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Health Care Inadequacies for Disabled Americans

Abstract
In lieu of an abstract, below is the first paragraph of the paper.

Many disabled individuals, including the mentally retarded, the physically disabled, and the elderly, face constant erasure in American society. Rarely, if ever, are people with disabilities portrayed in television commercials, and if they are ever present in a movie or television show, they commonly portray such disabled stereotypes as "supercrips." They also must face many unnecessary difficulties, including discrimination in the workplace, various abuses, and a lack of handicap accessibility. One of the most difficult aspects of life for a disabled American, however, is the inability to receive adequate health care, which commonly causes physical, financial, and emotional distress. In comparison with such countries as Canada, the United Kingdom, and Japan, all of which have universal health care systems, the United States has a long way to go in terms of caring for some its most vulnerable citizens. Americans with disabilities would benefit greatly from a universal health care system, such as the ones in Canada, the United Kingdom, and Japan. Whether an individual has a mental retardation, is growing older, or has a physical disability, a system such as this would provide equal care to all citizens and, further, would make America a better place for everyone overall.
Health Care Inadequacies for Disabled Americans
Emily Housecamp

Many disabled individuals, including the mentally retarded, the physically disabled, and the elderly, face constant erasure in American society. Rarely, if ever, are people with disabilities portrayed in television commercials, and if they are ever present in a movie or television show, they commonly portray such disabled stereotypes as "supercrps." They also must face many unnecessary difficulties, including discrimination in the workplace, various abuses, and a lack of handicap accessibility. One of the most difficult aspects of life for a disabled American, however, is the inability to receive adequate health care, which commonly causes physical, financial, and emotional distress. In comparison with such countries as Canada, the United Kingdom, and Japan, all of which have universal health care systems, the United States has a long way to go in terms of caring for some of its most vulnerable citizens. Americans with disabilities would benefit greatly from a universal health care system, such as the ones in Canada, the United Kingdom, and Japan. Whether an individual has a mental retardation, is growing older, or has a physical disability, a system such as this would provide equal care to all citizens and, further, would make America a better place for everyone overall.

The United States defines disability in a very extensive way. In the U.S. Department of Health and Human Service's publication of, "The Disabled: Their Health Care and Health Insurance," disability was described on seven levels. Level I disability "is the inability to perform basic life activities or ADLs without the help of another person" (2). ADLs are such basic things as walking, getting in or out of bed, and personal needs, such as dressing. Level II disability is a slightly worse category, which is the inability to live independently because of being unable to do light housework or to prepare meals. Level III disability is a category for individuals who do not need assistance from others but are unable to see, hear, lift ten pounds, walk three city blocks, climb a flight of stairs, or have difficulty with two ADLs (2).

Level IV disability is a category for persons with difficulty (but no inability) with two or more activities such as seeing, hearing, or climbing a flight of stairs. Level V disability includes persons with disability but no inability with such activities as seeing, hearing, or climbing a flight of stairs. Level VI disability includes persons with no limitations at all in functioning. Lastly, children's disability "was defined ... to include those (under age 18) who either had: a long-lasting physical condition which limited the ability to walk, run, or play or a long-lasting mental or emotional condition, which limited the ability to learn or perform regular schoolwork" (3). In the document, however, the numbers that were provided with each of the levels of disability seemed to be suggesting that, for example, only 3.7% of all children fit into the category of children's disability. However, when 3.7% is the equivalent of over 2 million children, the number should not be downplayed.

According to the United Kingdom's publication of, "Disability, poverty and development," disability is a "long-term impairment leading to social and economic disadvantages, denial of rights, and limited opportunities to play an equal part in the life of the community" (2). This definition of disability is clearly adopted because of the context relating to poverty. Finally, on Canada's official "Industry Canada" website, disability is broken into categories, cognitive impairment, deaf-blind, dexterity impairment, elderly, hearing impairment, learning disability, mobility impairment, speech and language impairment, and visual impairment. Specifically, cognitive impairment is described as an impairment that, "affects the ability to think, concentrate, formulate ideas, reason and remember. It is distinct from a learning disability insofar as it may have been acquired later in life as a result of an accident or illness." Another example is of dexterity impairment, which is described as, "Reduced function of arms and hands makes activities related to moving, turning or pressing objects difficult or impossible. This does not influence speech communication itself but
makes it hard to make a phone call or use a wide range of other equipment.” It is interesting to compare the differences in definitions because each is so different. No specific conclusion can be drawn from their differences, but it is important to recognize how each country views disability before digging deeper into their particular systems for taking care of those individuals with disabilities.

