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# Comparative Healthcare: Changing US Health Policy

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**Abstract**

The United States healthcare system differs from any other system because of its unique health coverage that varies depending on the individual. In other developed countries, healthcare access has been deemed a human right, and insurance access and healthcare costs are equal and shared among citizens. The US has failed to create a healthcare system that values the life of the American rather than the monetary value that the healthcare sector can provide for the country. Countries with far less gross domestic product have more inclusive healthcare systems that provide equal access to residents. Additionally, the US has various healthcare disparities that plague various minority groups such as the transgender community and racial and ethnic groups. Thus, the purpose of this podcast is to understand health policy and to construct an implementation plan that would improve the healthcare system within the United States. To do so, different healthcare models will be described, US healthcare disparities will be explored, and potential solutions to the healthcare crisis will be suggested.

**Episode Guides**

Episode 1

**Intro**

Hello everyone and welcome to the *Comparative Healthcare* podcast. Being that this is the first episode, I will be doing an introduction to healthcare models and including examples of countries that implement these models and how they work within those countries. Additionally, the social determinants of health will be described. The purpose of this podcast is to understand health policy and to construct an implementation plan that would improve the healthcare system within the United States.

**Social Determinants of Health**

- Social or economic factors
    - Direct or indirect effect on health
    - Nonmedical
- Upstream or downstream
    - Upstream determinants start causal pathways that lead to health effects, like the legal system
    - downstream determinants are temporally and spatially related to health outcomes but are influenced by results of upstream determinants
- Types of determinants
    - neighborhood, work, education, income, race, gender, sexuality, and childhood experiences (de Saxe Zerden)

**Definitions**

- insured-access to health insurance that they can afford
- uninsured-do not have health insurance
- underinsured-have insurance, but the cost of care is prohibitively high

**Healthcare Models Overview**

- National health insurance-providers are privatized but government pays for all medical bills through taxes
- Beveridge-no medical bills, paid by taxes
- Bismarck-employer offered healthcare, but insurance companies are not for profit
- Out-of-pocket-no government assistance, pay all
- Unique but have some similarities
- Easier to implement because of their similarities

I used various sources to define healthcare, but the most useful source was *The Healing of America* book because the author used his personal experiences in various countries to understand healthcare systems. I am going to use some of his personal experiences as examples of what is right, what is wrong, etc. with different healthcare systems.

**Bismarck**

To start, I will define the Bismarck model. The Bismarck model funds health care with taxes and "employs insurance companies that are funded by employees and employers" (Johnson, 340). Within the Bismarck model, health care providers and payers are private but plans "cover everybody, and they don't make a profit" (Reid, 17).

Like the US

- Funded by payroll withholding but has sickness funds, insurance is not lost when unemployed, and insurances plans are unrestricted
- Germany, Japan, France, Belgium, and Switzerland
- US reflects this system
    - Americans under 65, insurance is provider to the employee from the employer with the insurer bearing the medical bill costs and the insured paying a co-payment (Reid, 20)

Anecdote

- Author went to France, went to an orthopedist for shoulder stiffness and joint pain
- Quick consultation
- Cost $33.80 USD and he had to pay at the appointment
- French Bismarck model, insurance covers 70% of the fee, $24 USD
    - Patient receives a reimbursement (Reid, 48)
- In US, the patient would be expected to pay four times as much
    - Even more if the insurance company denies the claim

France spending

- France spends more than other European countries, but considerably less than the USA
- Less is spent to compensate doctors or hospitals
    - Evident that hospitals are more frugal based on appearance and decorations of these buildings (Reid, 49)
    - No intricate art, freshly painted walls, less concern about aesthetics
- Transparency
    - Charts down to the hundredth of a euro to inform patients what they will be spending (Reid, 49)
    - France is a "system of private doctors treating patients who buy health insurance to cover most of the cost" (Reid, 50)
        - The insurance plans cover every resident and offer roughly equal treatment

Differentiated from US healthcare

- France and US charge on a fee-for-service basis
- Insurance offered through employer
- BUT French residents are reimbursed for their medical expenses
- Private hospitals tend to specialize in certain medical services (Reid, 50)
- French insurance plans are nonprofit organizations

