly solicit on the street—represent the lowest, most marginalized class of prostitutes. They are most likely to be controlled by pimps,\textsuperscript{14} and to be subjected to violence in their work.\textsuperscript{15}

Although streetwalkers are the most visible and familiar,\textsuperscript{16} they comprise only ten to twenty percent of all prostitutes.\textsuperscript{17} However, streetwalkers

\textsuperscript{10} 855 F. Supp. 1108.
\textsuperscript{11} 1992 WL 86193.
\textsuperscript{13} Ann M. Lucas, Race, Class, Gender, and Deviancy: The Criminalization of Prostitution, 10 BERKELEY WOMEN'S L.J. 47, 48 n.3 (1995) (citing D. French, Working: My Life as a Prostitute 149 (1988)).
\textsuperscript{14} "The traditional pimp/prostitute relationship is most likely to occur in this setting, although about forty percent of street prostitutes work independently." Priscilla Alexander, Prostitution: A Difficult Issue for Feminists, in SEX WORK: WRITINGS BY WOMEN IN THE SEX INDUSTRY 184, 189 (Frederique Delacoste & Priscilla Alexander eds., 1987) [hereinafter SEX WORK].
\textsuperscript{15} See Martin Plant, Conclusions and Future Strategies, in AIDS, DRUGS AND PROSTITUTION 198, 201 (Martin Plant ed. 1990).
\textsuperscript{16} See Decker, supra note 2, at 106-07.
\textsuperscript{17} Alexander, supra note 14, at 189. See also Rhode, supra note 12, at 261.
account for eighty-five to ninety percent of all prostitution arrests. This disparity in arrests has added significance when coupled with the fact that poor women and women of color are overrepresented among streetwalkers. Thus, fifty-five percent of all women arrested for prostitution, and eighty-five percent of those sentenced to jail, are women of color.

The largest group of prostitutes, high-class "call girls" or "escorts," fall at the other end of the social and economic spectrum. These women often come from more privileged backgrounds. They typically have a higher level of education, exercise a larger degree of control over their lives, and earn substantially more for their services than do streetwalkers.

Between these two classes lies a group of women who work in various off-street settings, including massage parlors, brothels, hotels, and bars. While these women earn more and are less visible than streetwalkers, they work with less discretion and realize fewer profits than do call girls and escorts.

This article focuses primarily on streetwalkers—those women in the lowest tier of the prostitute class system—who are most likely to be economically, socially, and politically disadvantaged. However, the issues discussed may be relevant for many off-street prostitutes as well. This article does not address health care for call girls and escorts. While these women are not immune from many of the occupational hazards faced by lower-tier prostitutes, and although they too may have difficulty securing health insurance, their socio-economic status affords them much greater access to health care services.

B. Ideological Approaches to Prostitution

There is an ideological split among feminist scholars, reformers, politicians, administrators, and the general public as to the true nature of "sex work." Indeed, prostitutes themselves do not adhere to a single viewpoint. As Jody Freeman notes, "[w]omen who have been, or are presently, in the sex trade disagree over many contentious issues: whether their work is chosen, whether they participate in their own oppression, and whether their economic self-interest should outweigh the concern that prostitution con-

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18 Rhode, supra note 12, at 261; Alexander, supra note 14, at 196.
19 Forty percent of all street prostitutes are women of color. Alexander, supra note 14, at 197. One commentator has suggested that “[b]lack and brown women are on the corner rather than in massage parlors or hotel suites in part because of the low value assigned to their sexuality.” Regina Austin, "The Black Community,” Its Lawbreakers, and a Politics of Identification, 65 S. Cal. L. Rev. 1769, 1792 (1992).
20 Rhode, supra note 12, at 261; Alexander, supra note 14, at 197.
21 Call girls generally work independently, while escorts connect with clients through an "escort service.” Alexander, supra note 14, at 190.
22 Cooper, supra note 12, at 100 n.4.
23 See Ronald B. Flowers, Women and Criminality: The Woman as Victim, Offender, and Practitioner 126 (1987); Alexander, supra note 14, at 189-90; Cooper, supra note 12, at 100 n.4.
tributes to women’s subordination.”

These differences of opinion must be addressed in the formulation and administration of any policy affecting prostitution.

As access to health care increasingly depends on a person’s employment, or lack thereof, it is essential to explore competing views of “sex work.” If prostitution is simply immoral behavior, the administration of health care benefits should discourage this practice altogether. However, if prostitution is a freely chosen line of work, motivated by economic incentive and individual determination, disability insurance and the health care system should operate to include prostitutes. Finally, if prostitution is a manifestation of subordination that cannot be freely “chosen” at all, policy choices will be dramatically different.

1. The Conventional Morality View

A common and enduring view of prostitution is that it is a social evil that should be discouraged for the good of society, regardless of the beliefs and desires of those who participate. Grounded in traditional Christian norms regarding marriage, the family, and sex, this view pervades American society and underlies present legal attitudes toward prostitution. The purported state interest in prohibiting prostitution—whether it be preventing the commercialization of sex, protecting the sanctity of marriage, or protecting prostitutes from degradation—often implicates these traditional concerns. Even less value-laden justifications, such as preventing the spread of sexually transmitted disease, deterring crime associated with prostitution, or eliminating a “public nuisance,” are motivated by a desire to eliminate prostitution for moral reasons. Belinda Cooper states that “[r]eactions to attempts to change the [prostitution] law are often couched in terms that, though outwardly reasonable, merely serve to camouflage their essentially conservative-moralist bases.”

Although today the majority of the population does not outwardly express this conservative view, it is important to recognize that tradi-

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25 Id. at 105.

26 Id. at 103-07.

27 See *Rhode*, supra note 12, at 259-60; Cooper, *supra* note 12, at 104 n.30. These sources cite public-opinion polls conducted in 1971 and 1980 that indicate that only 46% of those polled thought prostitutes did more harm than good, and that 43% favored at least partial decriminaliza-
tional, moralistic social attitudes and beliefs often influence public policy regarding prostitution. Whenever legislators consider a proposal to improve the lives of prostitutes through the extension of public benefits, or through legalization or decriminalization, opponents object that it will somehow encourage women to engage in “immoral” behavior. Even if the ultimate goal is to eliminate secondary crime, the spread of disease, or neighborhood “blight,” conventional moralists resist reform measures that may sanction the “immoral” act of prostitution.

2. The Feminist Debate: Diverging Views

In recent years, the most articulate and extensive debates over prostitution have occurred among feminist scholars. It is therefore convenient to categorize differing views of prostitution by referring to two “strands” of feminism: radical feminism and liberal feminism.

This is not to say that academic feminists monopolize the prostitution debate. Indeed, prostitutes have demanded that their own voices be heard, organizing themselves into representative groups such as Call Off Your Old Tired Ethics (“COYOTE”) and Women Hurt in Systems of Prostitution Engaged in Revolt (“WHISPER”). However, to the extent that differing views on autonomy and choice divide prostitutes’ rights organizations, these theoretical differences mirror those which divide academic feminists.

28 Legalization differs from decriminalization in significant ways. As Priscilla Alexander explains:

Ideally, decriminalization would mean the repeal of all existing criminal codes regarding voluntary prostitution, per se, between consenting adults, including mutually voluntary relationships between prostitutes and agents or managers (pimp/prostitute relationships), and non-coercive pandering (serving as a go-between). It could involve no new legislation to deal specifically with prostitution, but merely leave the businesses which surround prostitution subject to general civil, business, and professional codes that exist to cover all businesses.

Legalization, on the other hand, has generally meant a system of control of the prostitute, with the state regulating, taxing, and/or licensing whatever form of prostitution is legalized, leaving all other forms illegal, without any concern for the prostitute herself. Traditional regulation has often involved the establishment of special government agencies to deal with prostitution.

Alexander, supra note 14, at 209-10.

A third option is partial decriminalization, which would decriminalize the specific transaction between a prostitute and her customer, but would retain criminal prohibitions against related activities, such as soliciting or advertising, pimping, recruiting women into prostitution, and renting a hotel room for the purpose of prostitution. See Rhode, supra note 12, at 262; Alexander, supra note 14, at 208-09.

29 Although these labels help to differentiate theoretical points of view among feminists, it would be misleading to suggest that feminists divide themselves into two distinct groups. A feminist may hold what might be called a “radical view” on prostitution, but not hold “radical views” on other topics. Similarly, a feminist who analyzes prostitution from a “liberal” point of view may not consider herself to be part of the “liberal camp.”
a. The Radical Feminist Approach

Radical feminists argue that prostitution is nothing more than the subordination of women in a somewhat disguised form. They liken prostitution to other manifestations of subordination, such as rape, domestic violence, and sexual harassment, and argue that even in the absence of physical violence, prostitution is a human rights violation. Groups organized to oppose prostitution, such as WHISPER, argue that prostitutes’ rights organizations, like COYOTE, are merely “euphemizing prostitution as an occupation.” Those adhering to the radical feminist approach emphasize that “[m]en have promoted the cultural myth that women actively seek out prostitution as a pleasurable economic alternative to low-paying, low-skilled, monotonous labor, conveniently ignoring the conditions that insure women’s inequality and the preconditions which make women vulnerable to prostitution.”

Radical feminists refute this myth, contending that “choice” is never actually available within a structure of subordination: women “choose” to engage in prostitution only because they are forced, coercively or by economic factors, to do so. If this view is correct, those prostitutes who insist that they have freely chosen their work are deluded by a false consciousness which secures their own subordination. As Andrea Dworkin argues:

> The brilliance of objectification as a strategy of dominance is that it gets the woman to take the initiative in her own degradation . . . . The woman herself takes on one kind of responsibility absolutely and thus commits herself to her own continuing inferiority: . . . she internalizes the demands of the dominant class and, in order to be fucked, she constructs her life around meeting those demands. It is the best system of colonialization on earth: she takes on the burden, the responsibility, of her own submission, her own objectification . . . . It is a tragedy beyond the power of language to convey when what

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32 Id.
33 Priscilla Alexander notes that “about ten percent of women who work as prostitutes are coerced into prostitution by third parties through a combination of trickery and violence. This figure appears to be relatively constant in the United States . . . .” Alexander, supra note 14, at 200. See also Carol Leigh, *Further Violations of Our Rights*, in *AIDS: Cultural Analysis/Cultural Activism* 177, 180 (Douglas Crimp ed., 1988).
34 As Diana Pearce argues:

> The disadvantaged position of women in the labor market is well known—the average woman still earns only about 66 percent of what the average male earns (for full-time work). This figure has changed very little in four decades. In 1988, the average woman college graduate, working full-time throughout the year, earned less than the average male high school graduate.

has been imposed on women by force becomes a standard of freedom for women . . . . 35

Radical feminists generally do not advocate legalization of prostitution because state regulation, taxation, and licensing would lend legitimacy to the subordination and objectification of women. However, some radical feminists call for partial decriminalization as a necessary step in eliminating prostitution entirely, and not as an opportunity to recognize prostitution as a legitimate occupation. Thus, they urge the repeal of laws that criminalize the sale of sexual services, but believe other related activities, such as pimping, advertising, and recruitment, should remain subject to criminal sanctions. 36

b. The Liberal Feminist Approach

In contrast, liberal feminists, prostitutes' rights organizations, and many prostitutes themselves argue that characterizing prostitution as subordination disregards women's ability to decide whether this line of work is in their best social, personal, and economic interests. They insist that women should be allowed to use their bodies for any purpose they consider appropriate. 37 They contend that prostitution actually empowers rather than denigrates women, asserting that, after weighing costs and benefits, women may freely choose this line of work. According to this view, prostitution is not an inherently coercive system of subordination, but a legitimate, respectable occupation.

The liberal feminist approach recognizes the systematic devaluation of women's contributions to the labor market, but counters that prostitution is one of the few areas where a woman may earn an income equal to that of a man, enjoy a flexible schedule, and choose her clientele. 38 Thus, liberal feminists call for full legalization of prostitution, so that women may freely exercise both sexual and financial autonomy.

II. OCCUPATIONAL HAZARDS: PROSTITUTES' SPECIAL HEALTH CARE NEEDS

As a society, we should be concerned about every woman's access to adequate health care. All women are vulnerable to a broad spectrum of physical and mental ailments. However, prostitutes face additional health

36 According to Deborah Rhode, "[s]uch a compromise would do much to avert the degradation and dangers of current approaches, but offer some safeguards against entrepreneurial initiatives . . . If our ultimate goal is to reduce sexual objectification, we cannot tolerate unrestricted commercial sex as a provisional strategy." RHODE, supra note 12, at 262.
37 See Freeman, supra note 24, at 90.
38 Deborah Rhode notes that "[i]n the current social order, selling sexuality offers many women a measure of psychological and economic independence not otherwise available." RHODE, supra note 12, at 262. See also Alexander, supra note 14, at 188-89.
care challenges. The lower-tier prostitute’s work environment regularly exposes her to health risks that many other women may not encounter, including violence, emotional stress, communicable disease, and exposure to the elements.

