

THE HUMAN RIGHTS IMPLICATIONS OF THE NORTH AMERICAN MODEL OF HEALTHCARE

KIRSTIE BLAIK (Sociology of Disease and Illness)

Abstract

This essay offers a critical analysis of how the North American model of healthcare can be positioned as a system that denies basic human rights to health and wellbeing. This is facilitated by an exploration of how the interplay of social status and poverty affect individuals seeking and gaining adequate and appropriate health care. To better understand the limitations of the North American model of healthcare, the system is explored in relation to issues of access based on lack of economic and social capital as posited by Bourdieu. A review of the impact of not having access to appropriate healthcare is also given and the postulation that the North American model of healthcare is responsible for the discrimination of those who cannot afford to pay for their medical care will be considered. This essay demonstrates how one of the richest countries in the world is failing its citizens who do not have adequate healthcare insurance or any form of health insurance. This is a major failing of North America to secure the best possible human rights for all Americans regardless of economic or social status.

Keywords: Healthcare, Human Rights, Poverty, Health Injustice, North America, Social and Economic Capital.

Before commencing a critical analysis of the human rights implications of the North American model of healthcare it is important that the concept of human rights is outlined. This will be facilitated by outlining the relevant articles from the United Nations Universal Declaration of Human Rights. The Universal Declaration of Human Rights was created in 1948 (Freeman 2011, 37). Despite the declaration being positioned as a tool for universal human rights, Freeman acknowledges that it was not created to give legally binding obligations to the member states but was intended to set out human rights goals which the member states could endeavour to replicate (ibid, 42). Specifically, Article 25 of the declaration is of interest when examining the human rights implications of the North American model of healthcare. Article 25 forces the questioning of the North American model of healthcare as it states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services' (UN 2014). Importantly, this situates the healthcare that is provided in North America at direct odds with the UN Declaration of Human Rights, as the American healthcare system is one in which 'citizens have no legal right to health care (beyond emergency treatment) and

no guarantee of access' (Geiger 2005, 210). Moreover, this positions the North American model of healthcare as a site of the denial of universal human rights in some circumstances.

It is important to note that the US system is not considered a universal model and as such can be considered a system that supports and propagates health inequalities. The US healthcare system is far removed from the universal system of socialised healthcare seen in the United Kingdom, and therefore is one that does not offer free or universal care. The merits of a socialised healthcare system that negates individual aspects of social and economic capital are explored by Portes et al., who argue that 'in other developed societies, universalistic programs have reduced or eliminated healthcare as a stratifying concept [yet] this is not the case in the United States' (Portes et al. 2009, 490). Therefore, it is possible that a major point of concern in relation to the US version of is the fact that it is not universal and, by its very nature, is a system that divides and conquers based on socioeconomic status.

When offering a comprehensive analysis of the North American model of healthcare it is fundamental that the United States is situated in line with the healthcare performances of other nations. This enables a positioning of the data on healthcare trends to be located within a global framework, thus enabling better understanding of the benefits and limitations of the American model, by showing the disparities between nations. According to Klein, healthcare in North America consistently falls 'beneath the United Kingdom ... in every measure of public health' (Klein 2010, 16). This sentiment is echoed by Grob and Horwitz, who state that the health indicators of North America, when compared to other industrialised nations, are not impressive, with the US consistently ranking last in infant mortality rates (Grob & Horwitz 2009, 3). Furthermore, research suggests that Americans are at a 'particularly high risk of forgoing care because of costs and of experiencing inefficient, poorly organized care, or errors' (Grob & Horwitz 2009, 3).

The low ranking of the American healthcare system in terms of morbidity, mortality and access to treatment positions is it at direct odds with the overwhelming amount of money that is deposited into the healthcare system by the US government. According to Hellander and Bhargavan 'spending on health care in the United States in 2008 far exceeded that seen in other countries' (Hellander & Bhargavan 2012, 173). Jonas et al. (2007) highlight the trend of ever increasing healthcare expenditures, claiming that in '1980 health care expenditures accounted for only 9.1% of the GDP ... [and increased] to 16.0% of the GDP in 2005' (Jonas et al. 2007, 130). This highlights a worrying trend that sees healthcare expenditure rising, while access to adequate and affordable healthcare is

diminishing. Therefore, this situates the system and the money that is being expended as vastly separate narratives because the high amount of financial expenditures is not mirrored in high numbers of satisfied customers or improved global healthcare rankings.

