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Health & Medicine, Healthcare

Is There an Inherent Right to Healthcare in the U. S.?

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This review is based on the analysis of the paper by David Orentlicher, outlining the inconsistency and instability in the U. S. Healthcare system in the current scenario. The explosion of chronic illnesses such as diabetes and heart disease are on the brink of overturning the current structure of the national healthcare insurance system in the U. S. At the very outset, this paper disagrees with the suppositionthat there exists an inherent right to healthcare in the U. S. The reasons for adopting this surmise, as well as steps taken to ensure a positive rehaul of the healthcare plans in the U. S. have been reflected upon, going forward.

Reasons why Right to Healthcare has secured a reluctant place in the United States

Following a historical pattern of granting negative, rather than positive rights to its citizens (Wideman vs. ShallowfordCmty. Hospital), the U. S. legislative system confers full autonomy on individuals to exercise free choice, yet does not constitutionally confer on the government the duty of facilitating or driving individual autonomy to gain implementation (Orentlicher, 2012, p. 327). This leaves no room for most people (including prisoners and mentally ill patients alike) to access healthcare, and eventually rely on statutory rights for the same (Orentlicher, 2012, p. 327). This need of the common man for healthcare services, led to the emergence and evolution of Medicare and

Medicaid born out of a necessity to implement national health insurance in the United States. These services went through a process of evolution of more than fifty years, before healthcare could be accepted as a right as late as in 1965. Medicare beneficiaries were brought under the ambit of this healthcare scheme owing to their lifelong work and fiscal contributions, making all senior citizens proud and privileged recipient of the services under the same. Even innocent children, for no fault of their own, were not considered under Medicare. On the other hand, Medicaid privileges were extended to people who were not held accountable for their lack of insurance, and that included children, disabled persons and single-parent families (Orentlicher, 2012, p. 330, 331).

There are many ways in which these “ rights” granted to the Americans ceased to be rights in the sense of the term.

Medicaid program –Under this program, only persons who fulfil the stipulated coverage categories for availing the benefits of this program, which includes children, pregnant women, parents with dependent children and disabled persons. The irony of this categorization is that, children are brought under the ambit only when family incomes are abysmally low (i. e. upto 200% of the national poverty level) while leaving out parents, despite family income being as low as less than 50% of the national poverty level. Moving past this flawed categorization, it has failed to extend coverage to many who are even eligible for it. This is owing to its screening process, requiring interested people to first qualify for the same. This can cause awkwardness and a feeling of loss of dignity in such people, who would rather forego the benefits than subjecting themselves to such screening on a public scale. This could

have been avoided in the existence of a universal right to healthcare under the same scheme (Orentlicher, 2012, p. 331-332). Unlike the Medicare program, Medicaid is dually funded i. e. by the central government as well as the state. This is based on the decision and calculation of each healthcare spending in each individual state and accordingly, varies from one state to another. Here also, we see that there is no consensus of the legislators' opinion on how funding should be provided to citizens, without any discrimination whatsoever. The quality provided is also below the mark, as physicians under Medicaid are paid far lesser than those under Medicare, making it a risky ground for people wanting to access benefits under the same. It is also ironical that the very factors of poverty that make people eligible under Medicaid, are disregarded when it comes to making these benefits available to such persons. Simple factors as assistance in transportation facilities may be needed by these people who cannot afford the same (Orentlicher, 2012, p. 333).

EMTALA (Emergency Medical Treatment and Active Labor Act) – This Act provides medical care to persons in active labor or severely crisis-based situations. However, this too does not guarantee complete treatment, and physicians need only stabilize the patient's condition, without fully treating it (Orentlicher, 2012, p. 335).

The entry of the Affordable Care Act, on the other hand, makes tall promises of providing coverage for all individuals with family incomes up to 133% of the federal poverty level, and the rest with income levels between 133 to 400% shall be eligible for subsidies. However, even under the ACA the earlier problems of federal-state dual funding shall continue, availability of

physicians willing to treat people shall still remain at risk and subsidies may still not make the way for people looking to access private healthcare (Orentlicher, 2012, p. 335).