A. Violence, Emotional Stress, Disease, and Exposure

Prostitutes, especially streetwalkers, encounter violence and harassment from pimps, customers, and police, who “exploit the prostitutes’ fear of authorities, low social status, and economic vulnerability.”39 In a recent survey of street prostitutes in San Francisco, eighty percent reported being physically assaulted since entering prostitution, and two-thirds reported being raped in the course of their work.40 A similar study found that seventy percent of all street prostitutes had been raped on the job at an average of eight to ten times per year.41

Unfortunately, laws intended to deter physical and sexual violence against women in general often do not protect prostitutes. The most common example of this is when the rape of prostitutes by pimps, frustrated customers, police, and even strangers, is trivialized by law enforcement personnel or the criminal justice system itself.42

In addition, the emotional stress of prostitution may lead to poor physical health. Anxieties felt by prostitutes stem from innumerable sources. Streetwalkers in particular are never certain whether they will be able to generate enough money to survive. They also constantly fear arrest and prosecution, physical and emotional abuse, rape, and deadly disease.43 Moreover, feelings of degradation, alienation, low self-worth, and loss of control may cause some prostitutes severe psychological damage.44

Drug and alcohol use further compromise the health of many prostitutes. Most prostitutes who currently use drugs did so before turning to prostitution.45 However, some prostitutes turn to drugs and alcohol as a

39 Fitzpatrick, supra note 30, at 552.
40 Carla Marinucci, School for Johns, S.F. EXAMINER, Apr. 16, 1995, at C1, C3.
41 Alexander, supra note 14, at 201. For further accounts of violence encountered by prostitutes, see ELEANOR M. MILLER, STREET WOMAN 138 (1986); Gloria Lockett, What Happens When You Are Arrested, in SEX WORK, supra note 14, at 39, 39-40.
42 For example, evidence of a rape victim’s prostitution activity has been admitted to prove “consent.” See, e.g., Demers v. State, 547 A.2d 28, 35-37 (Conn. 1988). See also Fitzpatrick, supra note 30, at 552.
43 See Lori E. Dorfman et al., Hey Girlfriend: An Evaluation of AIDS Prevention Among Women in the Sex Industry, 19 HEALTH EDUCATION QUARTERLY 25, 38 (Spring 1992) (noting that “sex workers’ conversations triggered mutual concerns, including deep fears (like getting killed on the job) . . . ”).
44 See FLOWERS, supra note 23, at 128. See also RUTH ROSEN, THE LOST SISTERHOOD: PROSTITUTION IN AMERICA, 1900-1918, at 97-100 (1982).
45 See Martin Plant, Sex Work, Alcohol, Drugs, and AIDS, in AIDS, DRUGS AND PROSTITUTION, supra note 15, at 1, 5 (citing P.J. GOLDSTEIN, PROSTITUTION AND DRUGS 45 (1979)).
temporary escape from the anxieties caused by prostitution. Whether chemical addiction begins before or after a woman enters prostitution, it inevitably leads to adverse health consequences.

Many prostitutes who solicit on the street also become ill from exposure and long hours without sleep. A German doctor researching diseases among prostitutes remarks, “working outside day and night leads to health disturbances. Prostitutes often have chronic bronchitis and kidney inflammations. And, more problems arise with increasing years of professional activity.”

Intimate contact with customers also increases a prostitute’s exposure to a host of viruses and bacteria. While this may lead to an increased incidence of tuberculosis, influenza, and other respiratory ailments, the most common occupational hazard facing prostitutes is venereal disease. This is true even though prostitutes use condoms more than any other group of sexually active women. While recurrent infection with some sexually transmitted diseases (“STDs”) may cause only discomfort, diseases such as syphilis, hepatitis, gonorrhea, and herpes have much more serious health consequences. More alarming is the fact that, as heterosexual intercourse becomes a more frequent mode of transmitting HIV, female prostitutes face a very real risk of work-related death.

B. Prostitution and the Spread of HIV

Safeguarding the public health has always been a major justification for the legal and social control of prostitution, and American society has a long history of blaming prostitutes for the spread of disease. However, research does not support the assumption that prostitutes are primary transmitters of disease. Indeed, studies have consistently shown that less than

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46 Priscilla Alexander notes that “[p]rostitution is hard work, both in physical and emotional terms. Therefore, it is not surprising that a significant number of prostitutes use drugs of one kind or another to make the work easier.” Alexander, supra note 14, at 202. See also Cooper, supra note 12 at 100 n.4.


48 See infra notes 54-55, 61 and accompanying text.

49 In addition to the primary effects of infection, some STDs also serve as cofactors in the transmission of HIV. For example, syphilis and herpes are considered “risk factors” because they cause genital lesions which allow the virus to more easily enter the bloodstream. A. Alyce Werdel, Mandatory AIDS Testing: The Legal, Ethical and Practical Issues, 5 NOTRE DAME J.L. ETHICS & PUB. POL’Y 155, 164 & nn.83 & 85 (1990).

50 See infra part II.C.

five percent of sexually transmitted disease cases may be attributed to prostitution.\textsuperscript{52}

Currently, prostitutes are being blamed for the spread of HIV.\textsuperscript{53} However, contrary to popular belief, HIV infection is more an occupational risk faced by prostitutes than a threat to public health. Two facts may explain this phenomenon.

First, prostitutes are more likely to use condoms during intercourse than any other group of sexually active women.\textsuperscript{54} This significantly decreases the chances of transmission between the prostitute and her customer. Assuming that condoms are effective ninety percent of the time, the risk of contracting HIV in a single sexual encounter with an HIV-positive partner while using such a barrier is approximately 1/10,000.\textsuperscript{55}

Second, research indicates that the risk of contracting HIV from one unprotected heterosexual encounter is low.\textsuperscript{56} Moreover, the rate of female-to-male transmission of HIV is substantially lower than male-to-female transmission. A recent study involving seventy-two HIV-positive women involved in long-term sexual relationships found only one incident of transmission from an infected women to her uninfected male partner.\textsuperscript{57} In contrast, this study showed a twenty percent transmission rate from infected men to their partners.\textsuperscript{58}

Thus, despite an increased frequency of sexual contacts, female prostitution does not appear to be a major factor in the spread of HIV. Indeed, the Centers for Disease Control ("CDC") report that only five percent of all men recently diagnosed with AIDS acquired HIV through heterosexual contact.\textsuperscript{59} Assuming that most heterosexual contact does not involve prostitution, one would expect the percentage of men infected through contact with female prostitutes to be even lower.

\textbf{C. The Prostitute's Risk of HIV Infection}

While prostitution poses little threat of spreading HIV to the public, prostitutes themselves risk contracting the virus. As previously noted,
female prostitutes face a far greater risk of contracting HIV from their male customers than their customers face of contracting the virus from them. Moreover, many prostitutes who consistently use condoms with their customers do not do so in the context of their prolonged, non-commercial relationships.

This seemingly inconsistent behavior results from several social and psychological factors which often disempower women. For example, for cultural reasons, some Latina women are reluctant to insist on condom use. Moreover, a prostitute or her non-commercial partner may view condoms as being “tools of the trade,” perfectly appropriate when used in a professional capacity, but unacceptable in a personal relationship. Thus, a prostitute who insisted on using a condom with her boyfriend or spouse would be treating him like a “john.” This failure to use condoms with non-commercial partners may pose a significant risk to the prostitute, especially if her sexual partner injects drugs.

Prostitutes also risk HIV infection through their own injection drug use. Indeed, some estimates of injection drug use among female prostitutes have been as high as fifty-one percent. Therefore, studies showing a high incidence of HIV among prostitutes often reflect “the symbiotic relationship between the illegal drug industry and sex work.”

Reformers who blame prostitution for the spread of HIV often cite studies indicating a high incidence of HIV infection among prostitutes. However, many of these studies categorize persons on the basis of status rather than on the basis of behavior. If the status of being a prostitute is separated from the behavior of injection drug use, a much different picture of HIV incidence among prostitutes emerges. Studies that control for

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60 Mary Anne Bobinski, Women and HIV: A Gender-Based Analysis of a Disease and Its Legal Regulation, 3 Texas J. Women & Law 7, 39 (1994).
61 A study of street prostitutes in the San Francisco Bay Area found that while 94% of female prostitutes either always or sometimes used condoms with customers, only 25% used condoms with steady partners. Dorfman, supra note 43, at 35.
62 See Bobinski, supra note 60, at 43 & n.155.
64 See Martin Plant, Conclusions and Future Strategies, in AIDS, Drugs and Prostitution, supra note 15, at 198, 199 (noting that “many prostitutes use condoms . . . to maintain a symbolic distance from their clients.”).
67 For an example of the progressive use of behavior-based, as opposed to status-based categories for incidence and transmission of HIV, see San Francisco Dept. of Pub. Health: AIDS Office, San Francisco HIV Prevention Plan, ch. 1, p. 18 (Dec. 1994). This plan replaces “traditional risk groups” with “transmission groups.” For example, “Gay/Bisexual Men” might be replaced with “Men Who Have Sex With Men and are Injection Drug Users,” and “Prostitutes” might be replaced with “Women Who Have Sex With Men.”
independent behavioral risks find that the rate of HIV infection in prostitutes who do not inject drugs is low. For example, a comprehensive, long-term study of prostitutes and HIV conducted by Project AWARE at San Francisco General Hospital found that the incidence of HIV infection among prostitutes who do not inject drugs was slightly lower than that among other sexually active women who do not inject drugs.  

Furthermore, many studies finding a high incidence of HIV among prostitutes are flawed. For example, early studies connecting prostitution and HIV infection often recruited their subjects from drug treatment centers or prisons, thereby obtaining samples of women who were more likely to have been infected through injection drug use than through prostitution. Other studies based their statistics on inaccurate seropositivity testing.

Although the incidence of HIV infection among prostitutes is more logically attributed to injection drug use than to prostitution itself, the fact remains that many HIV-positive women are engaging in prostitution to support their drug habits. These women face serious HIV-related health problems and are often in dire need of health care services. Moreover, the prostitute’s chemical dependency itself may be disabling, requiring medical treatment or rehabilitative care.

The occupational hazards faced by prostitutes are exacerbated when a prostitute is infected with HIV. Regardless of whether a particular prostitute’s work is physically fatiguing, the potential for exposure to infectious diseases constitutes a significant risk to an HIV-infected prostitute. HIV-positive women are much more susceptible to various venereal diseases, and experience more serious health consequences once infected. Indeed, exposure to HIV should not be discounted as a significant risk to women already infected with the virus, as the danger of cross-infection with a different viral strain is possible. Moreover, prostitutes with impaired

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70 A patient is seropositive if a blood test such as the ELISA or Western Blot indicates the presence of antibodies to HIV. A positive test result indicates that the patient is infected with HIV, although she may or may not be suffering from AIDS.

71 One study conducted in Seattle illustrates how inaccurate seropositivity testing may lead to inaccurate public perceptions. Researchers tested Seattle prostitutes for HIV using the enzyme-linked immunosorbent assay ("ELISA") test and found that 4.5% were infected with HIV. These results were widely published and cited as evidence of the high incidence of HIV among prostitutes and their threat to the public health. However, subsequent testing of these samples using the more accurate Western Blot test found that none of the prostitutes were infected. However, the correct information was never publicized. See Priscilla Alexander, A Chronology of Sorts, in AIDS: THE WOMEN 169, 170 (Ines Rieder & Patricia Ruppelt eds., 1988).

72 See supra note 45 and accompanying text.


immune systems often must face exposure to the elements and maintain close contact with customers who have other communicable diseases. Exposure to even common viruses and bacteria may have a devastating impact on an HIV-infected person's health.75

Furthermore, the medical and social impact of the AIDS epidemic on women in general has only recently come to the attention of researchers and policy makers. Since the beginning of the HIV epidemic, women have been excluded from research and clinical trials, have received inferior medical treatment, and have had a more difficult time qualifying for disability benefits.76

Yet, in the United States, one in eight people infected with HIV is a woman,77 and women comprise approximately fourteen percent of those diagnosed with AIDS.78 Moreover, the rate of HIV infection is increasing most rapidly among women.79

More disturbing is the fact that the incidence of AIDS is not spread equally among racial or ethnic groups: while women of color constitute roughly twenty percent of the United States population,80 they comprise about seventy-six percent of women with AIDS.81 Similarly, a recent CDC

75 Indeed, *pneumocystis carinii* pneumonia ("PCP") is now the leading cause of AIDS-related death. U.S. DEP'T OF HEALTH & HUM. SERVS., EVALUATION AND MANAGEMENT OF EARLY HIV INFECTION 150 (1994). *Pneumocystis carinii*, a fungus or parasite that may be transmitted from person to person, usually lies dormant in the host lung. MERCK MANUAL OF DIAGNOSIS AND THERAPY 694 (Robert Berkow ed., 16th ed. 1992). However, in individuals with compromised immune systems, it may cause pneumonia. Approximately 80% of patients with AIDS develop PCP. Id.