Upon understanding the different definitions in place, the differences in health care systems can be better understood. The health care system in the United States is extremely different from universal health care systems and is an unfair system for people with disabilities. As described in filmmaker Michael Moore’s documentary, “Sicko,” the United States uses a managed care system and requires individuals to seek out health insurance for themselves. Although some employers provide health benefits, those Americans who work somewhere that does not provide health care are expected to either go without or to find it for themselves. Unfortunately, health insurance companies frequently deny people access to insurance in the first place if they have pre-existing conditions. People with disabilities must, therefore, face extensive searches to find an insurance company that will accept them. After that, physicians are hired by these insurance companies to literally search for reasons to deny another physician’s claim.

An example of this is Linda Peeno, a medical doctor who was employed for many years as a medical director in an unnamed HMO. In 1996, Dr. Peeno confessed to the U.S. House of Representatives that as medical director, her job was to go over requests from doctors all over the country and find “holes” in their reasons for wanting a particular procedure to be covered by insurance. One of the most common reasons for denial, she suggested, was for surgeries that were considered to be “experimental” (Sicko). Specifically, Dr. Peeno confessed the following:

In the spring of 1987, as a physician, I caused the death of a man. Although this was known to many people, I have not been taken before any court of law or called to account for this in any professional or public forum. In fact, just the opposite occurred: I was "rewarded" for this. It bought me an improved reputation in my job, and contributed to my advancement afterwards. Not only did I demonstrate I could indeed do what was expected of me, I exemplified the "good" company doctor: I saved a half million dollars! (Peeno)

In a universal health care system, an event such as this would be unable to occur because of the overall structure. Health insurance companies would simply not exist, and no physicians would therefore be hired to such a thing as Dr. Linda Peeno did. Additionally, people with disabilities, who are commonly subject to various procedures, would not have to live in fear of being denied.

Universal health care is a system much different from the managed care system in place in the United States of America. Understanding the differences between the two is an extremely important aspect of understanding why universal health care would benefit people with disabilities in a much more positive and significant way. The National Coalition of Health Care describes the Canadian health care system in the following way.

Canadians do not pay directly for insured services; there are no deductibles, co-payments or dollar limits on coverage for covered services, which are defined as “medically required services rendered by medical practitioners,” including procedures performed by a dentist in a hospital setting. Individual provinces and territories may also cover services beyond those specified by the Canada Health Act; they may include prescription drug coverage, vision care, medical equipment and appliances. In general, non-essential services such as cosmetic surgery are not covered (NCHC 2).

The universal health care systems that are in place in the United Kingdom and in Japan work in much the same way; no individual is responsible for a necessary medical treatment. The only time that medical care is not guaranteed is for “non-essential services,” including cosmetic surgeries. Unfortunately,
many services in the United States that are essential are proven to be non-essential because of the greediness of the Insurance companies and the verdict that they are “experimental.” It is especially necessary for disabled Americans to have health care to rely on because they are more likely to be attending a doctor’s appointment or having surgery of some kind.

According to the American Medical Student Association (AMSA), who believes in implementing a universal health care system to the United States, “We live in the richest country in the world, yet many have no health insurance. Research shows that health disparities are rampant in America.” In fact, the AMSA mission statement says, “The American Medical Student Association is committed to improving health care and healthcare delivery to all people.” The use of the phrase “all people” is the cornerstone of universal or nationalized health care because American tax dollars would pay for the medical care of all citizens, instead of expecting individuals to take care of finding coverage themselves. Under a universal health care system, every family would receive health care that they could count on for a lifetime. People would no longer lose their life savings to pay for an expensive surgery or treatment, as people so often do in the United States, and physicians and patients would make patient care decisions, not insurance companies (AMSA).