Thus, in these myriad ways the American Constitution limits the applicability of the word ‘ right’ in as much as such limitations run rampant in even the UN Charter, which puts a bar on rights in the same vein it grants the same. The 1966 UN International Covenants on Civil and Political Rights as well as the 1948 UN Universal Declaration of Human Rights, are testimony to this arbitrary curtailing of rights, subject to core principles and law and order mechanisms functioning under the UN (Faria, 1999). Thus, we can see that there exists no inherent right to healthcare in the U. S. as it is marred by countless limitations and obstacles deeply entrenched in the policies political agenda of the government.

The next section charts the researcher’s opinion on how the current national health insurance programs can be improved and what can be done to achieve the same. A brief light shall be shed on the concept of ‘ right’ in the healthcare system and how this can impact the healthcare structure as a whole.

A New Road to Better Health for All

Healthcare access can be increased in a number of ways, so as to amplify economic efficiency that has posed as a major roadblock in extending universal healthcare in the nation. First, the use of emergency rooms should be restricted to severely crucial health conditions of patients brought in, which will further save the system tons of dollars (Kao-Ping Chua, 2005-

2006). From decades before, the Medicare and Medicaid programs extended benefits to people with a view to treating their illnesses. There never has been a scheme in the U. S. for preventive care, which can actually lead to a more cost-effective process in making universal healthcare possible. Added to that is the staggering number of 32 million people added to the insurance schemes under the newly established ACA, will not only render the overall system to explode but also cause strife and tension among healthcare professionals in effectively treating this rising number. Chronic illnesses such as diabetes, heart diseases, cancer, kidney disease etc. being on the rise today, the numbers of relatively young people coming in with the old-aged people for treatment, will surely drive the system to go into chaos (Goodman &Norbeck, 2013). This can be avoided if preventive care is extended to everybody, irrespective of their categorization under state and federal-funded schemes. The ones who are uninsured and are likely to face the music, shall be particularly advantaged by this. Even with the advent of the ACA, the frequent use of healthcare in these changing times, coupled with technology-driven tools in the treatment of patients is likely to another percent to the already exploding 18% of GDP contributing to healthcare in the U. S. Certain discrepancies in the dispensation of medical services should be removed, in the sense that the payment to physicians under Medicare and Medicare need to be brought at par. Under Medicare, physicians are paid substantially more for offering their services in the hospital or hospital owned unit, than treating patients in the privacy of their homes or offices. This is owing to the coverage of the hospital fee by the government in addition to the doctor’s fees, and is further exacerbated by the provisions

under the ACA. This needs to be resolved at the very outset in order to prevent healthcare professionals from being compelled to operate in the hospitals, thus making healthcare even more expensive. The powerlessness physicians experience in treating patients and changing rules of government-owned hospitals needs to be addressed, in order to extend proper medical benefits to all (Goodman &Norbeck, 2013). Making healthcare available to the poor (under Medicaid) and bracketing these benefits, as also caused a sense of exploitation in the people who can afford healthcare services via health insurance provided by their employers and feel they under-use these benefits.(Orentlicher, 2012, p. 337). Similarly, under ACA, access to healthcare is dependent on the fact that the financially well-off continue to bear the health expenses of the poor, and maintain this stand even in the face of rising healthcare costs (Orentlicher, 2012, p. 342). Universal health care on a uniform standard, with cost-cutting in place is the key to resolving this problem.

Another reason for the failure of the current system in America is owing to partnerships between federal and state governments. The actual decision on healthcare spending is left to the states, and in the unwillingness and budget controlling exercised to spend on healthcare, the numbers of the uninsured keep rising (Orentlicher, 2012, p. 342). The federal government can tie up with hospitals, physicians and organizations willing to provide medical care to citizens, rather than simply providing coverage. In extending universal access to healthcare, the government can either extend universal coverage, letting people choose their mode of care and their physician; or, provide a voucher to everybody to purchase health insurance, and get services the

worth of the lowest-priced private coverage plan, paying for the rest on their own. This standardized system of voucher would also prevent insurers from charging over and above the lowest plan, in accordance with federal mandates. This will immensely incentivize the process and keep the system in check, while providing healthcare services to all (Orentlicher, 2012, p. 346).

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