76 "Gender-neutral" medical policies often have had a disparate impact on women, in part because the human body is not gender-neutral. For example, researchers created the original definition of "AIDS" (used for medical diagnosis and epidemiological studies) by compiling several opportunistic infections common among HIV-infected gay men. However, men and women are not equally susceptible to some opportunistic infections, and they experience them in differing degrees. When researchers finally expanded their studies, they found that HIV-infected women did not suffer from several key biological indicators of AIDS (such as Kaposi's Sarcoma) to the same extent as men. See Bobinski, supra note 60, at 16. Instead, women infected with HIV develop several types of debilitating gynecological conditions, none of which were included in the definition of AIDS.

Because the AIDS definition was oblivious to the unique medical needs of women, many extremely sick HIV-infected women were excluded from clinical trials, denied social services predicated upon an AIDS diagnosis, and denied disability benefits. The CDC and the Social Security Administration have recently expanded their definitions of AIDS and disabling HIV to include medical conditions suffered by women. See CENTERS FOR DISEASE CONTROL & PREVENTION, Revised Classification System for HIV Infection and Expanded Surveillance Case Definition for AIDS Among Adolescents and Adults, 41 MORBIDITY & MORTALITY WKLY. REP., RECOMMENDATIONS & REPS. 1, 1 (1993); 20 C.F.R. Pt. 404, Subpt. P, App. 1, Listing 14.000.D.5 (1995). However, the effects of past discrimination continue to be felt. This is most significant in the continuing lack of information regarding the distinct impact of HIV on a woman's health.


78 Of the 467,899 persons who have been diagnosed with AIDS in the United States, 64,822 have been adult and adolescent women. CDC, SURVEILLANCE REPORT, supra note 59, at 8, 10.

79 According to the CDC, there were 13,838 newly reported AIDS cases in adult and adolescent women from July 1994 through June 1995, an increase of about 27% over the previous year's data. Id. at 10.


81 Of the 64,822 adult and adolescent women diagnosed with AIDS through June 1995, 24% were white (compared to 52.3% of men), 54.57% were African-American (compared to 29.85% of
study conducted in twenty-one states found that HIV seroprevalence rates were three to twenty-eight times higher among African-American women than white women.\textsuperscript{82} Indeed, in some Northeastern states, AIDS is the leading cause of death among African-American women between the ages of fifteen and forty-four.\textsuperscript{83} There is no evidence that the higher incidence of HIV and AIDS among women of color is due to any biological vulnerability unique to women of color. Rather, it reflects social and economic factors that combine to create a higher incidence of HIV infection among these women and their sexual partners.

If these statistics are considered along with those indicating an over-representation of minority women among street prostitutes, it is clear that the women who are least likely to receive health care services are often those who need them the most. This disparate impact marginalizes poor women of color. As one commentator notes: "[i]ndisputably, HIV seropositivity and AIDS are most prevalent in minority populations in the United States, which has tended to isolate them in terms of wider societal reaction."\textsuperscript{84} Indeed, public health policies directed toward HIV-infected prostitutes have been and will continue to be influenced by the fact that most women within this class are poor women of color.

III. CURRENT AVAILABILITY AND QUALITY OF HEALTH CARE FOR PROSTITUTES

The state of the American health care system has been the topic of much discussion in recent years. Systemic inequities clearly exist, and certain populations do not receive even the bare minimum of care necessary to lead healthy and productive lives. If a woman is wealthy, white, or lives in suburban America, she will have much better access to health care than a woman who is poor, non-white, or lives in the inner city.\textsuperscript{85} Numerous studies have shown that, compared to the more affluent population, low income persons receive inferior medical, prenatal, and preventive care, have less access to physicians and medical specialists, are denied treatment or hospital admittance due to lack of insurance, and have higher overall mortality rates.\textsuperscript{86}

\textsuperscript{82} CENTERS FOR DISEASE CONTROL & PREVENTION, NATIONAL HIV SEROSURVEILLANCE SUMMARY: RESULTS THROUGH 1992, at 15-16 (1994).
\textsuperscript{85} See, e.g., Geraldine Dallek, Health Care for America's Poor: Separate and Unequal, 20 CLEARINGHOUSE REV. 361 (1986).
\textsuperscript{86} See, e.g., Helen R. Burstin et al., Socioeconomic Status and Risk for Substandard Medical Care, 268 JAMA 2383 (1992); Sara Rosenbaum, Rationing Without Justice: Children and the American
Moreover, a patient's racial or ethnic background may be as determine of her access to health care as her ability to pay for services. For example, one study found that, even among insured patients, those who are African-American or are from the poorest urban neighborhoods receive poorer medical care than do others in similar hospitals. These same patients also are more likely to be discharged in an unstable condition.

Because prostitutes often live and work in urban areas, and because many are poor women and women of color, the inequities reflected in these findings significantly affect the amount and quality of health care prostitutes receive. For the most part, street prostitutes' only access to health care is through sexually transmitted disease clinics and county hospitals. Although both types of facilities provide services for free or for a minimal charge, they generally treat prostitutes' medical problems only once they have arisen, often in emergency situations. This virtually eliminates the possibility of preventive measures. Moreover, these facilities generally do not provide extended care programs, focusing instead on immediate medical need.

Although street prostitutes often seek and receive treatment at STD clinics, the services available at these facilities are sometimes insufficient to treat more serious gynecological conditions, such as pelvic infection, cervical dysplasia, and precancer of the cervix. Because most street prostitutes do not have access to gynecological specialists, these conditions often go untreated until they become so serious as to require surgery. At this point, treatment at a county hospital is the only option. Services available at STD clinics may also be insufficient to treat various non-gynecological medical conditions, including many complications related to HIV.

Unfortunately, street prostitutes also face barriers to receiving comprehensive treatment at county hospitals. Due to financial considerations or structural changes in the health care system, hospitals are more likely to close in low-income areas: of the 949 hospitals that closed nationwide

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87 Emily Friedman, Money Isn't Everything: Nonfinancial Barriers to Access, 271 JAMA 1535, 1537 (1994).
88 Katherine L. Kahn et al., Health Care for Black and Poor Hospitalized Medicare Patients, 271 JAMA 1169, 1171 (1994).
89 Unless a prostitute has some form of health insurance, she is unlikely to receive regular, preventive medical care. Thus, "the uninsured may . . . disproportionately receive their primary care in emergency departments." Burstin, supra note 86, at 2387. Moreover, studies show that African Americans receive far fewer doctor's office visits and consultations than do whites. See, e.g., Sorlie, supra note 86, at 350.
90 See Health: "Our First Concern," in VINDICATION, supra note 47, at 109, 112.
91 Id. at 112-13. Peter Greenhouse reports that although "pelvic infection and cervical precancer are the two biggest sexually transmitted disease problems for prostitutes . . . much more significant than AIDS in terms of numbers and probably even in terms of future implications [for prostitutes]," most STD clinics are ill equipped to handle such problems. Id. at 113.
between 1980 and 1993, 675 were community hospitals. Many physicians relocate their practices when a hospital closes, further precluding access to physician care in low-income urban areas.

In addition to differential treatment based on race, class, and geography, many prostitutes are denied or receive inferior health care because of their status as prostitutes. As noted in the 1986 "Statement on Prostitution and Health," put forth by the International Committee for Prostitutes' Rights:

Prostitute health and prostitute access to health care services are deeply affected by social stigma and legal discrimination. Those injustices function not only to deny healthy work conditions and effective services to prostitutes, but also to foster distorted beliefs about prostitutes among the general public.

Realizing that they will be asked to describe how they were infected or injured, and may be blamed for having exposed themselves to such dangers, many prostitutes will avoid seeking necessary or preventive health care. Concealing the nature of their work may not be an option, as medical records often indicate known or suspected prostitution activity.

IV. HEALTH CARE INSURANCE OPTIONS FOR PROSTITUTES

Because American society continues to reject the concept of socialized medicine, and because health care costs continue to escalate, access to care often depends upon whether an individual has some form of medical insurance. However, approximately 38 million Americans are currently uninsured. A substantial number of prostitutes fall within this group, as health care insurance is unavailable to these women through either the private insurance market or public health insurance programs.

A. Access to Health Care Through the Private Market

1. Employer-Based Health Coverage

Today, approximately eighty-five to ninety percent of privately-insured persons receive coverage through an employer-based group health policy. Although these insurance programs vary, employers generally

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92 Friedman, supra note 87, at 1536 (citing AMERICAN HOSPITAL ASSOCIATION, HEALTH CARE INFORMATION RESOURCES GROUP, HOSPITAL CLOSURES, 1980-1993: A STATISTICAL PROFILE (1994)).
93 Id.
94 Statement on Prostitution and Health, in VINDICATION, supra note 47, at 141, 141.
95 See infra note 214 and accompanying text.
96 For example, the California electorate recently defeated Proposition 186, which would have provided universal health coverage for all state citizens. See Douglas P. Shuit, Proposition 186 Defeat May Prove Fatal for Large-Scale Health Reforms, L.A. TIMES, Nov. 10, 1994, at A38.
provide employees with a number of insurance options, and pay all or part of employees' premiums.

Because prostitution is considered an illegal industry, employer-based health coverage is not available to prostitutes.\(^9\) Thus, even "universal" health care reform proposals that focus on employer-based health coverage (such as the plan recently proposed by President Clinton but not passed by Congress) would not benefit prostitutes.

The illegal nature of prostitutes' work similarly disqualifies them from receiving workers' compensation or state disability insurance. This often leaves prostitutes who are injured on the job or who become ill with no means of support. As Priscilla Alexander notes:

> [I]f [prostitutes] lose time from work for a sexually transmitted disease that they get from a client, they cannot get payment from the government or from insurance during the time that they are out sick. If they are raped and battered on the job, similarly they get no access. If they are beaten by the police when they are arrested, they similarly have no insurance to help them get through the time when they are unable to work.\(^{10}\)

### 2. Consumer Access to Health Care

Theoretically, individuals who do not have access to employer-based health insurance may obtain coverage by purchasing it directly from commercial insurers, Blue Cross or Blue Shield plans, health maintenance organizations ("HMOs"), or preferred provider organizations ("PPOs"). However, insurance to cover loss or injury occurring as a result of illegal activity is generally void as against public policy.\(^{101}\) Thus, "[t]he law does not lend its aid to a recovery, ordinarily, where criminal acts are contemplated when the insurance is secured."\(^{102}\) Recognizing this, many insurance policies contain clauses limiting liability for damage or loss caused during the insured's commission of an illegal activity.\(^{103}\)

Even if an insurer were unaware of the illegal activity taking place, most prostitutes would be unable to afford private, individualized health

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\(^9\) See part VII.A.2. for a discussion of why legalization of prostitution may not result in employer-based health coverage for prostitutes. Moreover, off-street prostitutes who work in massage parlors or for escort services are unlikely to receive employer-based coverage. Although such businesses are technically legal, the small size of these operations makes it unlikely that employer health plans will be adopted.

\(^10\) Health: "Our First Concern," in Vindicaton, supra note 47, at 109, 114.


Indeed, those prostitutes who face the greatest occupational hazards (streetwalkers in general, and prostitutes who are poor, women of color, or homeless) are the least financially able to insure themselves against those risks.

Although most individuals can drive the cost of coverage down by organizing and seeking group health insurance, this is not a viable option for most prostitutes. Forming a group would inevitably draw attention to the nature of the members' activities. Even if legality were not an issue, the risks inherent in prostitution would certainly deter an insurer from offering coverage. Insurers may and often do consider an individual's occupation, lifestyle, and even dangerous hobbies when evaluating actuarial risk. Because prostitution would certainly represent an increase in morbidity and mortality rates, predictions of high loss would increase premiums to the point that even call girls and escorts may not be able to afford group coverage. Thus, although some well-paid call girls can afford private health care insurance, most prostitutes cannot.

B. Government-Sponsored Health Insurance Programs

While lower-tier prostitutes generally do not have access to health care insurance through the private market, one might expect that they would fare better under national health insurance programs such as Medicare and Medicaid. However, absent a statutorily-defined disabling condition, medical insurance coverage administered through various public benefits programs is often unavailable to prostitutes. Even a prostitute with a medically demonstrable disability may have a difficult time receiving public disability insurance. The statutory framework governing Social Security Disability Insurance ("SSDI"), Supplemental Security Income ("SSI"), Medicare, and

104 Health: "Our First Concern," in VINDICATION, supra note 47, at 109, 114. As Andrea Dworkin notes, even those prostitutes who earn substantial amounts of money do not benefit from their hard work:

Instead, their money goes to men, because men control, profit from, and perpetuate female prostitution. The men their money goes to are pimps, racketeers, lawyers, police, and the like, all of whom, because they are men and not women, can turn that money into more money, social status, and influence.

ANDREA DWORKIN, LETTERS FROM A WAR ZONE 120 (1988).


106 A small number of prostitutes may obtain health care insurance through the insurance plan of a partner or parent.

107 Those who oppose extending disability benefits to prostitutes fear that these women will continue to earn income through prostitution while simultaneously receiving government benefits. I am not suggesting that this should be permitted. My argument presumes that the procedural safeguards that currently address fraud in the Social Security system will also apply to prostitutes. For a more detailed discussion, see infra part VII.D.
Medicaid presents several obstacles to eligibility that many prostitutes cannot overcome.

