Taylor Cooley

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Dr. C. Marsh

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Access and Eligibility of Modern Medicine

The healthcare system in the United States is failing. Young, old, black, white, rich, or poor: all entities within the healthcare system need an overhaul to provide equal care to patients of every background. That is what healthcare is for, is it not? Of course, all people deserve equal access to care. That's why the system was created in the first place. Politics have saturated an industry whose sole focus should be the treatment of patients. States are single-handedly denying their residents access to affordable healthcare, because they refuse to accept the legislation that is attached to the Affordable Care Act. In this essay, I seek to expose the inequality among various races and classes within the healthcare system, and how that relates to the unaffordability of health insurance, and the gaps within the Affordable Care Act that allow such unjust practices to occur.

Inequality is a long-standing social issue, but just as there is obvious social inequality for people of color there is the manifestation of that inequality of access within the healthcare field. A U.S. citizen is also valued as greater than a non-citizen. Libby Gordon, of socialworktoday.com, states: "According to the Center on Budget and Policy Priorities (CBPP), African Americans (19.6% uninsured) and Hispanics (32.7%) are much more likely to lack insurance than Caucasians (11.3%). Meanwhile 43.6% of noncitizen immigrants are without insurance." Statistically, it is obvious that minorities have a greater prevalence of being uninsured. This point is an indication that not only is it more difficult to be an insured minority,

but because of this, minorities are less likely to seek preventative healthcare. Rather they only pursue entirely necessary medical attention, which in the long term, equates to a higher cost then standard preventative care. Robert Zarr, of Physicians for a National Health Program, quoted Harry S. Truman, a former US President, as saying “the time has come to help millions of Americans living without a full measure of opportunity to achieve and enjoy good health and to have prevention against the economic effects of sickness.” President Truman is calling the American people into action. It is time for all people to have access to the wonders of modern medicine. Everyone’s grandma, younger brother, and crazy aunt Helga deserve equal access to the preventative and curative properties that science has afforded us.

Oftentimes, the uninsured cannot afford a standard checkup, so the only time they interact with the healthcare system is when they are truly ill. However, at that point they still cannot afford the care, but the healthcare system is set up as to not deny any patient care regardless of their ability to pay for the care. Moore and Coddington, in their essay entitled "Healthcare Reform Initiatives: The New Wave," present the idea of “inconsistent access to care” stating: “More than 45 million Americans are without insurance, and there are limited care options for the uninsured (often little or no access to preventative care, office consultations by specialists, and/or elective procedures)” (75). Although the Affordable Care Act has lessened the number of people without insurance, 11% of the American population is still without access to insurance, and the inequality is still very present. In Keith Wailoo’s article he proposes the idea of a “pain gap between the haves and the have nots,” he speaks of a study conducted in an Atlanta emergency department stating “white patients being treated for long bone fractures were dosed more liberally than black ones.” This study shows evident inequality in pain treatment and assessment.

On any given day, thousands of people enter the doors of trauma centers, with one purpose: to seek care for an injury or illness. Being a healthcare facility, the physician and staff cannot ask to see proof of insurance before treating that patient. Instead the hospital must incur the cost of that physician's time and any supplies used to treat the uninsured patient. If the proposed patient was insured the injury or illness could possibly have been treated within the office of a primary care physician, instead of an emergency room. But, if they cannot afford the care, how are they expected to prevent the illness, and conversely how are they expected to be able to afford the outrageous cost of insurance? N. F. Hanna, from the *New York Observer,* states that, "A study in *The American Journal of Medicine* found that 62 percent of all 2007 bankruptcies, using a conservative definition, were medical bankruptcies." Hanna has been a practicing physician for over forty years, and draws on his own experience to point out the flaws in the healthcare system. His patients, day in and day out, face neglect due to their financial inability to afford health insurance.

Assuming the uninsured seek care at formalized healthcare institutions, who pays for that care? Essentially it is the government's responsibility, but where does that money come from? An article posted in connection with the Cleveland Hospital states: "As the recession cuts into tax receipts, Medicare's giant hospital trust fund is running out of cash more rapidly and could become insolvent as early as 2016. At the same time, the government's already large share of the nation's health care bill will keep growing" (Higgs). Fortunately the entire Medicare system has yet to dry up, but it is still a struggling system. Many of the middle aged Americans that are paying into the Medicare system fear for its existence when their time comes to withdraw their benefits. This poses the question to many: who will pay for all of this healthcare related debt, and how can we keep from accumulating more debt?

In the same article posted by Robert Higgs it is stated that "healthcare costs will average $8,160 this year for every man, woman and child." It is absurd to think that a mother and father can both pay the bills, keep food on the table, and pay for health insurance for the entire family on an average household income of just over $40,000.

