Social policy for the uninsured

This social policy paper presents one of the major health issues that the country is facing today and that are Insurance for the Uninsured patients.

This paper discusses the: The Policy and Its Beneficiaries, It’s Use, The Early Policies for the Uninsured, The Current Policies for the Uninsured, The Society’s Response, and Analysis of the Policy’s Validity. The Policy and Its Beneficiaries The uninsured” is a term that is coined to people who don’t posses any form of insurance who primarily include paperless immigrants, minorities, children and or teenagers without insurance, employees of small businesses, people who belong on the lower part of the social strata and also a significant number of the elderly. In effect, such a group of people suffered a lot in terms of seeking and receiving the health service that is necessary to prolong their lives. Corollary with this, are the disposition of those patients who initially have a health insurance but experience a significant degree of difficulty in terms of having the insurance company subsidize the treatment and or operation that is necessary for their health condition.

Such a problem creates an ethical dilemma on the end of the doctors, patients, insurance providers and also the courts (Jost, 1998). It’s Use The bill that was passed on 1960 which eventually legislated on 1965 paved the way for the establishment of the Medicare and the Medicaid. Medicare caters to the elderly which insured the hospitalization and other doctor services that are necessary; on the other hand, Medicaid emphasized on the needs of the marginalized and the disabled. The Medicare and the Medicaid resolved all conflicts between the hospitals and the government because of the assurance of monetary funds for those who are insured and the paying of services which are formerly given free or in a reduced fee. However, critics

of Medicare and Medicaid counter argued that such insurances are too costly; hence a new initiative was raised by a physician in Minnesota which is now known as the Health Maintenance Organization (HMO) (Jost 1998, 107-108).

The Early Policies for the Uninsured The depression that happened during the 1890’s paved the way to the proposal to cater to the health needs of the unemployed. The state demanded for state-sponsored saving plans in order to aid the displaced wage earners. In effect of this, a short-lived unemployment insurance company was created in Chicago (Nelson, 1969, p.).

It is also during this era that on R. Commons, a staff member of the Industrial Commission appointed by Congress in 1898, perceived unemployment as the most serious of all industrial problems, hence the root of most of the country’s social problems including the health care of citizens. On 1901, at a convention that happened at the American Economic Association, Charles A. Tuttle, a professor at Wabash College, proposed a plan of indemnification for workers displaced by new machinery, a system similar to what would later be known as unemployment insurance. Tuttle claimed that since the workers are the ones who are primarily affected by the changes in technology, it is only noteworthy that they will be given benefits for certain problems that stemmed out due to certain accidents (p. 5).

As such, it could be said that before the 1950’s the earlier forms of managed health care are organized and employers started to give hospitalization to their workers. On the turn of the 1960’s the Federal government establishes

the free health insurance for the elderly such as the Medicare and a joint state-federal program to provide health care for the marginalized people (Medicaid). On the 1970s the Nixon administration then introduced the HMOs in order to reduce costs. During the 1980s HMOs has been increasing its costs in a rapid manner that is why wealthy Americans are only the ones who has the capability to afford insurances. It is only on the turn on the 1990s that former President Clinton proposed the National Health Security Act in 1993 that aims on providing insurances to all Americans including the uninsured, however such a bill has died later on in Congress (Jost, 1998, p. 107).

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The managed health care proved to significantly reduce costs, and by 1995, it was estimated that 150 million Americans have their HMOs. However, conflicts between doctors and patients emerged when allegation such as doctors and HMO administrators have created some sort of incentive programs which would make the latter diminish its recommendations for certain medication, treatments, or operations. Such a case paved the way for a direct refusal for the needed medical care, treatment and operations. In addition, complaints such as delays on the release of authorization and/or funds were also cited (Jost 1998, 109). The Current Policies for the Uninsured Initially, insurance is something that is only made available to wealthy Americans.

On the turn of the 20th century, there have been two major changes which took effect in terms of how insurances are disseminated. The rise of the private insurances and the government subsidized insurances has seemed to provide a temporary solution on the problem of inequality in terms of health services. Such an initiative has caused companies to provide insurances to their employees and by 1950’s almost two thirds of the population already have insurance. Due to the relative availability and accessibility of the population to insurance, some segment of the population were forgotten, hence the uninsured (Jost 1998, p. 06).