    - Can not be denied insurance because of preexisting conditions, coverage is not terminated if you lose your job, claims cannot be denied once a doctor submits a bill, there is no deductible, and delays in reimbursement is illegal (Reid, 51)
    - Main priority is well-being of residents rather than paying investors
    - All health care providers are considered in-network
        - Referrals from general practitioners to visit a specialist are unnecessary (Reid, 52)
- Insurance is required in France
    - You cannot opt out even if you believe you are of perfect health
- In addition to the established sickness funds, the French can buy additional coverage so that the co-pays that are not reimbursed by the sickness funds are paid

Carte vitale or "card of life"

- All residents over the age of 15 have this card
- At clinics and hospitals that accept the carte vitale, medical professionals can scan the card and see the patient's complete medical history
    - This includes payment by the insurance funds for the patient (Reid, 58-59)
    - Carte vitale acceptance signs are posted at medical facilities
- This is more efficient than in the United States
    - After an appointment, doctors simply put the treatment the patient received onto the card and insurance funds are notified of what the patient paid, how much they should reimburse, and how much the doctor should be paid for the services provided (Reid, 59)
    - Reduce administrative costs if something similar existed in the US
- The French often protest and alter the health care policy if they are unsatisfied, something the US cannot achieve

How to balance the Bismarck model and the cost of medical school

- French doctors make half of what American doctors make in a year
    - College and medical school are free in France
    - No burden of the cost of higher education as in the US (Reid, 62)
- The author interviewed a French doctor, Dr. Bonnaud
    - Concedes that he would be richer in the United States, but he would constantly be fighting insurance companies about what to prescribe
    - In France, doctors have the privilege to offer treatment options that are best suited for the patient rather than focusing on insurance spending costs (Reid, 62)
- Bismarck healthcare is not without fault as health insurance funds are at a deficit and the cost of the health care system is increasing faster than the economy (Reid, 64)
    - These problems motivate doctors strikes and frequent health care reform

**Beveridge Model**

- Healthcare from the government that is paid for with taxes
- Medical care is a public service as there are no medical bills (Reid, 17-18)
- Hospitals and clinics are owned by the government and doctors are government employees
- Unique because spending per capita is low because the government controls what doctors do and how much to charge (Reid, 18)
- Examples exist in Great Britain, Italy, and Spain
- The purest forms of socialized medicine are Cuba and the US Department of Veteran Affairs (Reid, 18)

Anecdote

- After the author arrived in the UK, his daughter had a painful ear infection
- They had no time to find a primary care doctor, so they went to the emergency ward at St. Mary's Hospital (Reid, 117)
    - Less spending on aesthetics, no freshly painted walls
    - Cut cost to save money, money spent on health care rather than frivolous expenditures
- After treating the ear infection and prescribing medication, the author was ready to pay the medical bill and the nurse politely said that there is no bill, and the NHS covers all medical treatment costs (Reid, 118)
- In the US, a similar trip to the hospital would cause some $200 from the hospital, $150 from the doctor, and $100 from the lab technician (Reid, 118)
    - The author states that he would have to battle the insurance company for a few months to get bills paid
    - This does not exist in the UK because there are no bills
    - His wife stated, "Now I see why we pay that 17.5 percent" (Reid, 18)

History of the Beveridge Model

- This model was created in the United Kingdom and muscled the current British National Health Service (NHS) into existence
- In the UK there is no fee associated with going to the doctor, whether it is for a yearly appointment or a major surgery
- Doctors are paid solely by the government and residents never receive a medical bill
    - To pay for this health care model, Brits pay sales tax ranging from 15 to 17.5 percent (Reid, 104)

    - Brits forgo treatments the NHS will not cover and wait in longer lines to receive care (Reid, 104)
- After World War II, the citizens of the United Kingdom supported the National Health Service model as health care during the war was controlled by the Emergency Hospital Service