Universal health care systems are supportive of people with disabilities in many ways; emotionally, physically, and financially. First of all, not having to worry about whether a medication or surgery would be covered from a health insurance company is much less of an emotional burden. Physically, the treatment of people with disabilities is automatically higher in quality when it is the “physicians and patients making patient care decisions, not insurance companies” (AMSA). Lastly, the large financial burden would be much less if an individual did not have to pay for every form of treatment in the hopes that the insurance company would cover it. Instead, medical treatments would be paid for by the tax dollars that are devoted specifically to health care.

People with disabilities would emotionally benefit from a universal health care system. These emotional benefits would begin when a person with disabilities would not have to seek out his or her own insurance policy. Trying to find insurance that would accept someone with a pre-existing condition would be difficult enough, but once an insurance policy was found, a frequent concern would be in trying to pay any additional costs and in worrying about whether or not a procedure or a medication would be covered by the insurance. In a universal health care system, none of these stresses would exist. There would be no such thing as insurance companies, so no stress would be involved for any of these reasons. Medical expenses would be taken care of, and no disabled individual would have to make the decision between a medical treatment and their life savings or retirement.

People with disabilities would physically benefit from a universal health care system. Individuals and organizations who are against universal health care for the United States commonly use the argument that the quality of the care, directly affecting the physical success of a disabled American, would decrease significantly if all citizens were given the right to health care. The statistics, however, speak for themselves. In fact, “Studies show that citizens in universal health care systems have more doctor’s visits and more hospital days than in the U.S.” (Battista). Furthermore, “Access to health care is directly related to income and race in the United States. As a result, the poor and minorities have poorer health than the wealthy and the whites” (Battista). People with disabilities are often poor and are certainly a minority among the American population, and this argument completely supports the idea that people living with disabilities in the United States are already at a great disadvantage for services because of their medical conditions. Lastly, the myth wrongly claims that, due to the increase in demands, there would simply not be enough equipment of physicians. The fact is, though, that we have a surplus of approximately 30%, and the increase in services would be about 15% (Battista). For Americans with disabilities, there would be no reason for concern about the possibility of not receiving quality care.
People with disabilities would financially benefit from a universal health care system. According to “Disability, poverty and development,” a publication from the British government department for international development, “The cost of disability has three components: the direct cost of treatment, including the costs of travel and access; the indirect costs to those of are not directly affected; the opportunity costs of income foregone from incapacity.” Additionally, it is estimated by the UN, that 25% of the “entire population is adversely affected in one way or another as a result of disabilities” (DFID 4). With universal health care in place, the cost of having a disability is extremely high and having all medically related care taken care of would be of major financial benefit to people with disabilities.

The United States provides many federal programs and ways to care for its disabled citizens, but the numerous “loop holes” suggest that disabled Americans would benefit more from a universal health care system. Federal program from the United States of America include Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), Veterans’ Disability Pensions, and Medicare and Medicaid (Adler 1). According to the U. S Department of Health and Human Services 1990 document entitled, “The Disabled: Their Health Care and Health Insurance,” “Looking only at non-elderly persons with disabilities, $85 billion or about 7.7% of all Federal outlays were spend for programs targeted on disability during fiscal year 1989” (Adler 1). Although this amount has increased over time, the fact remains that this money could be designated specifically for a nationalized insurance plan and therefore be distributed more evenly throughout the disabled population. Furthermore, the 11 million disabled and elderly Americans who are unable to work receive a maximum of $579 a month with Supplemental Security Income (SSI). The payments per month can even run as low as $200, which is expected to cover the cost of housing and food, let alone any medical needs. In order to be eligible to receive SSI as a disabled or elderly individual who is unable to work, there must be a limit of outside income and assets, “for example, never more than $2,000 in savings or cash” (Sparks-Meyers). The United Kingdom government has recently implemented a new plan for the disabled, including, “a reduction by one-half in the proportion of people living in extreme poverty by 2015” (Disability, poverty and development 2).