Health insurance is considered an amenity when applying for a job, but if someone is self employed or unemployed then the insurance policy is the responsibility of that individual. In their research on healthcare reform, Moore and Coddington point out that "higher health insurance costs lead to more uninsured, which leads to more cost shifting, which then leads to still higher health insurance costs" (75). If an individual is required to pay for their own insurance, we should not cripple them by making it virtually impossible to afford it. More people would be insured if it were a non-negotiable inclusion in job benefits, or if it was cheaper to obtain. If employers were required to provide it without gouging their employees, then the number of uninsured would be cut substantially. Moore and Coddington propose a way of combating the unaffordability of health insurance, stating: "these proposals call for phasing out the purchasing of health insurance by employers, replacing it with direct purchases by households. These proposals achieve universal coverage either by mandating that everyone purchase insurance or by providing a safety net plan for everyone who doesn't submit proof of insurance" (76). The statement made by Moore and Coddington proposes household coverage versus individual or workplace sponsored plans. This plan would create a more equal playing field with all families having the same, or similar plans therefore alleviating the inequality of care within the healthcare system. If the plan is a household plan versus a workplace plan, then the family can tailor their plan to fit their specific needs. A family with a chronically ill child can have a plan that provides for a cheaper specialized care deductible, and a family with a member

diagnosed with cancer can tailor their plan to have a lower copay for prescriptions. Equality and control of one's own plan go hand in hand. The nationalized healthcare plan should be a household sponsored plan paid for by the federal government, and if you want more coverage then everyone else you can cover the cost differential. By doing so, that would lay out an equal playing field for all Americans, minority or not.

The Affordable Care Act is a healthcare plan that was released during the Presidency of Barack Obama. The goal of the Affordable Care Act is to provide better healthcare to all parties at lower costs. Yet there are more flaws in this plan then expected. Hammer, Phillips, and Schmidt state in their essay "The Intended—and Unintended—Consequences of Healthcare Reform" that in respect to the Affordable Care Act issues include the "removal of lifetime caps on coverage/ payments, discontinuance of restrictions on annual limits, discontinued payment of over-the-counter medications, and the elimination of retiree health subsidies" (51). Not only are there many side effects to this legislation, the Affordable Care Act requires people to be insured, or suffer a substantial fine. Not only is insurance expensive, but now if you cannot afford it then you will be fined a large amount, and the states are individually not required to implement the legislation that comes along with the Affordable Care Act. If the Affordable Care Act causes more issues then there were prior to its existence, it should in turn be taken out of commission, and a nationalized healthcare plan should be considered. The proposed insurance component that accompanies the legislation is suppose to make it possible for everyone to be insured, via Medicare, Obamacare, or Medicaid, but when there are so many gaps in the coverage provided under the legislation, and states choose not to implement it more times then not the patient is better off just being uninsured and incurring the fine that comes with not being insured. There are so many rules, regulations, and qualifications to receive one of the above mentioned forms of

insurance that oftentimes, uninsured people do not even qualify for one of the plans. Under a nationalized plan, all people would qualify for the plan regardless of sex, religion, ethnicity, etc. The problems that arise with a nationalized healthcare plan are who is to be responsible for paying for the coverage, and what company gets to provide the coverage, so as to not create a monopoly insurance company.

This problem is not just an issue directed towards the consumer, or the patient, but rather to the providers as well. Hammer, Phillips, and Schmidt argue that "providers should understand the consequences of reform—intended and unintended—and make the necessary changes to improve access to high-quality care for all Americans" (55). If a physician or healthcare practice is going to require something of their patients, they need to fully understand the repercussions and also financial responsibility they are imposing on those patients. If the provider requires a certain plan to be seen by the physician, make sure it is an affordable plan that all the patients can obtain without cutting needed benefits. If both the consumer and the provider work cohesively, the access to medical treatment would be possible, at an affordable price without cutting components that are so pertinent to the consumer.

Madison Park of CNN writes that "[s]ince establishing a national health plan in 1999, Rwanda has insured about 91% of its population with health care—a greater percentage than the United States." Voters need to understand that there are other options out there besides just the ones we are spoon-fed by the government. It is possible for almost entire nations to be covered under one nationalized healthcare plan, and if we advocate for this kind of legislation we will help to cease the inequality that is so ever present in the healthcare field.

In conclusion, the failing healthcare system within the United States must be adapted to better serve the people with which it seeks to support and treat. In an article in *Orthopaedic Nursing*, Judith Erlen argues:

> Groups experience health disparities because they are unable to afford and cannot access healthcare services. They have a mistrust of the healthcare system and lack knowledge about prevention of disease, risk reduction, and health promotion. Similar to the late nineteenth-century immigrants in the Lower East Side of New York City, these populations are vulnerable and need advocates. Healthcare reform is necessary to address existing health disparities and therefore improve healthcare access, increase services, and ultimately enhance health and quality of life. (184)

Just as the nineteenth-century immigrants were not advocated for, many American minority groups lack an advocate. There is no one to fight for equality within the healthcare system, to make health insurance more affordable, or to amend the gaps that have so careless been overlooked within the Affordable Care Act.

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