1. Medicare

Medicare eligibility is generally linked to the Social Security program, providing coverage to Social Security and railroad retirement recipients who are over the age of sixty-five or disabled. Disabled persons who are eligible for SSDI qualify for Medicare, but only after they have been eligible for cash benefits for at least two years. SSDI is not a needs-based entitlement program. Rather, financial eligibility for SSDI depends on having paid into the Social Security system for a specific number of work quarters, within a specific time period.

It is currently unclear whether a prostitute could pay into the Social Security system and thereby be financially eligible for SSDI. Normally, workers contribute to the Social Security system through a payroll tax (matched by their employers), or through a self-employment tax. Prostitutes cannot contribute through an automatic payroll deduction because they are not traditional employees, receiving regular paychecks. Therefore, unless prostitutes' earnings can be characterized as "self-employment income," these women will be unable to contribute to the current Social Security system.

The Social Security Act defines "net earnings from self-employment" as "gross income . . . derived by an individual from any trade or business." However, neither the Act nor the Social Security regulations define "trade or business." Instead, courts have been left to make this determination on a case-by-case basis.

No court has addressed whether prostitution constitutes a "trade or business" for purposes of Social Security taxation or benefits. However, because most policymakers believe that prostitution is socially undesirable, it is unlikely that a court would allow prostitutes to contribute to, or collect benefits under, the Social Security system. To hold otherwise would encourage these women to build earning records based on prostitution in

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112 Prostitutes working through "legitimate" businesses such as massage parlors and escort agencies may not have this problem if they remain employed for a consistent number of pay periods, and if their employers are willing to comply with tax and employee reporting laws.
114 See, e.g., Loveless v. Weinberger, 492 F.2d 1291 (6th Cir. 1974) (holding that grandmother's caring for minor grandchildren was not a "trade or business"); Hollohan v. Heckler, 805 F.2d 143 (6th Cir. 1986) (holding that lessor’s performing minor janitorial services was not a "trade or business").
order to be eligible for future governmental benefits. To many, this would appear to reward, rather than punish, illegal activity.  

If prostitution is not considered to be a "trade or business," a prostitute will be eligible for SSDI only if she has established an independent, legal work history. This poses special problems for women in general because many have been excluded from jobs which allow them to pay into the Social Security system on a consistent basis. Thus, even if a woman has worked legally prior to engaging in prostitution, it is possible that she will not have accumulated a work history sufficient to entitle her to SSDI and Medicare benefits.

2. Medicaid

Those prostitutes who do not meet the work history requirements for SSDI may be eligible for Supplemental Security Insurance ("SSI") or Aid to Families with Dependent Children ("AFDC"). Eligibility for either of these programs also entitles the recipient to Medicaid coverage. Medicaid is a joint federal and state program that conditions eligibility on meeting established financial and categorical requirements. These state-administered programs aim to provide funds to the "deserving" poor, usually defined as those persons whose income and assets fall below a certain level and who are aged, blind, permanently or temporarily disabled, pregnant, or members of families with dependent children. Each state

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115 However, even if prostitutes were allowed to contribute to the Social Security system, presumably, few would do so. Fearing prosecution for prostitution and possibly income tax evasion, many prostitutes would be wary of voluntarily disclosing the nature of their "trade or business" to a government agency. Of course, if prostitutes choose not to contribute to the Social Security system, they should not be allowed to collect benefits through SSDI.

116 In addition to the continuing disparity between wages paid to women and men, Diana Pearce notes:

(M)ore women than men are unable to obtain regular, full-time, year-round work. Many women, especially mothers seeking to support their households on their earnings, encounter serious obstacles to full participation in the labor market, including inadequate, unavailable, or unaffordable day care and discrimination based on full-time work since only part-time or seasonal work is available to them. As a result, only about 40 percent of women maintaining households alone are full-time, year-round workers, compared to almost two-thirds of male householders. About one-third of women heading families alone, compared to 20 percent of men, are not in the labor force at all.

Pearce, supra note 34, at 268.

117 The fact that most prostitutes are not eligible for Medicare may present problems in accessing health care resources. In her work with HIV-positive prostitutes, the author has observed that many health service providers now require a person to be eligible for Medicare, not just Medicaid, in order to receive services. Thus, many long term, cost-intensive services (such as substance abuse treatment programs) are unavailable to prostitutes.

118 42 C.F.R. § 435.120 (1994).


120 On the concept of deserving and undeserving poor, see Michael Katz, The Undeserving Poor: From the War on Poverty to the War on Welfare (1989).

may establish its own eligibility requirements, subject to broad federal regulatory guidelines. While federal law requires that state Medicaid programs cover certain categorical groups, states may choose not to extend coverage to others. Thus, Medicaid does not guarantee health care to the poor. In fact, most poor single people—those considered to be the "undeserving" poor—are not covered by Medicaid. Currently, only forty percent of all Americans with incomes below the poverty line are eligible for Medicaid.

In order for a prostitute to be eligible for Medicaid, she must demonstrate that she is somehow "deserving" of these benefits by fitting into one of the categories established by federal and state regulations. Prostitutes who have or are expecting children, and who earn less than a statutorily designated amount per month may qualify for AFDC and automatically receive Medicaid. However, the percentage of poor people eligible for Medicaid through AFDC is decreasing. According to one source, "AFDC eligibility levels have dropped in recent years as welfare increases have failed to keep pace with inflation." Thus, a prostitute may find that she exceeds financial eligibility for AFDC even though her income and assets place her and her family far below the poverty level.

For those prostitutes who do not have children, the only way to qualify for Medicaid is through SSI. However, to be eligible for SSI, a claimant must establish that she is totally and permanently disabled under the relevant statutes. Recently, the nature of prostitutes' work has taken on additional significance in this context, disqualifying some women from receiving any health care coverage at all.

V. PROSTITUTION AND THE DISABILITY DETERMINATION

In April, 1992, a district court in Illinois denied disability benefits to a prostitute named Cynthia Love. Reviewing the record below, the court determined that substantial evidence supported the findings of the administrative law judge ("ALJ"). The ALJ had concluded that Love's alleged impairments were not severe, and that she was capable of performing past work. In addition, the ALJ had determined that Love's "occupation as a prostitute, although illegal, is substantial gainful activity."

122 McCormick, supra note 119, at 270-72.
125 Furrow, supra note 98, at 570.
126 Because most prostitutes do not report their earnings for tax purposes, financial eligibility will usually be difficult for her to contest. However, throughout the application and appeals process, a claimant's records and testimony may reveal the nature and earnings of her work.
128 Id. at *3. The district court noted that "[t]he illegality of her occupation does not negate the fact that Love has a substantial source of income." Id. However, the court could cite no authority for
Two years later, in *Speaks v. Secretary of Health and Human Services*, a California district court reached a similar conclusion regarding a prostitute’s claim for disability benefits. Influenced by recent circuit court decisions including illegal acts within the definition of “substantial gainful activity,” the district court denied benefits to a prostitute named Veda Speaks. The court adopted the recommendation of a federal magistrate who had determined that because Speaks was currently performing “substantial gainful activity,” she did not qualify for SSI disability benefits.

The *Love* and *Speaks* decisions have effectively closed the door to SSI for many prostitutes, thereby eliminating disability benefits and health care coverage for a substantial number of women. The *Speaks* decision is particularly forceful because it relies on the holdings of several federal circuit courts, and because the court’s determination is based solely on the conclusion that Speaks was engaging in substantial gainful activity.

To understand the rationale of the *Speaks* decision, its precedent, and its future implications, a basic understanding of the disability determination is required.

A. Evaluating an SSI Disability Claim

When a claimant applies for disability benefits under Supplemental Security Income, her application, medical records, and other relevant documents are reviewed by a disability claims analyst. If the analyst denies the initial application, the claimant may file for reconsideration. At this point, a different analyst and a medical consultant employed by the Social Security Administration review the claimant’s file. If more information regarding the claimant’s physical or mental condition is needed, the medical consultant may require the claimant to attend a “consultative exam,” administered by an independent medical group but paid for by the SSA.

If the claimant’s application is denied after reconsideration, she may appeal for a hearing before an administrative law judge. After the ALJ issues a decision, either party may ask the SSA Appeals Council to review the claim. Finally, the claimant or the Secretary of Health and Human Services may obtain review of the ALJ’s or Appeal Council’s ruling in a United States district court.

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130 Id. at 1112-14.
The central focus of this process is the disability determination. Congress has defined “disability” for both SSI and SSDI purposes as the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months.” To determine whether a claimant meets this definition, a disability analyst makes what is known as the “Initial Determination,” a five-step sequential evaluation established by the Department of Health and Human Services:

- **Step One:** A disability claims analyst looks to see whether the claimant is currently working, that is, whether she is engaging in “substantial gainful activity.” If the claimant is working, her claim is denied without further evaluation. The analyst will find that the claimant is not disabled, regardless of her medical condition, age, education, or work experience.

- **Step Two:** If the claimant is not engaging in substantial gainful activity, the analyst will determine whether the claimant suffers from a “severe impairment,” which “significantly limits [the claimant’s] physical or mental ability to do basic work-related activities.” The analyst focuses on the effect of the claimant’s physical or mental impairments, considering the combined effect if more than one impairment is claimed.

- **Step Three:** If the claimant demonstrates a severe impairment, it is compared to the Listing of Impairments compiled by the SSA. Any claimant who suffers from a listed impairment, or who demonstrates the equivalent of a listed impairment, will be presumed to be disabled without further evaluation.

- **Step Four:** If the claimant’s impairment does not meet or equal a listed impairment, the analyst will consider whether the claimant retains any “residual functional capacity.” The analyst will assess the claimant’s remaining physical and mental abilities, and determine whether she is still able to perform any “past relevant work.” A claimant who can meet the physical and mental demands of work done in the past is not considered disabled.

- **Step Five:** If the claimant cannot perform past relevant work, the analyst considers her age, education, and work experience to determine whether she can perform any other type of work currently existing in the national economy. If she can, she is not considered disabled.

**B. Substantial Gainful Activity**

According to Step One of the Initial Determination, an individual who is engaged in substantial gainful activity (“SGA”) is not disabled, regardless of her medical condition, age, education or work experience. Work is generally considered to be “substantial” if it “involves doing significant physical or mental activities.” Part-time work may be considered

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SGA, but work done on a sporadic or intermittent basis usually is not. Work is "gainful" if it is done for pay or profit, or is of the type usually done for profit. Thus, a person need not be actually realizing a profit from her work for it to be considered SGA.

A disability analyst may look to a claimant’s earning levels as an indication of whether her work is SGA. A statutory presumption of SGA arises if a claimant has average monthly earnings greater than $500, as of January 1, 1990. Conversely, if a claimant has average monthly earnings less than $300, after January 1, 1990, she is presumed not to be engaging in SGA. The claimant may rebut a presumption of SGA by showing that she cannot be self-employed, or that she can perform a job well only with special assistance or only for brief periods of time.

C. The Legacy of Dotson: Illegal Activity as SGA

Given the value American society places on hard work, and the stigma it attaches to illegal activity, categorizing criminal activity as "work" is inconsistent. However, in Dotson v. Shalala, the Seventh Circuit formally recognized that illegal activity may constitute substantial gainful activity.

Dotson applied for SSI, alleging disability based on asthma, multiple allergies, and drug addiction. After having been denied at the application and reconsideration stages, Dotson appealed and received a hearing before an administrative law judge. Dotson testified that he used $200 to $300 worth of heroin and cocaine daily, and that he supported his drug habit by panhandling and stealing. Based on detailed testimony regarding the nature of Dotson’s begging and thievery, the ALJ concluded that this constituted substantial gainful activity worth approximately $5,600 per month.

On appeal, the Seventh Circuit upheld the ALJ’s decision denying SSI benefits because Dotson’s illegal activities constituted SGA. The court noted that, while the Secretary of Health and Human Services evidently intended disability regulations to apply within a traditional employment

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141 Katz v. Secretary of Health and Human Servs., 972 F.2d 290, 292 (9th Cir. 1992) (citing Keyes v. Sullivan, 894 F.2d 1053, 1056 (9th Cir. 1990)).
142 Kornock v. Harris, 648 F.2d 525, 527 (9th Cir. 1980) (citing Cornett v. Califano, 590 F.2d 91, 94 (4th Cir. 1978)).
144 Id. See also Callaghan v. Shalala, 992 F.2d 692, 695-96 (7th Cir. 1993) (holding that unprofitable business owner was engaging in SGA).
148 1 F.3d 571 (7th Cir. 1993).
149 Id. at 573.
150 Id.
151 Id. at 574.
152 Id. at 578.
context, nothing in the Social Security Act or its regulations required that SGA be lawful. In the court's view, "[a] claimant who can manage through illegal means is just as undeserving of benefits as a claimant who can survive without violating the law." The characterization of illegal activity as SGA has an analog in tax law. In United States v. Sullivan, the United States Supreme Court held that unlawful earnings come within the meaning of "gross income" and are therefore subject to income tax. The court could not find "any reason why the fact that a business is unlawful should exempt it from paying the taxes that if lawful it would have to pay." The Dotson court carried this notion over into the disability context, noting that the Social Security Act had adopted the tax code's definition of gross income in determining financial eligibility for SSI.