In terms of disabled children, mental retardation is the number one cause for disability in the United States (“The Disabled”). According to Tom Shriver, the president of the Special Olympics, “The health care system practices discrimination against the mentally retarded. And that discrimination is active, conscious, and ongoing” (Moran). As of 2002, there were seven million Americans with mental retardation, many of whom experience discrimination in various aspects of life, including health care. Shriver “stresses that those with mental retardation are routinely denied access to care by dentists, surgeons, and psychologists, but the national problem is largely ignored” (Moran). In the Surgeon General’s report, “Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation,” the health care neglect experienced by people with mental retardation is documented. In fact, the Surgeon General’s report encourages the medical community and the public in general to provide better services for this group.

The 1990 USA census bureau estimated that 6.2 to 7.5 million Americans are mentally retarded, which is “10 times more common than cerebral palsy and 28 times more prevalent than neural tube defects such as spina bifida. Mental retardation also affects 25 times as many people as blindness” (Moran). Disproportionate numbers of additional disorders accompany individuals with Down Syndrome, including “obesity, diabetes, congenital cardiac conditions, and thyroid disease” (Moran). This links directly to the inadequate medical services, as does the life expectancy of 45 to 66 years, which is almost 10 years less than the expectancy of a non-mentally retarded American.

The United States Surgeon General published a “National Blueprint to Improve the Health of Persons with Mental Retardation,”
which outlined the many problems with the United States health care system and its treatment of people with mental retardation. According to the report, “adults, adolescents, and children with MR experience poorer health and more difficulty in finding, getting to, and paying for appropriate health care” (xii). These difficulties, which are described as essentially having to seek out health care individually, make it extremely difficult for Americans with mental retardation to achieve appropriate medical care. Additionally, the financial cost is an added burden. With a universal health care system in place, though, none of these concerns would need to exist because the individuals with the disability would be guaranteed health care and would not have to search for providers on their own.

The Surgeon General’s Report continues with, “As with many other disabling conditions, the multiple disorders associated with MR are found disproportionately among low-income communities that experience social and economic disparities when they seek health care” (xii). This reflects on the idea that Americans with disabilities are more likely to be out of work, simply because they are unable, and are therefore living on very little. Furthermore, “Mental retardation compounds these disparities because many health care providers and institutional sources of care avoid patients with this condition.” If these patients were living in a country that provided universal health care, they would not be “avoided,” legally, as they would be covered under the law and therefore would not be denied care.

Women with disabilities also face additional difficulties and discrimination when it comes to receiving adequate health care. According to “Disability, poverty and development,” “Women with disabilities suffer a double discrimination, both on the grounds of gender and of impairment; their literacy rates are lower than their male counterparts” (3). Disability World, a bimonthly web-zine of international disability news and views, published the following . . . “Disabled women are the largest majority among female population because disability is a category that crosses all other categories; gender, race, age, sexual orientation, religion, etc.” (Degener). “Women’s Issues: Disabled Women and the Right to Health Care” ended with, “Disabled women need to access health care and the health care services need to be respectful and non-discriminating. Governments bear the ultimate responsibility that doctors and other health care providers begin to respect the human rights of disabled women.”

Another group of disabled individuals in the United States are war veterans, who, like other disabled Americans, are facing difficulty affording health care. According to an article in the Bloomberg News,

Former U.S. soldiers who were disabled fighting in Iraq and Afghanistan and live far from government hospitals and rehabilitation centers pay more for health care than other veterans, a government report found. . . Under existing rules, the injured soldiers must pay $1,157 a year for their premiums until they turn 65, according to the report (“Injured Iraq”).

Like all American citizens, war veterans who return disabled should have the right to receive adequate health care without having to pay out-of-pocket for it. And because these Americans became disabled while fighting for the right of America and its values, they should simply not have to face any discrepancies whatsoever when it comes to medical care. If they were living in a country that had a universal health care system in place, they would not be paying anything for their health care. This seems especially reasonable, considering the fact that these soldiers were injured while fighting for American freedom.

The discrimination of various disabled groups proves that United States health care system is flawed in many ways. This is particularly true, however, for disabled Americans. The following is a quote from Dr. Bruce Vladeck in his article, “Universal Health Insurance in the United States.”

We used to say that the United States shared with South Africa the distinction of being the only industrialized nation without universal health insurance. Now we don’t even have South
Africa to point to. Almost 20% of the non-elderly population in this country lacks health insurance at any given time, and the disparities in access to care and health outcomes are very much greater in the United States than anywhere else from which there are reasonable data (Vladeck).