Initiatives on the part of the government were introduced in order to solve this problem. General welfare programs during the 20th century were also introduced in order to cater to the marginalized. In addition, a New Deal program was also made available to the population living in the rural areas. On the span of the 20th century, progressive and labor interests asserted the

necessity of compulsory national health insurance, but such efforts were hindered by a number of significant and powerful institutions in the country such as various business interests and the medical profession in itself (Jost 1998, p. 06).

Current policies on the use of the United States health care policy have faced a lot of changes. For instance, Keith Epstein (2002) has presented the issues of uninsured patients which normally are comprised of young adults (p. 524) and minorities (p. 529). Epstein touched three major issues in which is comprised of the question weather the United States can afford health insurance for all; if Medicare should cover the prescribed medicines for the marginalized senior people; and if small businesses could band together to apply for the insurance of their employees in order to reduce its costs. The fist issue was addressed by Epstein by arguing that since the passing of the Balance Budget Act of 1997, there has been a huge cut back on medical costs.

Medicare has cut on reimbursement and some states have also cut on Medicaid payments. However, Young (President of the Health Insurance Association of America) as cited from Epstein, claimed that America can do afford insurance for all if it only has the will power. Young emphasized that the uninsured has already been subsidized due to the increase of costs in insurance payments and also for hospital services because initially, these insurance companies and hospitals are adding up their costs in order to cover for uninsured patients. Solutions in subsidizing the uninsured in terms of taxes are also one of the solutions that he presented (p. 526).

The issue in subsidizing the marginalized seniors' drug prescription has also been tackled as could be resolved by having the government subsidize a certain percentage of the price by those seniors of having the salary cap of less than $13, 000. However, part of the issue is the lack of funds or the possible soar of the taxes in order to subsidize such a change. The third issue is with regard to the passing of a bill which would allow small companies across states to band together in order to apply for insurance for their employees and consequently to reduce costs. Such an idea according to Lehnhard, (Blue Cross Senior Vice President) would only provide temporary savings on the end of these small companies because since the associations will not be regulated by the state rules, it is possible that such companies would engage in discriminatory underwriting. An example that was given is that there might be some cases wherein the program would encourage health people from joining, and unhealthy people from not joining (p. 530).

The Society's Response It could be significantly noted that although the government has catered on the needs of the uninsured, there are a couple of problems that the society perceived on the implementation of such a policy. Jost emphasized that the one of the primary dilemmas of patients were brought forth due to the unfavorable outcomes that stemmed out due to the request of some patients to choose their own physicians. The primary purpose of the manage health care plans is to reduce costs, however, patients when needed a specialist that they perceive to cater more to their condition, the aforementioned suddenly realized that such would pave the way for the further increase of fees amongst the health plans, in addition to

the payment that the patient has to shoulder. Some health care plans intentionally limit the number of physicians that the patients can choose from so that referrals for treatment, medication and or operations could be regulated by the company, hence reducing costs and increasing profits.

However, some health care plans allow their consumers to apply for a Point of Service (POS) which will allow them to choose their own doctors; only for an added fee. Albeit, it is noteworthy to say that even though some patients are disappointed with such a kind of set-up among health care plans, there are some statutory laws imposed by some 30 states for pregnant women, allowing the latter to select an obstetrician that could act as their primary health care provider (p. 101-103). Another criticism that the society perceived with the current health care system is with regard to the malpractice that is being conducted by in-house physicians, which on a legal perspective provides various complications on how patients could file suit.

For instance, in cases of malpractice, the current system views the physician alone to be liable to the damages done to the patient and makes the managed-care plans company exempted from the legal repercussions. The case presented was that of Ron Henson, who died in Kaiser Permanente Hospital and later on sued HMO. The conflict stem out due to the claim of Mrs. Henson that Kaiser controlled the costs of her husband’s treatment by limiting hospital admission in cardiac cases. The society is also wary on the privacy and ethical issues that stemmed out of the policy that allows the government to have full access to uninsured patient’s files.

The importance of disclosing medical information for the patient’s health purposes alone (Shalala, 1998 as cited from Jost 1998, p. 105) and for government use for health and law enforcement has been criticized as further broadening the law for access for medical records. The proposal set forth by Shalala has been criticized due to favoring the government to have more access to medical records, hence a possible case of invasion of privacy. However, Shalala have emphasized that such a proposal is only a more clear interpretation of the law that currently exists. Analysis of the Policy’s Validity The main area of concern that this analysis focused upon is: Has the government effectively cater to the medical and health needs of the uninsured? According to the statistics, the uninsured comprises of 23 million male, 20 million female, in which 21 million are white, 13 million are Hispanic, 7 million are black, and 2 million are Asian or Pacific Islander (Tunzi, 2004, p.