Having established that illegal activity may constitute SGA, the Dotson court went on to determine whether the ALJ's conclusion that Dotson's activities were both substantial and gainful was supported by the evidence. In doing so, the court focused on the specific nature and frequency of Dotson's activities. Dotson testified that, in order to steal, he first had to "case" the area, plan how to steal the property, and then actually steal it. He spent a significant amount of time riding in a car, looking for property to steal, and delivering it to small business owners for sale.

Furthermore, Dotson's current practice was to steal chainsaws. The ALJ concluded that "lifting and carrying the chainsaws . . . [is] . . . significant physical activity." In addition, the ALJ ruled that "the planning and execution of the larceny entail[ed] significant mental activity." The Seventh Circuit found the ALJ's conclusions reasonable while noting that the ALJ could have conducted a more in depth inquiry. However, the Dotson court was careful to point out that despite statutory earning presumptions, not all illegal activity would amount to SGA. The court cited two examples to illustrate this point: "acting as a lookout at a drug house might constitute a gainful yet insubstantial activity, whereas someone who chronically engages in acts of vandalism may be substantially, but not gainfully, occupied."

153 Id. at 576. See also Hart v. Sullivan, 824 F. Supp. 903, 905 (N.D. Cal. 1992) (finding that statutory and regulatory provisions do not require that substantial gainful activities be lawful). 154 Dotson, 1 F.3d at 576. 155 274 U.S. 259 (1926). 156 Id. at 263. 157 Id. 158 Dotson, 1 F.3d at 577. 159 Id. at 574, 577-78. 160 Id. at 574. 161 Id. 162 Id. at 578. 163 Id. at 576 n.7.
Thus, the particular factual circumstances surrounding the illegal activity—its nature, duration, and frequency—are the focus of the SGA inquiry. The Ninth Circuit took this case-by-case approach in *Corrao v. Shalala*,\(^ {164}\) which also involved a claimant engaging in illegal activity in order to support a drug habit.\(^ {165}\) However, in this case, the court concluded that the claimant’s illegal activities did not amount to SGA because they did not involve “significant physical or mental exertion” of the type of work usually done for pay or profit.\(^ {166}\)

Corrao applied for SSI, alleging disability due to mental illness, drug dependency, and fatigue. He testified that he obtained the one and one-half grams of heroin necessary to support his daily habit by purchasing heroin for others and retaining a portion of the purchased drug as payment.\(^ {167}\) By purchasing up to $600 worth of heroin daily for up to three persons per day, Corrao obtained and consumed approximately $4,200 of heroin per month. While this in-kind “income” established a statutory presumption of SGA, the court found that the presumption had been rebutted.\(^ {168}\)

The court noted that the amount of time Corrao invested in obtaining heroin was not substantial:

... Corrao spent only a minimal amount of time working. The record reflects that when one of Corrao’s purchasers was interested in obtaining drugs, he would contact Corrao. The individual would pick up Corrao, drive him to the purchase area, wait for a few minutes while the transaction was performed, and drive Corrao home. The entire activity, including the car ride, took only twenty-five to forty-five minutes.\(^ {169}\)

The court also focused on the relatively effortless nature of Corrao’s activities:

Even more significant to our holding is our conclusion that Corrao’s activities did not require any significant mental or physical exertion. Corrao did no planning prior to these purchases ... Corrao did not organize drug dealers, nor did he have an organized or extensive clientele. ... Corrao did not use his own money for the transactions but was provided with funds by the ultimate purchaser. ... There is no indication that he ever sold his portion of the drugs for cash or other items. In sum, there is no indication of initiative, organization, responsibility, or physical or mental exertion by Corrao as is required for SGA.\(^ {170}\)

\(^{164}\) 20 F.3d 943 (9th Cir. 1994).
\(^{165}\) *Id.* at 945.
\(^{166}\) *Id.* at 948-49.
\(^{167}\) *Id.* at 945.
\(^{168}\) *Id.* at 948.
\(^{169}\) *Id.*
\(^{170}\) *Id.* at 948-49.
D. Extending SGA to Include Prostitution: Speaks

In Speaks v. Secretary of Health and Human Services, the court was asked to extend the definition of SGA established in Dotson to include plaintiff Veda Speaks’ activities as a prostitute. Speaks claimed that her drug addiction qualified as a “severe impairment” within the meaning of the Social Security regulations, and that she was therefore entitled to receive SSI disability benefits. According to the administrative law judge, Speaks had been working as a street prostitute since 1971, making at least $600 per month. Based on these earnings, the ALJ found that Speaks was engaging in SGA. Therefore, the ALJ found that it was not necessary to continue with the sequential analysis to determine whether Speaks’ drug addiction qualified as a disabling impairment.

Speaks appealed to the district court. The parties filed cross motions for summary judgment, which were taken under submission by a United States Magistrate Judge. The magistrate’s initial Report and Recommendation concluded that the ALJ’s determination that Speaks was engaging in SGA should be reversed, and that the case should be remanded so that a complete sequential evaluation of Speaks’ disability claim could be conducted.

In his initial report, the magistrate determined that the definition of SGA established in Dotson could not be applied in the present case: “Literally, the . . . definition of substantial gainful activity does not exclude unlawful activity. However, as repulsive as the idea may be that a criminal who is making substantial illegal income might also qualify for SSI, to interpret the law otherwise leads to even more absurd, undesirable consequences.” The magistrate concluded that Speaks’ activity could not be considered SGA because such a determination would, in effect, require her to continue in her illegal profession instead of receiving disability benefits.

The magistrate also noted that, if for various physical or mental reasons Speaks could no longer perform any legal job, Social Security Administration (“SSA”) regulations would require that she be denied benefits even if she completely abandoned her illegal activities. That is, if Speaks voluntarily left prostitution, she automatically would be disqualified from receiving SSI benefits under the fourth step in the sequential disability determination, which determines whether a claimant is capable of doing past relevant work. Thus, whether Speaks could generate a legal income would be irrelevant as long as she were physically and mentally capable of

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172 Id. at 1109.
173 Id. at 1109-10.
174 Id. at 1112.
175 Id. at 1111.
176 Id.
177 20 C.F.R. § 416.920(e) (1995) states:
performing acts of prostitution. If Speaks abandoned prostitution for a host of legitimate personal or social reasons, she would be denied SSI benefits. This result seemed illogical to the magistrate, who concluded that "Congress could never have intended that ex-prostitutes and ex-thieves must return to prostitution and thievery if those are the only things they are capable of doing for a living." However, after the magistrate made his initial conclusions, the Ninth Circuit handed down its decision in Corrao, specifically stating that illegal activity may constitute SGA. Consequently, the Secretary of Health and Human Services filed an objection to the magistrate's Report and Recommendation. Recognizing that the Ninth Circuit's reasoning was "directly contrary to the interpretation of the regulations made by the magistrate judge," the magistrate submitted a Supplemental Report and Recommendation to the district court. The magistrate reversed his prior recommendation, indicating that Speaks was indeed engaging in SGA.

First, the magistrate asserted that prostitution was an illegal activity that fit squarely within the definition of SGA established in Corrao. However, rather than analyzing the specific facts of the case to determine whether Speaks herself was engaging in SGA, the magistrate focused on prostitution generally.

Next, the magistrate claimed that prostitution could be distinguished from Corrao's drug sales (which were found not to constitute SGA) because prostitution was much more similar to "traditional employment" or a "sole proprietorship." On this point, the magistrate noted that "[p]rostitution is indisputably a profession which, though illegal in California, is legal elsewhere." The logic of the magistrate's second argument is flawed for two reasons. First, Nevada is the only state that has some form of legalized prostitution. Yet if the magistrate was referring to the legalization of prostitution in Nevada, the analogy fails. Even in Nevada, prostitution is legal only in licensed and highly regulated brothels located in the state's lesser-populated

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Your impairment(s) must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not disabled.

(emphasis omitted).

178 This interpretation logically extends to all other forms of illegal activity. For example, an applicant who deals drugs must continue to do so if able.

179 Speaks, 855 F. Supp. at 1111.

180 Id. at 1112.

181 Id. at 1113.

182 Id. at 1112.

183 Id. at 1113.

184 Id. (quoting Corrao, 20 F.3d at 949).

185 Id. at 1113.
counties. Thus, the type of unregulated, urban prostitution that Speaks practiced is clearly illegal in all United States jurisdictions.

Second, if the magistrate’s analogy to legal activity were accepted, the distinction between prostitution and drug dealing would collapse. Indeed, even the sale and delivery of controlled substances is legal under certain circumstances (for example, in the business of pharmaceuticals).

Moreover, as the Corrao court emphasized, the legality of an activity is irrelevant for purposes of determining SGA. The Ninth Circuit implied that acting as a drug dealer could constitute SGA within the meaning of the statute, if the specific acts performed involved significant mental and physical activity, and if they occurred on a fairly regular basis. However, focusing on the particular nature, duration, and intensity of the activity performed, the court ultimately concluded that Corrao was not engaging in SGA.

If the Speaks court had correctly applied Corrao, it would have analyzed the particular nature, duration, and intensity of Speaks’ prostitution activity in order to determine whether she was performing any “significant physical or mental activity.” However, the court made no reference to how often Speaks solicits or engages in prostitution, how much she is paid for each service provided, whether her activities involve planning or organization, whether her activities require a substantial investment of time, or to what degree her activities are physically exerting.

Indeed, the only fact the court considered was that Speaks had earned approximately $600 per month engaging in prostitution. Although $600 establishes a presumption of SGA, because it exceeds the $500 statutory limit, the income guidelines established by the regulations “do not relieve an ALJ of the duty to develop the record fully and fairly.” Thus, further inquiry should have been made to determine whether the particular circumstances surrounding Speaks’ activities rebutted this presumption.

Again, the Speaks court could have avoided this error by correctly applying Corrao. The Corrao court also faced a statutory presumption of SGA based on Corrao’s illegal income. However, after full analysis, the Corrao court determined that this presumption had been rebutted. In contrast, the Speaks court failed to fully develop the record. In effect, the court found that Speaks’ activities were gainful, yet failed to determine whether they were substantial.

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186 See Cooper, supra note 12, at 111.
187 Corrao, 20 F.3d at 947.
188 Id. at 948-49.
189 Id. at 949.
190 Speaks, 855 F. Supp. at 1112.
192 Dotson v. Shalala, 1 F.3d 571, 576 (7th Cir. 1993) (quoting Dugan v. Sullivan, 957 F.2d 1384, 1390 (7th Cir. 1992)).
193 Corrao, 20 F.3d at 948-49.
VI. Social and Legal Implications of the Speaks Decision

The Social Security statutes and regulations should not be read to create a favored status for criminal activity by exempting it from the definition of SGA. In many cases, a court examining the precise nature and amount of a claimant's illegal activity will correctly conclude that the claimant is performing significant mental and physical activities.

However, where prostitution is involved, several unique factors combine to render the current application of the disability determination unwise and unfair. There are several physical, emotional, and societal harms accompanying prostitution that are not present in other illegal activities. These may include physical and emotional abuse at the hands of customers, pimps, and police, continual exposure to disease and harsh working conditions, social stigmatization, and feelings of sexual objectification and degradation. The presence of one or more of these conditions suggests that we should hesitate to extend the definition of SGA to include prostitution without first exploring other options.\(^{194}\)

In addition, general policy considerations counsel against literal application of Social Security statutes and regulations in the prostitution context. Extending the definition of SGA to include prostitution creates inconsistencies within government-sponsored disability programs. It also contradicts governmental policy objectives by requiring women to remain in or return to prostitution, by undermining criminal laws aimed at deterring prostitution and the spread of HIV, and by disproportionately affecting poor women and women of color.

A. Inconsistencies Within Disability Programs

The Speaks decision creates inconsistencies between government-sponsored disability programs by categorizing prostitution as work for the purpose of denying a woman SSI, while refusing to recognize the same activity as work for purposes of eligibility for SSDI, workers' compensation, or state disability insurance. Granted, these programs have different policy objectives. SSI is a "welfare" program, which provides economic support to low-income individuals regardless of their contribution into a common, governmental fund. In contrast, SSDI, workers' compensation, and state disability are "insurance" programs. In these programs, covered employees and their employers "purchase" insurance against disability by contributing a portion of their income to the Social Security program, either through a FICA payroll deduction\(^{195}\) or a self-employment tax.\(^{196}\)

\(^{194}\) For further discussion of differences between prostitution and other illegal activity in this context, see infra part VII.C.


Thus, an individual who does not contribute to a government-sponsored insurance program should not be allowed to collect its benefits. However, if an individual is disqualified from contributing to a social insurance program simply because her work is considered illegal, and if she cannot afford private health insurance, she should not be excluded from government-sponsored welfare programs as well.

Indeed, the SSI/Medicaid program was developed as a “safety net” for persons who are not eligible for government-managed insurance programs, but who are nevertheless “categorically needy.” This program represents a policy decision to extend benefits to low-income individuals who are permanently and totally disabled. Therefore, a prostitute who otherwise would be considered disabled under the five-step Initial Determination should not be disqualified at the first step merely because prostitution may in certain circumstances constitute SGA.