Even if 20% doesn't seem like a large percentage, it is important to remember that a large portion of that percentage is disabled. There is something to be said about the fact that the United States is now the only industrialized nation without universal health care. In continuing to stand alone with its form of health care system, the large disabled population in the United States is at a vast disadvantage.

Lisa Iezzoni and Bonnie O'Day describe some of the problems with the health care system for the disabled as it is today in the United States. In their book, *More Than Ramps: A Guide to Improving Health Care Quality and Access to People with Disabilities*, they state, “the health care delivery system in the United States is not structured to care effectively for persons with disabilities” (3). They go on to describe the variance in medical needs depending on a specific disability, but continue with the following:

Regardless of the specific disability, however, persons with sensory and physical impairments are particularly susceptible to subsidized health care in the United States... Persons with chronic medical conditions and disabilities often slip through the fault lines crisscrossing health care delivery systems, partly because these individuals can have extensive health-related needs and partly because delivery systems still focus primarily on acute, short-term treatments. Even persons with chronic conditions frequently do not receive routine, recommended health care services. One study found that Americans receive, on average, roughly half of recommended health care services (11).

The fact that the people in America who most need care for various medical services and are not receiving it is detrimental, literally, to their health. When the Americans with Disabilities Act passed in 1990, discrimination was described as, “not making reasonable accommodations to the known physical or mental limitations” (26).

One of the easiest ways to recognize the faultiness of the health care system in the United States is to analyze a real-life example of what one disabled American has had to go through. In *More Than Ramps: A Guide to Improving Health Care Quality and Access to People with Disabilities*, a man named Fred is described. Fred is in his early sixties and has had diabetes for many years. He has a doctor in the hospital of his small town but sometimes has to travel to a city hospital that is three hours away for specified care. He can’t afford to pay for the gas to have someone else drive him there, so the transportation alone is problematic. He is a recipient of Social Security Disability Insurance (SSDI) but he can barely live off of what he receives, let alone pay for his many medicines. Because he has to use insulin three times a day, his medical bill runs over $700 dollars a month, which is more than he receives in the first place and is not counting his living expenses that are needed to pay for food, clothing and shelter (34). If Fred was living in a country such as Canada, the United Kingdom or Japan, his medicines would be covered and he would not have to worry about that extremely high monthly expense. Even though transportation costs would still exist, not having to worry about the specific medical expenses would truly benefit Fred.

An international comparison of health care systems at the Pacific Northwest Regional Economic Conference (PNRE) in 2001 evaluated the health care system of the United States side by side with countries with universal health care systems, including Canada, the United Kingdom, and Japan. The presentation from the PNRE Conference cited the World Health Report 1999, noting the fact that, as of that year, the United States was the only country analyzed whose systems required individuals to seek out their own health care providers. In such countries with universal health care systems, taxes are the primary way in which health care is paid for (“World Health Report”). In fact, the World Health Report also noted the following:

*With the exception of only the United States, the*
high income market-oriented democracies mandate universal coverage. Their health outcomes are very high. They have contained expenditures to a much smaller fraction of GDP than has the USA (7–10% versus 14%). In the one country where it was studied — Canada — introduction of National Health Insurance resulted in increased wages, reduced unemployment and improved health outcomes. Therein lies a lesson.

The effects of a universal health care system extend beyond “the increased wages, reduced unemployment and improved health outcomes” that are described because they allow individuals with disabilities equal coverage.

In addition to these benefits, the World Health Report 1999 displays a great inconsistency in life expectancy between the United States and countries with universal health care. Specifically, Canada’s average life expectancy was 79 years, and the United Kingdom life expectancy is 77.2 years, while the United States was 76.7. Japan, a country with a universal health care system in place, has the highest life expectancy at 80 years. In comparing the average life expectancies of the United States, Canada, the United Kingdom, and Japan, it is important to recognize that all three of the countries mentioned have higher life expectancy. The average life expectancy of someone from any of the countries analyzed with Universal health care is 78.1. Again, this number is significantly higher than the life expectancy in the United States, and there is no doubt a correlation between the number of years and the type of health care that is being received.