In order to locate the North American healthcare market as a site of social injustice it is important to unpick the narratives that situate health as a marketable industry that sees healthcare as a commodity. According to Klein health has become a commodity and that 'nowhere in the world do people spend more resources to promote their health, and nowhere in the world are more people uninsured and thus without the means to pay for hospitalization' (Klein 2010, 16). This demonstrates that there is a widening gap between those who can afford a good health, and those who cannot because of a lack of financial funds and health insurance. The consensus that the healthcare system in the US is comparable to a commodity and linked to capitalist ideals of financial organisations is echoed by Angel et al. (2006). According to Angel et al., although 'most middleclass families can budget for routine health expenditures and count on employer-based insurance to cover potentially catastrophic health care expenditures, the poor ... cannot protect themselves against unpredictable ... illness or accidents' (Angel et al. 2006, 55). Furthermore, Angel et al. assert that 'catastrophic medical expenses are one of the leading causes of bankruptcy even for families with substantial resources' (ibid.). This postulation situates the US model of healthcare as a flawed system that has been commodified and turned into a business that those in the lower strata of the economy cannot afford to partake in.

When examining healthcare as social injustice it is useful to detail the numbers of uninsured Americans, as in a system that does not offer free care, they become the individuals who are at great risk of experiencing social inequality. According to Geiger, in 2003 there were 44 million Americans with no public or private health insurance and, despite these large figures, it is estimated that this figure has been increasing at a rate of 2 million per year (Geiger 2005, 210). The data suggested by Geiger has little impact until it is examined in relation to the 'human cost' of a commodified healthcare system. In 2009 45,000 people died as a result of not having healthcare insurance in North America (Woolhandler & Himmelstein 2011, 720). Moreover, it is fundamental to understand that changes in economic status throughout the life course can mean that the ability to purchase insurance should not be taken for granted. This is asserted by Hellander and Bhargavan who declare that 'nine million working-age Americans ... who had health insurance through a job that was lost ... became uninsured between 2008 and 2010' (Hellander & Bhargavan 2012, 162). This shows the important and interconnected relationship between employment, finances and the ability to access

healthcare in the North American system, and how changes in employment can have catastrophic consequences for individuals even if they have been previously insured.

In relation to North America it is impossible to uncouple narratives of poverty and ethnicity. In critical terms both poverty and ethnicity should be considered as inter-dependent and influential upon each other in specific circumstances. The relevance of ethnicity and income are understood by Geiger, who argues that the opportunities to 'maintain a healthy and longer life and to fulfil one's human potential are skewed ... by income, education, primary language, race, ethnicity, and area of residence' (Geiger 2005, 207). This demonstrates that ethnicity and income should be considered as two of the stratifying factors of the American healthcare system. Sered and Fernadopulle are in agreement as they postulate that 'Black workers are also more likely than whites to be employed in temporary jobs, which rarely include health care benefits ... [and] black Americans are less likely than white Americans to have health insurance' (Sered & Fernadopulle 2005, 157). Almgren and Lindhorst also agree that 'the probability of having health insurance through the majority of the life span ... is tied to race – primarily through the mechanisms of income, education, and occupational status' (Almgren & Lindhorst 2011, 142). In terms of understanding this phenomenon from a sociological perspective, Geiger argues that the 'distribution of the uninsured follows ... ethnicity-specific discriminatory patterns that characterize social injustice in the larger society' (Geiger 2005, 210).

When examining the ways in which the poor are situated as a distinctly separate entity to those who are affluent in North America, the concept of social and economic capital as posited by Bourdieu can be considered as a viable framework for exploring social stratification and status. Bourdieu posits that the amount of social capital that individuals have access to is dependent on 'the size of the network ... he can ... mobilize and on the volume of the capital (economic, cultural or symbolic) possessed in his own [right]' (Bourdieu 1986, 51). From Bourdieu's standpoint social exclusion is linked to a lack of social capital which is bound up in the ways that a lack of income interplays with social status and prestige. Bourdieu goes on to argue that it is impossible to separate economic capital, such as access to financial support from other forms of capital such as social capital as it lies 'at the root of all the other types of capital' (ibid., 54). Uphoff et al. argue that in relation to health and social capital, being in possession of a large amount of social capital can 'benefit the health of those who have access to [healthcare] through their having sufficient economic capital and it may harm the health of those who are excluded from participation in the relevant networks' (Uphoff et al. 2013, 10). This demonstrates that the interconnectedness of social and economic capital in

relation to access to healthcare should be further explored as it shows the 'over-riding importance of material conditions in influencing our health' (Chappell & Funk 2010, 370).