In addition to program-wide discrepancies between SSI and SSDI in the treatment of prostitution as “work,” inconsistencies exist within the Social Security Administration’s Initial Determination of disability itself. Although prostitution has been construed as SGA for purposes of Step One, this definition has not been extended to Step Five. If a claimant cannot perform past relevant work, Step Five instructs an analyst to consider the claimant’s age, education, and work experience. If these factors indicate the claimant can “engage in any other kind of substantial gainful work which exists in the national economy,” she will not be considered disabled. Although this type of work is described as “work that exists in significant numbers either in the region where such individual lives or in several regions in the country,” prostitution has not been included in this formulation.

Of course, to include prostitution in the Step Five analysis would lead to absurd results: any person who was no longer physically or mentally able to perform previous work, but who could still engage in sexual activity, would be denied disability benefits. However, if the Speaks interpretation of prostitution as SGA were consistently applied throughout the Initial Determination, this would in fact be the result. The fact that prostitution now receives two different interpretations within a single analytic framework indicates that perhaps the definition of SGA was not intended to extend this far.

B. Requiring Women to Remain in or Return to Prostitution

By denying Speaks disability benefits based only on a determination of SGA, the Speaks court did not require the ALJ to determine: 1) whether Speaks could do any past relevant work; or 2) whether she maintained any

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198 Id.
“residual functioning capacity.” According to the decision, whether Speaks could generate a legal income was irrelevant as long as she was physically and mentally capable of performing acts of prostitution. However, this determination implies that Speaks had at some point opted not to engage in any other type of work, choosing instead to engage in the “lucrative” business of prostitution. It does not consider the possibility that Speaks would never have engaged in prostitution in the first place if she had any other economically viable alternative.

The Speaks court did not give any consideration to the radical feminist argument that women “choose” to engage in prostitution only because they are forced—coercively or by economic factors—to do so. According to radical feminist theory, the Speaks court is complicit in denying women choice and forcing them to remain in relatively powerless, subservient social positions. Denying Speaks disability benefits solely because her means of survival meets the formal requirements of SGA is, in effect, requiring her to continue to engage in prostitution. If it is true that Speaks engages in prostitution only because she cannot maintain any other form of employment, denial of public support would force Speaks to remain in prostitution in order to survive. As the magistrate’s Initial Report and Recommendation noted, “the Secretary’s denial of plaintiff’s claim for SSI—without deciding that plaintiff is capable of any other activity—is tantamount to telling her that it is expected that in the future she will earn her living through prostitution.”

The Speaks decision leads to unacceptable results under the liberal feminist approach, as well. Even if Speaks had freely chosen to enter prostitution, the SSA regulations would now deny her the freedom to leave this line of work. Theoretically, a woman who has chosen prostitution over other types of legal employment can return to those occupations when she wishes to do so. However, if a woman leaves prostitution and subsequently finds that she cannot secure or maintain legal employment—due to her physical or mental impairment, or to a wide range of social factors—the fact that she had once worked as a prostitute may bar her from receiving SSI. If an analyst or ALJ determines that a woman who voluntarily left prostitution could still engage in some form of sex work, this would be considered “past relevant work.” Under the fourth step of the disability

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199 Contrary to popular belief, prostitution is not a lucrative business for many prostitutes. See supra note 104.
200 Speaks, 855 F. Supp. at 1111.
201 Even if the social and economic factors that led a woman to engage in prostitution are overcome, it is often difficult for an ex-prostitute to establish herself in the legal work force. According to the International Committee for Prostitutes’ Rights, “the stigmas and regulations which prevent job mobility for prostitutes . . . make it extremely difficult or impossible for prostitutes to change work when desired or when necessary for health reasons.” Statement on Prostitution and Health, in VINDICATION, supra note 47, at 141, 142. This would be even more difficult for a woman suffering from some type of mental or physical impairment. Moreover, the argument that prostitutes could return to legal employment assumes that jobs are currently available to applicants who are, perhaps, poor women of color.
determination, such a claimant is denied disability benefits without further inquiry. In this situation, a woman would be forced to return to prostitution in order to pay for basic necessities, which may now include special health care services.

C. Inconsistency with Laws Criminalizing Prostitution and Laws Criminalizing the Spread of HIV

The Speaks decision is also problematic when viewed in light of continuing efforts by state legislatures to discourage prostitution, and the recent advent of statutes criminalizing conduct thought to be responsible for the spread of HIV.

Prostitution has long been considered a grave social evil, responsible for the corruption of female morality,202 the deterioration of the nuclear family,203 the subversion of national security,204 and the spread of venereal disease.205 As such, reformers and policy makers have succeeded in criminalizing prostitution in all but one state.206 Although degrees of public toleration vary from community to community, the message from state legislatures is clear: as a threat to the general welfare, prostitution should be subject to criminal sanctions.

When moral objection to prostitution is backed by public health concerns, anti-prostitution legislation becomes even more popular. Given the enduring image of the prostitute as a transmitter of disease,207 it is not surprising that demands to enforce criminal sanctions against prostitutes have become more frequent and insistent since the beginning of the AIDS epidemic.208 Although empirical evidence shows that prostitutes who do not inject drugs have no higher incidence of HIV infection than any other group of sexually active women,209 and that prostitution is not a major factor in the spread of HIV, coercive AIDS legislation has focused specifically on this group.210

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202 See Cooper, supra note 12, at 101-02.
203 See Grover, supra note 54, at 25; Lucas, supra note 13, at 47.
204 See Daly, supra note 51, at 196.
205 See supra note 51 and accompanying text.
206 See supra note 186 and accompanying text.
207 See Cooper, supra note 12, at 105. See also Bobinski, supra note 60; Lucas, supra note 13, at 54-55.
208 One notable exception is San Francisco District Attorney Terence Hallinan’s view that prostitution should be treated as a public health issue rather than as a crime. See Kenneth B. Noble, Fighting Crime, Gently, N.Y. TIMES, Jan. 18, 1996, at A14. Indeed, as a city supervisor, Hallinan formed a task force on prostitution to study the possibility of legalizing prostitution in response to the HIV public health emergency. See Jane M. Adams, Uneasily, Some Consider Legalizing Oldest Trade, CHI. TRIB., Jan. 11, 1994, § 1, at 6.
209 See supra note 68 and accompanying text.
210 The impetus for criminalizing "risky behaviors" came in 1988, when the Presidential Commission on the Human Immunodeficiency Virus Epidemic recommended that states enact HIV-specific criminal statutes. See Thomas W. Tierney, Criminalizing the Sexual Transmission of HIV: An International Analysis, 15 HASTINGS INT’L & COMP. L. REV. 475, 499 (1992). Since then, twelve states have passed laws making it a crime for HIV-infected individuals knowingly to engage in
Legislators may offer several justifications for imposing criminal sanctions on prostitutes, or other people who behave in a manner "likely to transmit HIV." Laws criminalizing behavior allow society to formally register its moral condemnation of particular behaviors. They also attempt to punish "blameworthy" individuals for irresponsible and dangerous behavior. Finally, legislators may defend the use of criminal sanctions by noting their deterrent effect.

However, current laws criminalizing prostitution and the spread of HIV do not adequately serve these functions.\(^{211}\) Indeed, they are continually undermined by state action—such as the SSA determination in *Speaks*—that tolerates or implicitly encourages prostitution.

Although many policymakers wish to morally condemn prostitution, construing this activity as "work" under SSI regulations may actually frus-
trate this purpose. While denying disability benefits to prostitutes may be seen as a means of punishing women who engage in socially unacceptable behavior, equating prostitution with legal work for the purpose of allocating government benefits may actually lend legitimacy to this type of behavior. If fear of legitimizing prostitution keeps policymakers from classifying prostitution as "work" for government-managed insurance programs such as SSDI, it is inconsistent to allow this to occur in the SSI context.

A deterrence justification for denying disability benefits to prostitutes is similarly unpersuasive. This justification presupposes that women freely choose to enter and leave prostitution, and that the denial of disability benefits will persuade some to select other (legal) employment options. However, this argument ignores the circumstances under which this "choice" often occurs, including the need to support a family and other financial, social, and physical constraints. In addition, the argument assumes that other gainful employment options are available—regardless of one's race, ethnicity, gender, social status, and level of education.

Moreover, even under the liberal feminist belief that true choice exists, it is unlikely that denying prostitutes disability benefits will deter women from entering or leaving prostitution. Like most individuals, prostitutes are unlikely to contemplate that they may one day be permanently and totally disabled. Moreover, prostitutes already face many occupational deterrents, such as social stigma and increased risk to personal health and safety. If these immediate consequences do not deter a woman from choosing to engage in prostitution, neither will the remote possibility that some day she may be denied disability benefits.

D. Disparate Impact on Poor Women and Women of Color

Perhaps the most disturbing consequence of extending the definition of SGA to include prostitution is the disparate impact this has on claimants. Poor women and women of color will be systematically denied disability benefits and Medicaid, while more affluent and white women will not.

Because prostitutes are not likely to report their occupation or earnings for tax purposes, an analyst or ALJ will only know that a particular woman maintains an income through prostitution if this fact is noted somewhere in her file, or if it is presented in testimony at an administrative hearing. A prostitute's occupation is more likely to be discovered if she is a poor woman or a woman of color for several reasons.

212 Although this disparate impact may be extreme, an equal protection challenge to the SSI scheme would not survive without some showing of invidious discriminatory intent. See Washington v. Davis, 426 U.S. 229, 236 (1976); Arlington Heights v. Metropolitan Housing Corp., 429 U.S. 252, 264-65 (1977).

213 Some women may volunteer this information believing that it will graphically illustrate the dire circumstances caused by their inability to work. Few will realize that this information may now be used to deny them disability benefits.
First, medical records submitted by the claimant or gathered by the SSA to substantiate a claim for disability often note that the patient has engaged in prostitution. This information may be reported by the patient to explain repeated exposure to venereal disease or physical abuse, or it may be based on a physician's speculation regarding the cause of disease or injury. In the case of speculation, a physician's prejudices and stereotypes regarding poor women and women of color may factor into his or her theories of causation.

Second, it is not uncommon for a claimant's SSA file to contain her criminal record. Since poor women and women of color are over-represented among street prostitutes, and therefore are disproportionately arrested for and convicted of prostitution, they are more likely to be denied benefits due to criminal histories reflecting prostitution.

A final inequality exists due to the nature of the disability claimed. As noted earlier, seventy-six percent of women with AIDS in the United States are women of color. This statistical disparity is significant because, due to the statutory definition of AIDS and other social factors, HIV-infected women have had a more difficult time qualifying for disability benefits than women claiming other impairments. Like many other public health policies directed toward HIV-infected women, the disability determination has a disproportionate impact on poor women of color.

VII. Possible Solutions

Although prostitutes have many unique and significant health-related problems, the care they receive is woefully inadequate. Rather than remediying this situation, the Speaks decision makes prostitutes' access to care even more difficult. However, several options, including legalization, accurate application of current Social Security Administration regulations, and alteration of the SSI disability determination, might ensure adequate health care for prostitutes.

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214 In the author's experience providing legal services to HIV-positive prostitutes, this scenario was common.

215 Indeed, this information is often beneficial for a claimant attempting to establish disability based on chemical dependence or mental impairment. If, for example, a claimant has a long history of narcotics offenses, arrests for disorderly conduct or public drunkenness, and thefts committed to support a drug habit, this may be powerful evidence to support a disability claim based on chemical dependence.

216 See Alexander, supra note 14, at 196-97. See also Gloria Lockett, Leaving the Streets, in Sex Work, supra note 14, at 96, 96-97.

217 See supra note 81 and accompanying text.

218 See supra note 76 and accompanying text.
A. Legalization: Treating Prostitution as a Legitimate Job

The prostitutes' rights approach urges for prostitution to be treated as any other profession. Thus, prostitutes could organize and demand better working conditions, set professional standards, advertise, and regulate the industry.\textsuperscript{219} From a health care perspective, recognizing prostitution as a legitimate profession has several advantages.

Although one might argue that decriminalization is preferable to legalization in many contexts, simply removing criminal sanctions will not significantly improve prostitutes' access to health care services. Although both reform options would eliminate many of the hazardous conditions prostitutes face in their work, legalization may also give prostitutes access to health care coverage through employer-based or government-managed insurance programs.

1. Private Health Insurance

Legalization would increase the availability of private health insurance for prostitutes. First, private insurers would no longer be prohibited\textsuperscript{220} from offering coverage because prostitution would no longer be an illegal activity. Second, legalization would eliminate many of the hazardous conditions that accompany prostitution today. This, in turn, would reduce insurers' reluctance to offer coverage to prostitutes.