The United States health care system does not provide necessary programs to its disabled citizens because there is such a significant gap in what they are provided with and what is needed. Although there are some that are implemented, the programs mean virtually nothing when there is not a medical coverage guarantee to back it up. According to the Surgeon General’s report, “Closing the Gap: A National Blueprint to Improve the Health of Persons with Mental Retardation,” there are several “core values” for the Blueprint, which was created for mental retardation, a specific type of disability. The first core value was, “We ought to be about keeping people healthy.” The second was, “For things to change, we must change the stigma of MR to understand and respect.” In terms of health care, both of these are certainly important goals, but under a universal health care system, people with mental retardation would not be discriminated against because it would not be their job to seek out a healthcare provider. The third core value was, “Every action must fully include . . . people with MR, . . . family involvement, and . . . people telling us what they need, as opposed to our telling them what they want.” The fourth value was, “Providers have to look beyond the disability and see the person . . . !” The fifth was, “If we do all of the action steps, and we don’t do it in a person’s first language, and we don’t do it showing respect . . . for their culture, it means nothing . . .” Lastly, “There must be coordinated, community-based services that are integrated, available, and accessible. Let’s not make it all so difficult” (2). All of these values sound excellent on paper, but what has been done to actually implement them? Numerous goals were outlined in the Surgeon General’s report, but none of them explained how it could be done. Instead, each goal began with something that should be done. Many would agree that these changes should be made, but under a universal health care system, most of these concerns would be taken care of.

In British Columbia, Canada, programs are in place to help place various disabled Canadians in jobs. A portion of the strategy for the “Employment Strategy for Persons with Disabilities” is as follows:

Persons with disabilities need access to a range of services that will help them prepare for work. This client group varies in the amount they can work and the degree to which they can become self-reliant. Some, with minimal support, can work full-time and become financially independent, while others may only be able to work part-time, requiring ongoing ministry assistance (1).

As it is further described, the plan of action for this specific employment program is to get as
many disabled individuals jobs that are accommodating to their disabilities. This program is good for the avoidance of the poverty cycle that is so often present in disabled individuals because of their inability to work. In the United States, poverty relates directly to health care because of the fact that individuals are required to pay for their own health insurance. However, in a country such as Canada, even disabled individuals living in poverty are able to have access to health care because it is available to all citizens.

Because there is such a high rate of Americans with disabilities who are unable to work, there is a high rate of disabled Americans living without health insurance. Even worse, though, is that an estimated 37 million people are living below the poverty line in the United States each year, 7 million of whom are disabled children and adults and 4 million of whom are elderly (Sparks-Meyers). According to “Disability, poverty and development,” “Disability exacerbates poverty, by increasing isolation and economic strain . . . Children with disabilities are more likely to die young . . . People with disabilities who are denied education are then unable to find employment, driving them more deeply into poverty” (3). A chart shows the “vicious cycle” of poverty and disability by showing that disability leads to “denial of opportunities for economic, social and human development,” and then to “deficits in economic, social and cultural rights” (4). According to Lisa Iezzoni and Bonnie O’Day in their book, More Than Ramps: A Guide to Improving Health Care Quality and Access to People with Disabilities, “Persons with physical or sensory disabilities are . . . much more likely than others to have never completed high school, to be currently unemployed, and to live in poverty” (8).

The World Health Organization has publicly endorsed health care systems that take care of all people. In the “Message from the Director-General,” within the World Health Report 1999, the following is stated. “There is a need to develop more affective health systems. In many parts of the world, health systems are ill-equipped to cope with present demands . . . the goal must be to create a health care system that can reduce health inequalities; enhance fairness in the financing and delivery of health care” (x-xi). The health inequalities that undoubtedly exist are the ones that make it more difficult to be treated when you’re a disabled American, because so often those with disabilities need much more extensive care than others. Ironically, however, the World Health Organization’s 1999 report explains in detail the “Improving Health Outcomes” that they’re committed to furthering. Many aspects of health care are mentioned, including the care of children, adolescents and women, the care of people with HIV/AIDS, cardiovascular diseases and cancer, and reproductive health, among others, were specifically outlined, but the care of people with disabilities was not. Although this is a slightly upsetting recognition, it is not entirely surprising, as people with disabilities are frequently “removed from the equation” in many aspects of life. It is unfortunate that they were not recognized in a specific part of the outcomes, but it is the hope that people with disabilities, particularly Americans, are well taken care of.