It is impossible to uncouple the concept of life chances from narratives that explore social injustice in relation to access to healthcare. According to Gabe et al., when 'life chances' are explored the enquiries must focus on 'health, survival and mortality ... [as] health, survival and mortality differ systematically by social class' (Gabe et al. 2004, 3). Furthermore, Gabe et al. acknowledge that life chances are bound up with healthcare inequalities and that such inequalities are present even in 'even in the most advanced welfare states, and even where all children have food and shelter and access to comprehensive medical care' (Gabe et al. 2004, 3).

Interdependent aspects of life chances, such as income and economic status, can be considered as part of the paradigm of social class and subsequent socioeconomic position. Thomas postulates that because income is often used as a marker of socioeconomic status 'it has been the socioeconomic variable most frequently linked to health status' (Thomas 2003, 198). Thomas also asserts that: 'As income increases, the prevalence of both acute and chronic conditions decreases ... Not surprisingly, members of lower-income groups assess themselves as being in poorer health than do the more affluent' (ibid.). The obvious relationship between income and good health is the issue of being able to pay for medical care and treatment. It is clear that high levels of income will equate to good levels of health and wellbeing. Therefore, the ability to pay for services and treatment situates wealthy Americans apart from their poorer counterparts as they are 'able to ameliorate many health problems that the unaffluent may not' (Thomas 2003, 199).

Although some government funding is available to cover the cost of insurance, it is not available to everyone. In 2003 the government funded 'Medicare' programme for those aged over 65 was equated to 20% of all spending on healthcare, while the 'Medicaid' programme for those in poverty equated to 14% of all spending on healthcare (Walshe 2003, 50). Importantly, Portes et al. (2009) understand that it is not just those who are in economic poverty that cannot afford access to healthcare insurance and medical care. Workers that receive low-pay and small business entrepreneurs may also be unable to access health insurance, thus situating such individuals alongside 'the unemployed and redundant workers at the bottom of the class structure forming the mass of the health disadvantaged' (Portes et al. 2009, 492). Furthermore, Portes et al. go on to argue that despite very low wages, many employees at the lower end of the economic scale are considered

by the American government to have wages that are 'defined as too high to qualify for government-subsidized indigent care' (ibid.).

Healthcare organisations in North America require that patients who have no health insurance pay for their treatment. Kotlikoff argues that the insistence on the charging of medical care to credit cards is clearly evidenced as 'one in five low and middle-income households now report charging major medical expenses on their credit cards' (Kotlikoff 2007, 7). According to Kotlikoff, this has created a financial shift from the burden of non-payment being with the healthcare organisations, to the burden of non-payment being with the credit card companies (ibid.). More importantly, Kotlikoff understands that when medical debts are buffered by the credit card companies, the companies 'have no compulsion against charging fantastically high interest rates on outstanding balances and forcing delinquents into bankruptcy' (ibid.). This highlights the fact that the healthcare paradigm in North America is being outsourced and financially commodified by financial institutions that seek to gain profit through healthcare payments.

Drawing conclusions, this essay has demonstrated that healthcare inequalities, which directly affect individual human rights, are situated in the paradigm of social inequality that connects poverty, social status and expected 'life chances'. Through the denial of treatment, due to lack of healthcare insurance and funding, the North American model of healthcare is a system that consistently undermines and negates the Universal Declaration of Human Rights. In particular the US model of healthcare is at direct odds with article 25 of the declaration that states that health is a basic human right (UN 2014).

A two-tier healthcare system, that comprises a section of society that can pay for medical care and another that cannot pay for medical care, means that the North American system is based upon hierarchical relationships that promote and proliferate an insider-outsider culture relating to levels of economic capital. This can be seen in the fact that those who have sufficient social and economic capital have finances to buy good health, and those who have little social and economic capital are left without access or in severe debt. This, in turn, has life-long implications for the individuals who have insufficient social and economic capital; it is a system that sees the poorest people die because they cannot afford medical care.

Economic and social capital plays a key role in both the health inequalities and basic human rights of Americans. The health inequalities that are persistent in the American model of healthcare are

inextricably linked to income and social inequalities that are perpetuated by poverty. Ultimately, this situates the American healthcare system as a site of social and economic contest, and begs further investigation from sociologists who are attempting to explore the nature of economics, social exclusion and the marginalisation of healthcare provisions.

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