As pro-legalization advocates argue, criminalization creates many of the hazards prostitutes face today, and denies prostitutes the power to change their working conditions:

Criminalization of prostitutes for purposes of public health is unrealistic and denies human rights to healthy work conditions. As outlaws, prostitutes are discouraged, if not forbidden, to determine and design a healthy setting and practice for their trade. . . . [Criminalization] forces prostitutes into medically unhygienic, physically unsafe and psychologically stressful work conditions.\textsuperscript{221}

Legalization accompanied by worker-enforced regulation would improve prostitutes' work environment and health by allowing prostitutes to solicit in regular business zones, by requiring that regular business codes for cleanliness and worker safety be applied, and by requiring leaves of absence for illness and vacation time.\textsuperscript{222}

The elimination of hazardous work conditions would make private health insurance coverage for prostitutes much more likely by reducing

\textsuperscript{219} Given the problems prostitutes have had with state authorities throughout history, it is not surprising that most prostitutes' rights organizations would advocate self-regulation rather than state-regulation in the event of decriminalization or legalization. See, e.g., Statement on Prostitution and Health, in VINDICATION, supra note 47, at 141, 142-43.

\textsuperscript{220} See supra notes 101-03 and accompanying text.

\textsuperscript{221} Statement on Prostitution and Health, in VINDICATION, supra note 47, at 141, 142.

\textsuperscript{222} Id. at 142-43.
insurers' projections of possible loss. In theory, insurers would be able to offer prostitutes insurance coverage at affordable premium rates. Moreover, state regulations—similar to those employed to prevent insurers from discriminating against HIV-infected or homosexual applicants—could be employed to prevent insurers from denying prostitutes coverage based on factors that do not relate to a reasonable rate-making process.

2. Employer-Based Health Care Coverage

If the sex industry were legalized and regulated, large brothels employing a significant number of prostitutes could afford—and may have an economic incentive—to adopt an employee health insurance plan. Indeed, states could require such insurance as a condition of licensure, and could regulate insurance offered to brothel employees so as to keep premiums at an affordable level.

However, if prostitution were merely decriminalized, or if it were legalized but not regulated, it is unlikely that the industry would voluntarily organize itself into firms large enough to provide employee health care plans. In legal industries, it is mainly medium to large-sized firms that have an economic incentive to offer some form of self-insurance; smaller employers are less likely to offer health insurance, due to cost and administrative problems. Of course, if the government were to require employers to provide health coverage for their employees (as called for by President Clinton's health care plan, for example), legalization of prostitution would result in greater coverage for prostitutes.

As the situation in Nevada illustrates, mandated health care within the context of legalized prostitution is not problem-free. Prostitutes currently employed in Nevada's brothels are subjected to weekly medical examinations and are tested for HIV once a month.

Although this type of arrangement addresses public health concerns, it also raises concerns regarding informational privacy and the right to refuse medical treatment. Informational privacy is particularly significant when personal information indicates a stigmatized status such as prostitution or HIV-infection. The right to refuse medical treatment is implicated when prostitutes are forced to submit to medical examinations.

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223 According to the National Association of Insurance Commissioners ("NAIC"), an individual's sexual orientation should not be used to infer morbidity or mortality risk. Moreover, underwriters are not to inquire into an individual's occupation, marital status, living arrangements, beneficiary designation, or geographic location for the purpose of inferring sexual orientation. NAIC, MEDICAL/LIFESTYLE QUESTIONS AND UNDERWRITING GUIDELINES, PROPOSED BULLETIN (1989), reprinted in Furrow, supra note 98, at 551-52.

224 Almost half of all uninsured (legal) workers are found in businesses with fewer than 25 employees. Furrow, supra note 98, at 537 (citing statistics from the Employee Benefit Research Institute).

225 See Werdel, supra note 49, at 165 n.79.
Ironically, if these examinations require testing for HIV, they may drive prostitution further underground and undermine public health measures intended to decrease the spread of HIV. A woman may avoid HIV testing if she fears that her health status will become common knowledge. Similarly, a prostitute who has reason to believe that she will be forced to give up her only means of survival, without any compensation for unemployment or disability, will avoid knowledge of her HIV status.

3. Access to Public Benefits Through SSDI

Even though access to employer-based health care insurance may not materialize, prostitutes in need of health care would still benefit from legalization. If prostitutes were allowed to pay Social Security and income tax, they might be eligible for state-sponsored disability coverage, such as Social Security Disability Insurance or workers' compensation.\(^2\) Taxing prostitutes' income would generate additional revenue for the state, which may help to offset the ever-increasing cost of national health care. More importantly, it would give prostitutes the benefit and security of a contribution-based health care alternative.\(^2\)

B. Applying Current SSA Regulations to Avoid Adverse Consequences

Although the availability of health care for a large number of women would improve significantly if prostitution were legalized, every state but Nevada has refused to eliminate anti-prostitution legislation. Indeed, even the less extreme option of decriminalization has been rejected. It may be more realistic, therefore, to look to the existing SSA regulations to remedy prostitutes' lack of health care. The undesirable consequences of \textit{Speaks} could be avoided if current regulations were interpreted and applied so as to discern the true nature of the claimant's activity, or to protect claimants from having to face continuing occupational hazards.

1. Making an Accurate Determination of SGA

One way to avoid the undesirable consequences of \textit{Speaks} would be to determine whether the illegal activity at issue is in fact substantial and gain-

\(^{226}\) However, even a prostitute who had paid into the Social Security system for a sufficient number of quarters would still be required to prove that she was disabled before she could collect benefits under SSDI. Because the SSDI and SSI disability determinations are identical, a prostitute seeking to collect Social Security benefits would face the same problems in proving disability under the current definition of substantial gainful activity ("SGA") as she would under SSI.

\(^{227}\) However, taxing prostitutes' earnings does not necessarily lead to health care provision. For example, prostitutes in former West Germany were treated like legal workers for taxation purposes. However, they did not receive public health insurance or pensions in return. See Cooper, \textit{supra} note 12, at 110 (citing to various German and American sources).
ful. This calls for an examination into the factual circumstances to determine the nature, extent, and duration of the prostitution activity involved. As discussed above, the Speaks court did not actually follow Corrao. Although the court noted that illegal activity could indeed constitute SGA, it failed to follow the Ninth Circuit’s lead in focusing on the specific facts of the case in order to determine whether the claimant’s activity was indeed substantial.228

If Corrao is to be followed, an analyst or judge should not be allowed to rely solely on the amount of income generated per month to determine SGA.229 Instead, she should be required to determine the actual nature, duration, and intensity of the activity at issue. The court in Love went further in this regard than did the court in Speaks. In Love, the court noted that the claimant “entertains three to four customers each day.”230 However, this information alone does not establish whether the claimant is performing any “significant physical or mental activity.” Such a limited inquiry does not suffice when compared to courts’ detailed analyses of the nature, duration, and intensity of other illegal activity in cases such as Dotson and Corrao.

Of course, such an inquiry ultimately would lead an analyst or judge to determine that some prostitutes were engaging in SGA. Indeed, a sophisticated call girl or escort who maintains an organized clientele, works on a regular basis, and operates through a system of referrals and commissions, may be found to be engaging in SGA under a fair reading of the regulations.

However, because these women generally do not have criminal or medical records that indicate the nature of their work, this fact is not likely to come to the attention of a disability analyst or ALJ.231 Moreover, these are not likely to be the women who, but for their prostitution activity, would be considered disabled. Even if a woman were no longer able to engage in sophisticated forms of prostitution, the fourth step of the sequential disability analysis—which determines residual functioning capacity—would generally lead to a denial of disability benefits. The education, skills, or training that at one time allowed her to maintain a sophisticated prostitution practice would most likely be considered “transferable” to another line of work. Thus, if a sophisticated call girl continued to possess skills or training applicable to “sedentary work,” she would not be considered disabled for SSI purposes.

228 See supra part V.D.
229 20 C.F.R. § 404.1574(a)(1) (1995) provides: “Your earnings may show you have done substantial gainful activity. . . . Generally, if you worked for substantial earnings, this will show that you are able to do substantial gainful activity.” (emphasis added). This led the court in Stillwell v. Sullivan to note that “[t]he Administration’s regulations demonstrate . . . that the Secretary has not chosen to exercise his statutory authority to promulgate regulations that rely solely on a person’s earning in all instances where that person’s earnings exceed the amounts set forth . . . .” No. CIV.A.91-1108-MLB, 1992 WL 401971, at *5 (D. Kan. Dec. 30, 1992).
231 See supra part VI.D.
However, many streetwalkers or less sophisticated off-street prostitutes who do not possess the education, skills, or training that make them otherwise employable would be found disabled if a proper inquiry into the nature of their activities were made. Women who engage in prostitution only occasionally, when in dire need of money, would not be automatically disqualified from receiving SSI because work done on a sporadic or intermittent basis is not considered SGA.²³²

Even street prostitution performed on a regular basis may not be "substantial" in that it does not involve significant mental or physical activity. Like the heroin dealer in Corrao, many prostitutes do little or no planning, and some spend minimal amounts of time soliciting or engaging in prostitution. Moreover, few streetwalkers oversee the activity of other prostitutes²³³ or maintain organized clienteles of their own.²³⁴

However, the question of physical exertion poses some problems. Unfortunately, if courts truly intend to treat prostitution the same as any other type of work for SSI purposes, they must apply the SGA determination consistently and inquire into the most intimate aspects of the prostitute’s “work.”²³⁵

In other contexts, disability analysts make detailed inquiries into the claimant’s exertional, postural, and environmental limitations.²³⁶ This would obviously be an extremely sensitive inquiry in the case of prostitution, and it is easy to understand why a court would be more reluctant to inquire into the specific nature of the activity involved in Speaks than in Corrao.²³⁷ However, in order to accurately determine whether a prostitute’s activity is of a substantial nature, the court would have to inquire into the nature, duration, and intensity of both solicitation and the sexual act

²³² See, e.g., Kornock v. Harris, 648 F.2d 525, 526-27 (9th Cir. 1980).
²³³ See Miller, supra note 41, at 39 (noting the predominance of male pimps); Decker, supra note 2, at 239 (same).
²³⁴ See supra part I.A.
²³⁵ It would be difficult to argue that this process impinges on an individual’s right to privacy in a legal sense. While sexual activity is generally considered to be of an intimate nature, the right to privacy in sexual relations is not absolute. See, e.g., Bowers v. Hardwick, 475 U.S. 186 (1986) (upholding Georgia statute criminalizing sodomy). In the prostitution context, it is not the sexual act that is criminalized, but the exchange of money for that act. Because the disability determination relates to both the nature of the activity and the ability to reap some financial benefit therefrom, it could be argued that in submitting a claim for disability, the prostitute is voluntarily relinquishing her right to privacy in this context. However, when one considers that applying for SSI may be the prostitute’s only possible access to health care, or that her only other option is to subject herself to the hazards of prostitution (including criminal sanctions for prostitution or spreading HIV), the voluntary nature of this “choice” is undermined.
²³⁶ Social Security Administration Form SSA-4734-U8 (“Residual Physical Functional Capacity Assessment”). Exertional limitations may include difficulty in lifting objects, standing, walking, and sitting. Postural limitations may include difficulty climbing, balancing, stooping, kneeling, crouching, and crawling. Environmental limitations may include inability to endure extreme heat, cold, wetness, humidity, or noise.
²³⁷ Whether this would cause more discomfort for the court or the prostitute would depend on how the individual claimant viewed her activities. For some, this would be merely “talking shop.” For others, having to disclose intimate and possibly shameful details in an intimidating, institutional setting may be extremely traumatic.
itself. Otherwise, SGA will be determined only in reference to the amount of money a prostitute earns.\textsuperscript{238}

The invasive nature of this inquiry provides a strong argument against the extension of the definition of SGA to include prostitution, and the option of altering the disability determination will be discussed below. However, if the definition of SGA is to continue to apply in the prostitution context, the inquiry into the nature of a claimant’s activities should be handled in the most professional, tactful, and non-judgmental manner possible. In order to minimize trauma to the claimant, it would be desirable to elicit this information in a context less intimidating than the courtroom, perhaps through declaration or affidavit.\textsuperscript{239}

Ultimately, this inquiry may not defeat a prostitute’s claim for disability benefits. The act of solicitation may at times involve no more than standing on a corner and waiting for a client to approach. And while performing the sexual act itself may entail physical exertion, it is also entirely possible that a disinterested, detached prostitute does not significantly exert herself when engaging in various forms of paid sex. Indeed, this may be why an HIV-infected (or otherwise sick) woman may be able to engage in prostitution, but not be able to perform any other type of work.

2. Exempting Detrimental Activity from the Definition of SGA

Another way to avoid the undesirable consequences of Speaks, unaddressed in that case, would be to focus on the fact that returning to a particular line of work would be hazardous to the claimant’s health. According to the Program Operations Manual System ("POMS"), the Social Security Administration’s internal policy and procedural guidelines, “a severely impaired claimant who work(s) to the detriment of health may be found under a disability . . . even though the work ordinarily would be considered substantial gainful activity under the applicable guides.”\textsuperscript{240} The POMS further directs an ALJ to consider that “work endangering life or health will not defeat a claim for benefits.”\textsuperscript{241} While the POMS lacks “the force and effect of law,”\textsuperscript{242} it does provide the view of the Secretary of Health and

\textsuperscript{238} As noted earlier, the amount of money a prostitute is paid for sex is often much higher than the amount she actually receives for her own subsistence. Dworkin, supra note 104, at 120.