A common argument against a universal healthcare system is the financial cost. Most often, people who use this argument claim that taxes become so high due to this system that families and individuals would experience a threat to their lifestyles because of such a large amount of money out-of-pocket. On the contrary, the OECD Health Data suggested that the private spending on health care in the United States is significantly higher than the private spending in countries with a nationalized health care system. Specifically, the United States spends four times more out-of-pocket, per capita, than Canada, and ten times more, per capita, than the United Kingdom. This added expense is more of a problem for Americans than higher taxes would be. Additionally, because all citizens would be automatically provided with health care, a weight would be lifted from the shoulders of most Americans because the stress of having to seek out health insurance would be gone. As a result of the misconception that a universal health care system would add enormous expense to Americans, a nationalized health care system is
often looked down upon instead of looked at fairly. And for people with disabilities, not having to worry about health care would make for a much happier quality of life.

Although many misconceptions exist regarding the implementation of a universal health care system, another of the most common is that a universal health care system would deprive the general public of needed services because of a lack of physicians, nurses, and equipment. In Dr. John Battista and Dr. Justine McCabe’s talk, which was given to the Association of State Green Parties in Moodus, Connecticut in 1999, “there would be no lines under a universal health care system in the United States because we have about a 30% oversupply of medical equipment and surgeons, whereas demand would increase about 15%.” Furthermore, “around 30% of Americans have problem accessing health care due to payment problems or access to care, far more than any other industrialized country. About 17% of our population is without health insurance. About 75% of ill uninsured people have trouble accessing/paying for health care.” The conclusion that was drawn from these facts by Battista and McCabe was:

The US denies access to health care based on the ability to pay. Under a universal health care system all would access care. There would be no lines as in other industrialized countries due to the oversupply in our providers and infrastructure, and the willingness/ability of the United States to spend more on health care than other industrialized nations.

In saying that all people would have access to the health care system, Americans with disabilities are included. The fact that the quality of universal health care is something that people frequently assume would not exist in a universal health care system is very unfortunate, especially for people with disabilities. If all Americans knew that the quality of care would be as good or better than the quality that currently exists in the United States but the financial aspect would no longer be a factor, more people would prefer a universal system.

Another common myth regarding universal health care systems is that this type of system would result in government control and intrusion into health care, resulting in loss of freedom of choice. However, this is disproved by Battista and McCabe with multiple facts. First of all, people would still have some choices in terms of their medical coverage, unlike our managed care system currently in place in the United States where people are forced to “see providers on the insurer’s panel to obtain medical benefits.” Second, there would be no management of care under a universal health care system which would mandate insurer pre-approval, as is the case currently in the United States. Additionally, health care fees would have to be set (as they are now in about 90% of the cases) but the providers would be able to negotiate fees, “unlike the current managed care system in which they are set in corporate board rooms with profits, not patient care, in mind.” Lastly, the system would really be run by a “public trust,” not by the government. Overall, a single-payer system (universal health care) would be more democratic and less intrusive than the current United States medical care system because of these reasons. Any problems existing with free choice would confidentiality and medically be resolved (Battista and McCabe).

Numerous factors contribute to the fact that the United States still does not have a universalized health care system. According to Bruce Vladeck, PhD, in his publication “Universal Health Insurance in the United States: Reflections on the Past, Present and Future,” there are five historical explanations for the United State’s health care system as it is and for why it is not a nationalized one. First, Americans have a much more negative attitude regarding their government system than do people from other countries. Second, “the absence of a traditional aristocracy and the attendant social hierarchies in the New World produced a culture much less accepting and respectful of authority, much more individualistic and independent, than existed anywhere else.” The third is the following:
Although in fact socioeconomic status in the United States is at least as stratified as it is in other industrialized countries, in much of the rest of the world a large proportion of the population identifies itself as working class, or working people. In the United States, everyone self-identifies as middle class. This leads to a very simple syllogism about why the United States has no universal health insurance: there is no self-identified working class—no labor party, no national health insurance. It is hard to disconfirm that syllogism. But it leads to the fourth point (Vladeck).