1357). Given the number of policies by different states, the government, non- government organizations and the initiatives of the hospitals and other health facilities, could it be significantly deduced that such endeavors could be deemed as effective and or could be projected as having a long-term feasibility given the complex interplay of various determinants of the subsidy and care for the uninsured? The author have gathered evidences based on the following factors: first would be the nature and extent of the problem; second are the particular features of the policy for the uninsured and third are the assessments of the policies that gave been formulated by other individuals on a policy that is similar to such (Bardach, 2000, p. 8). The

problem of the uninsured has been something that the government has been seeking to solution since the last century.

However it appears to be that the proposals from the time of Roosevelt all the way to Clinton all remained to be rarely enacted (Epstein, 2002, p. 532). The US Census Bureau in September 2003 documented that on 2002, 43. 6 million Americans did not possess any type of insurance which then marks a 2. 4 million increase from 2001.

As such, it has been deduced that the sluggish economy and the budget deficits of the state and local government have mainly caused such a problem (Tunzi, 2004, p. 357). Contrary to the notion that majority of the uninsured population came from the deeply marginalized, the US Census Bureau on 2002 revealed that 80% of these population came from working families. On such, 20 million of them are working full-time; 6 million have been working part time and 9 million of which having a family wherein at least one person is insured (Tunzi, 2004, p. 1357). If that is then the case, then how come these people don’t have any insurance? Tunzi claimed that the primary reason of such is due to the fact that only two thirds of Americans are given insurance by their companies.

In relation with this, 20% of uninsured individuals could not afford employer-based health coverage whenever such is presented. Corollary with this is that 50% of uninsured came from families that are under the 200% of the federal poverty level. These are families of four which are only earning $34, 100 per annum (Tunzi, 2004, p. 357). For the purpose of this policy analysis,

the author focused on three major health insurances: Medicare, Medicaid and HMO.

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Such an idea appealed to the government, hence on 1973, the Health Organization Maintenance Act of 1973 was passed. The managed health care proved to significantly reduce costs, and by 1995, it was estimated that 150 million Americans have their HMOs. However, conflicts between doctors and patients emerged when allegation such as doctors and HMO administrators have created some sort of incentive programs which would make the latter diminish its recommendations for certain medication, treatments, or operations. Such a case paved the way for a direct refusal for the needed medical care, treatment and operations. In addition, complaints such as delays on the release of authorization and/or funds were also cited (Jost

1998, 109). As such deducing from all of these premises, it could be said that the current health insurance policy has not been very effective.

However, Young (President of the Health Insurance Association of America) as cited from Epstein, claimed that the United States can do afford insurance for all if it only has the will power. Young emphasized that the uninsured has already been subsidized due to the increase of costs in insurance payments and also for hospital services because initially, these insurance companies and hospitals are adding up their costs in order to cover for uninsured patients. Solutions in subsidizing the uninsured in terms of taxes are also one of the solutions that he presented (p. 526). The issue in subsidizing the marginalized seniors' drug prescription has also been tackled as could be resolved by having the government subsidize a certain percentage of the price by those seniors of having the salary cap of less than $13, 000. However, part of the issue is the lack of funds or the possible soar of the taxes in order to subsidize such a change.

Conclusion " The uninsured" is a term that is coined to people who don't posses any form of insurance who primarily include paperless immigrants, minorities, children and or teenagers without insurance, employees of small businesses, people who belong on the lower part of the social strata and also a significant number of the elderly. In effect, such a group of people suffered a lot in terms of seeking and receiving the health service that is necessary to prolong their lives. Corollary with this, are the disposition of those patients who initially have a health insurance but experience a significant degree of difficulty in terms of having the insurance company subsidize the treatment and or operation that is necessary for their health condition. Such a problem

creates an ethical dilemma on the end of the doctors, patients, insurance providers and also the courts.

The author have deduced that the health care industry of the country has not been very effective due to its dilemma in terms of distributing fairness in terms of the allocation of health services that is due not only to every American citizen but also to other races who lives in the country as well. Such a growing injustice in the health industry has been attempted to be solved many times starting from the nurse advocates, the hospitals, non-government organizations and also the government as well. However, even though more than seven decades has passed since the necessity of insurance was perceived, the government still is quite slow in terms of providing solutions to the health problems of its citizens. The budget deficit has been blamed due to the lack of monetary support, however, it is very evident that the government’s finances were clearly improperly allocated to certain war endeavors which a number of critics have argued to be null on the first place.