\textsuperscript{239} Other types of information considered to be essential to the disability determination are elicited through declaration or SSA-generated questionnaires. For example, the SSA regularly requests a claimant to provide information regarding drug and alcohol use through the Drug and Alcohol Use Questionnaire (Form SSA-5704A), and to provide information regarding the extent to which an alleged disability affects daily functioning through the Daily Activities Questionnaire (Form SSA-2059).

\textsuperscript{240} Program Operations Manual System §§ DI 24005.010, DI 401.160E.

\textsuperscript{241} Program Operations Manual System § DI 24005.010.

Human Services on how SSA employees should interpret legally binding statutory and regulatory law concerning SGA.\textsuperscript{243}

The argument that activity is not SGA if it is detrimental to the claimant’s health has been recognized in numerous cases. In \textit{Schlabach v. Secretary of Health},\textsuperscript{244} the court found that, because there was no substantial evidence that the claimant could perform gainful activity without seriously endangering his health, his claim of disability should be upheld.\textsuperscript{245} In reaching its decision, the court relied on \textit{Oppenheim v. Finch},\textsuperscript{246} where the Fourth Circuit held that “[i]t must be shown medically that [claimant] can perform the physical activities [required by previous jobs] without serious aggravation to present physical impairment or to general health.”\textsuperscript{247} More recently, in \textit{Stillwell v. Sullivan},\textsuperscript{248} a Kansas district court found that, where work was “detrimental to [claimant’s] mental health and very likely aggravated her condition,” it could not be considered SGA.\textsuperscript{249}

Although these cases involved more traditional disability determinations, the idea that activity detrimental to the claimant’s health should not be considered SGA has also been recognized in cases involving illegal activity. In \textit{Hart v. Sullivan},\textsuperscript{250} the claimant argued that drug distribution impaired his health because receiving payment in heroin led to his continued use of the drug.\textsuperscript{251} Although the court claimed to be sympathetic to the claimant’s “vicious cycle of dependence,” it was not persuaded that drug distribution was impairing the claimant’s health. Rather, the court determined that the claimant’s consumption of profits led to his physical deterioration.\textsuperscript{252} Thus, the court held that “[t]he exception for activities detrimental to the claimant’s health applies only when the work activity itself is harmful.”\textsuperscript{253}

Given this line of reasoning, prostitution is an activity that could be considered detrimental to a claimant’s health under the Administration’s POMS. Prostitution may be distinguished from the illegal activity in \textit{Hart} in that the work of prostitution itself is inherently dangerous. Prostitutes, especially those who work on the streets, face numerous occupational hazards on a daily basis: they are physically and sexually abused by clients, pimps, and police; they are forced to solicit outside in harsh weather; and they are continually exposed to a wide range of communicable diseases,

\textsuperscript{244} 469 F. Supp. 304, 316-17 (N.D. Ind. 1978) (reversing decision to deny disability based on acute hypertension, arteriosclerosis, arthritis, diabetes, etc.).
\textsuperscript{245} Id. at 317.
\textsuperscript{246} 495 F.2d 396 (4th Cir. 1974) (remanding for reconsideration of decision to deny disability based on skeletal-muscular pain, visual difficulties, and gastrointestinal problems).
\textsuperscript{247} Id. at 398.
\textsuperscript{248} 1992 WL 401971 (reversing decision to deny disability based on severe mental disorder).
\textsuperscript{249} Id. at *7.
\textsuperscript{250} 824 F. Supp. 903 (N.D. Cal. 1992).
\textsuperscript{251} Id. at 906.
\textsuperscript{252} Id.
\textsuperscript{253} Id.
some of which are fatal.254 As discussed earlier, such hazards are exacerbated when a prostitute is infected with HIV. Just as a claimant who has exhibited a particular sensitivity to some occupational hazard may not be required to return to his prior place of work, a prostitute should not be required to return to the streets.

C. Altering the Disability Determination

If an inquiry into the nature of the claimant’s prostitution for SGA purposes proves to be ineffective or unjustifiably intrusive, and if application of administrative guidelines fails to protect claimants from continuing occupational hazards, then the SSA disability determination must be altered. However, the Initial Determination need not be completely reformulated; an exception to the general rule that illegal activity constitutes SGA and therefore immediately disqualifies a person from receiving disability benefits would suffice.

An exception could be made where it appears from the claimant’s record or testimony that the denial of SSI benefits would require a claimant to continue to engage in illegal activity that would: 1) pose a threat to her physical or emotional health; or 2) pose a threat to the health of another. This proposed modification would not guarantee that all prostitutes would receive disability benefits; it would merely require the analyst or judge to go beyond the first step in the Initial Determination and make additional findings.

One may argue that this exception would apply to all illegal activity to some extent. For example, thievery and drug dealing are inherently risky activities. These criminals often encounter violence, as when a drug deal “goes bad.”255 Moreover, violence against others stemming from armed robbery and the drug trade has reached what some call “epidemic proportions.”256

However, the dangers encountered by a thief or drug dealer are somewhat different than those in the prostitution context. While thievery or drug dealing may occasionally place a criminal at risk, many prostitutes face physical danger on a daily basis. Physical and sexual abuse by pimps, customers, and police is commonplace among street prostitutes, and the risk of exposure to venereal disease is present in virtually every sexual act.

Nonetheless, this exception could be read to encompass any illegal activity that involves some risk and exposes others to some danger, greatly limiting those criminal activities that may constitute SGA. Therefore, to

254 See supra part II.A.
prevent the exception from swallowing the rule, a specific showing of injury or threat of injury could be required. The concept of injury in fact, long accepted in the standing context, would provide a ready framework for this determination. Thus, a prostitute would have to allege more than the fact that the activity she engages in carries with it inherent risks. She would have to demonstrate that she had experienced some physical or emotional injury in the past, or that she faces an imminent threat of such injury in the future. Similarly, a showing of current HIV infection would suffice to show an increased future risk to the prostitute's physical health, as well as an increased risk to the public health.

Another option is to exempt illegal activities that pose a threat to a claimant's emotional health from the definition of SGA, thus recognizing the emotional injury many women experience as a result of being objectified and exploited through prostitution. This type of injury further distinguishes prostitution from thievery or drug dealing. While a thief steals an object from another and a drug dealer trades a separate, tangible object, the prostitute "sells her body."

Prostitution is therefore different from other illegal activities in that the prostitute may be considered a victim of crime as easily as she may be considered a perpetrator. As a spokesperson for WHISPER has noted, the reality of prostitution is such that the state should "stop defining prostitution as a 'victimless' crime or as a crime committed by women, and acknowledge it for what it is—a crime committed against women by men." Although one may argue that thieves and drug dealers are, in a general sense, "victims of society," this is not the same type of direct, recurrent victimization experienced in prostitution. Thieves and drug dealers typically exert power through their criminal acts. And although these criminals do experience some degree of stigmatization, in some communities they may achieve respect and admiration for their prowess or business savvy. In contrast, although some prostitutes claim that their work is empowering, prostitution often places a woman in a subservient position. In either event, prostitution invariably results in stigmatization.

Of course, the prostitute's view of the nature of prostitution is significant in this context. If a prostitute shares the radical feminists' view that prostitution is nothing more than the forced subordination of women for the benefit of men, she will certainly feel objectified and exploited. Indeed,

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257 See, e.g., Lujan v. Defenders of Wildlife, 504 U.S. 555, 560 (1992) (holding that injury in fact must be (a) concrete and particularized, and (b) actual or imminent).
258 Wynter, supra note 31, at 270.
259 For example, Regina Austin notes "the respect shown to drug dealers by their neighbors and the beneficiaries of their philanthropic largess," and proceeds to analyze the "coherent case for the appreciation of the black male lawbreaker." Austin, supra note 19, at 1776-77. See also id. at 1776 n.21.
260 Belinda Cooper notes that, although various surveys indicate public morality does not actually condemn—and may even accept—the institution of prostitution, the public continues to express a negative attitude towards prostitutes themselves. Cooper, supra note 12, at 104-05 n.31.
this injury may be exacerbated by the fact that the state indirectly condones such exploitation through the denial of disability benefits.

On the other hand, if a prostitute views sex work as a legitimate and respectable occupation, emotional injury may be minimal. However, the prostitute’s view of her work may change if she now feels “trapped” in prostitution due to her current inability to engage in other types of work and the unavailability of disability insurance. While initially she may have valued her ability to freely choose her line of work, she may no longer feel that she has any “choice” at all. In this case, she may begin to view her work as exploitative and degrading.

D. Safeguarding Against Fraudulent Claims

Whenever a new group attempts to secure government benefits, opponents argue that undeserving but crafty applicants will manipulate the system and somehow divert resources away from those truly in need. Ensuring the equitable distribution of limited resources is certainly a valid administrative and social concern. However, where prostitutes are involved, there appears to be something more at work. Underlying the SSA’s objection to granting disability benefits or health insurance to prostitutes is a belief that these women will continue to engage in prostitution. If this were the case, SSI payments made at the public expense would be supplementing—rather than replacing—the prostitute’s illegal income.

This argument assumes, of course, that women engage in prostitution for reasons other than mere survival. It assumes that, even with an SSI income of approximately $600 per month and free Medicaid insurance, many women would still be attracted to prostitution. The average street-walker earns a comparatively menial income while being subjected to significant work-related hazards. Presumably, these women would be far less likely to continue to engage in prostitution if they had some other means of financial survival.

However, the fear of fraudulent claims is not completely unfounded: some women will continue to earn money through prostitution while receiving disability benefits. However, the possibility that recipients may engage in SGA while simultaneously receiving SSI is not unique to the prostitution context. Therefore, the statutes and regulations governing disability benefits contain several provisions designed to ensure that SSI recipients do not continue to engage in SGA. For example, Title 20 of the Code of Federal Regulations, section 416.989 provides for periodic re-evaluation of a recipient’s disability. If a recipient is found to be engaging in SGA at the time of

261 This fear is undoubtedly present in the context of other illegal activities as well.
262 See supra note 22 and accompanying text; supra part II.
263 Indeed, the legal and social constraints placed on prostitution may make prostitutes less likely than other SSI recipients to continue to work.
re-evaluation, disability benefits will be discontinued. If the claimant is earning income from an activity that does not constitute SGA, the disability determination remains unaltered, but that amount of income is deducted from her SSI payments. 264 Similarly, while the regulations allow a recipient to engage in SGA during a “trial work period,” if this activity lasts longer than nine months, benefits may be terminated. 265

Current SSA regulations also contain special provisions for chemically dependent recipients which could be applied to prevent the misuse of public resources. One could argue that a woman who engages in prostitution to support a drug habit will be very likely to continue in this activity while simultaneously receiving public assistance. However, eligibility for SSI may be conditioned upon a claimant’s participation in an approved drug addiction treatment program. 266 If a prostitute failed to participate, her benefits would be discontinued. 267

Thus, procedural safeguards built into the SSA regulations can be applied to income earned through illegal means to ensure that SSI payments are used to replace rather than to supplement a prostitute’s earnings. Granted, it may be difficult to detect income derived from illegal sources. However, this does not distinguish prostitution from other types of legal work: SSI recipients who continue to work often attempt to conceal this fact because they know it will reduce or terminate their benefits. 268 Therefore, prostitutes are no more likely to defraud the Social Security system by earning outside income than are other SSI recipients.

VIII. CONCLUSION

Like any group of individuals, prostitutes need and deserve access to health care services. Indeed, prostitutes’ need for access is heightened by the fact that their work environment exposes them to health risks many other women do not encounter. Unfortunately, the amount and quality of health care available to many prostitutes is inadequate. Some receive inferior health care or are denied health care altogether because of social stigma and discrimination based on their status as prostitutes. Moreover, because prostitutes most often live and work in urban areas, and because many are poor women and women of color, the socio-economic inequities that inhere in the American health care system make access to adequate care even more difficult.

Adding to this problem is the fact that health care insurance options are unavailable to lower-tier prostitutes. Most of these women cannot

access health care services through the private insurance market or through public health insurance programs. Now, as a result of the *Speaks* decision, the last health care option remaining for many prostitutes has been eliminated. Even a prostitute with a medically demonstrable disability may be denied public support and health care coverage if an analyst or ALJ determines that she is still able to engage in sexual activity.

However, the extension of substantial gainful activity to include prostitution leads to inconsistent and undesirable results. In addition to program-wide discrepancies between SSI and SSDI in the treatment of prostitution as "work," inconsistencies exist within the SSA Initial Determination of disability itself. Treating prostitution as SGA also contradicts more general policy objectives, by requiring women to remain in or return to prostitution, by undermining criminal laws aimed at deterring prostitution and the spread of HIV, and by disproportionately affecting poor women and women of color.

Although many prostitutes find that they have virtually no access to health care, there are many possible solutions, including legalization of prostitution, accurate application of current SSA regulations, and alteration of the SSI disability determination. Each of these alternatives would result in increased availability and quality of health care for prostitutes, particularly for those of lower socio-economic status.