The fourth and fifth reasons both involve the lack of a labor party in the United States, as well. It is ironic that the United States largely identifies itself as “middle class” when there is so much wealth, but it is not distributed equally at all because there is a small percentage of really wealthy Americans who are the most affluent.

On behalf of Americans with disabilities (and, really, Americans in general), what can be done that would result in the United States’ adoption of a universal health care system? According to Dr. Bruce Vladeck, change occurs in one of three ways. The first way is through “realigning elections,” which means that an election is an extremely critical one because of the state of the country when the election occurs and what is “riding on the shoulders,” so to speak, of average Americans if the election does or does not turn out in a specific way. An example of this was Lyndon B. Johnson in 1964, which resulted in the creation of Medicare and Medicaid. The second way that change occurs is after a domestic fallout war. “Social change comes more rapidly during wartime than in peace,” Vladeck wrote in his article. The third way that change occurs in the United States “is characterized by a major cultural shift that produces a rapid change in public policy.” The example that Vladeck used was the tobacco industry because it smoking so quickly became a negative thing when it had been looked at as the “norm” for so long. Once change is established in one of these three ways, the health care system in the United States must be reformed by education the American people about the truth of health care as it is in our country and about what it could be. When the majority of the people understand that universal health care does not exhibit the many misconceptions that exist, perhaps they will be more accepting of a government that implements the system.

Countries with universal health care do much more for their disabled citizens than the United States, according to Martin Tolchin in the New York Times article, “Other Countries Do Much More for Disabled.” In the article, Tolchin says, “Several industrialized nations, including Canada, Britain and the Scandinavian countries, do much more than the United States to support long-term care for the severely disabled.” In discussing Canada specifically, Tolchin describes that eight out of ten provinces “provide some form of long-term coverage for all citizens.” Again, the phrase “all citizens” is really only appropriately used in reference to a country with universal health care. The programs that take care of and provide coverage for Canadian citizens with serious disabilities are run for and paid for by the provinces. Regardless of age, the benefits are available to people based on the specific services that they need, including in-home care and nursing home facilities.

In the United Kingdom, nursing homes are available to the elderly who need the services and are operated by social agencies and local governments. Similar to nursing homes in the United States, which cost a lot of money for the individuals living there and often times their families; these facilities in the UK cost nothing to the individual. Japan offers similar programs, but there are two types of long-term care offered. The first are “geriatric hospitals” which resemble American nursing homes, for which the government pays the entire bill for those people who are 80 years old or older. Additionally, there are homes offered for the elderly who are unable to live entirely on their own but do not require 24-hour care. These homes are sponsored by unions and churches, so that the family does have to provide funds by generally very little. These are most similar to assisted-living apartments in the United States for senior citizens. Any of the residents in these
locations who get sick are then sent to the geriatric hospitals.

All Americans would benefit from the placement of a universal health care system, but there is no doubt that these benefits would be far greater for Americans who are living with various types of disabilities. The evidence speaks for itself in determining the value of implementing a universal health care system in the United States of America, including average lifespan and quality of care. In addition, there are numerous physical, emotional, and financial benefits for disabled individuals living in a country with universal health care. There are many types of disability, which include the elderly, individuals with mental retardation, individuals with physical impairments, and children, and all of them would benefit from a universal health care system because they would all be treated equally instead of searching, on their own, for insurance companies who are oftentimes immoral in their treatment of the disabled.

Three common misconceptions regarding universal health care include high cost, governmental control, and the deprivation of needed services. Facts and statistics prove these wrong. If this were better understood, and Americans had a clearer idea of what universal health care would mean in terms of bettering the country, there would be fewer people fighting against it. The link of disability to unemployment and, therefore, to poverty is an undeniable one that would be less of a problem if Americans did not have to pay such high fees out-of-pocket to cover necessary medical expenses. Although numerous issues need to be addressed in order to best understand why universal health care would benefit people with disabilities, the fact remains that the current health care system in America is not on the side of the people and, until it is, people with disabilities will experience a detriment in terms of health care.

Works Cited