Problems with Beveridge Model

- Since its creation, the Beveridge model faces the issue of the overuse of medical care
- The NHS has exceeded its budget nearly every year that it has implemented because once health care is free, people tend to use it worry-free and more frequently (Reid, 111)
- To account for some of the expenses that are paid for by the NHS, there is a $10 USD charge for prescriptions
    - However, prescription costs are exempt for anyone over sixty, pregnant people, and the chronically ill making 85% of prescriptions free (Reid, 112)
    - Still, eyeglasses, contact lenses, false teeth, and some dental bills are paid by the patient rather than the NHS (Reid, 112)
    - Administrative costs are low as there is no billing or bureaucracy within this health care model (Reid, 112)
- As in the United States, the medications, tests, and procedures that the NHS will cover are rationed, but the decisions are more public in the UK
    - For example, expensive drugs that treat cancer and AIDS are not included in the treatments covered by the NHS (Reid, 115-116)
    - Conversely, refusal to cover specific treatments in the United States is not justified by the fact that the funds will cover health care in some capacity as the saved money will likely be used to pay investors

Gatekeeper system

- Under a gatekeeper system, there are additional steps that stop patients from going to a specialist until after they have been referred by a general practitioner
- Requires residents to register with a general practitioner to manage large procedures and specialist services (Reid, 113)
- Queue also exists
    - Patients wait months to see a specialist once referred from their general practitioners
        - However, in recent years, long waits are expected for elective procedures, but conditions with acute pain have expedited wait times
        - Similarly, any suspected cancer, cardiac issues, and chest pains have wait times as low as same-day consultations (Reid 114-115)

**National Health Insurance Model**

- Combination of the Beveridge and Bismarck models
    - Providers are privatized but the government pays for health insurance for all funded by taxes (Reid, 18)
- This model is cheaper and simpler than the American health care system because there are no offices that deny claims, no profit to be made, and there is a single payer covering everybody (Reid, 18-19)
- Countries that implement the NHI model are Canada, South Korea, and Taiwan
- US Medicare is an example of the NHI model as there is near universal participation and low administrative costs (Reid, 20)

History of the NHI

- Tommy Douglas invents Medicare and achieves free hospital care in a poor province, Saskatchewan, and its success inspired free health care to spread throughout the country
- The NHI model in Canada began by the demonstration effect
- Similarly, the United States has fifty states, one of which could mirror the implementation of a different health care system and, upon its success, would cause health care policy change

Canada and the NHI

- Patients do not pay for health care
    - However, there is a doctor shortage, especially in rural areas
    - For acute illnesses, accidents, and emergency care, the NHI ensures that care is provided promptly to the patient
    - For less urgent issues, patients wait months to years to get a consultation and another handful of months to schedule surgery with a specialist (Reid, 128)
        - Waiting periods are the longest for orthopedic surgery, MRI scans, cataract surgery, coronary bypass, and radiation treatments (Reid, 128)
- Each Canadian province and territory implement its own version of Medicare
    - With some provincial governments paying all doctor and hospital bills and others requiring a co-pay before insurance coverage begins (Reid, 133)

Anecdote

- In Canada, the author interviews some doctors about their thoughts on the NHI model

- Dr. Steven Goluboff states that it is "so rewarding, and *soooo* frustrating, to work this system" (Reid, 137)
- Dr. Goluboff says it is rewarding to offer patients the medical care they need
    - And no bills or paperwork (Reid, 138)
- However, Dr. Goluboff states that it is "scandalous" that if a patient needs an MRI or a psychiatric evaluation they can only be added to a list and be told to wait (Reid, 138)

Principles of provincial plans

- Each provincial plan must follow five basic principles: public administration, comprehensiveness, universality, portability, and accessibility
    - Under public administration, health insurance must be operated by a public body on a non-profit basis (Reid, 134)
    - Comprehensiveness means that the Medicare plans must pay for all necessary medical services (Reid, 134)
    - Every resident must have equal access to treatments because of universality (Reid, 134)
    - Under portability, the plan must pay for coverage in all parts of the country (Reid, 134)
    - Accessibility means that patients must be treated for the same fee, regardless of age or illness (Reid, 134)
- Most Canadians also pay for private health insurance to cover dental care, private hospital rooms, prescriptions, etc., but the cost is low because most procedures are covered by Medicare (Reid, 135)
- To avoid two-tier medicine where the rich receive better health care from private insurance, it is illegal to pay privately for a procedure covered by Medicare
    - Yet they still must wait in lines that are too long (Reid, 136)
- The physicians of Canada make half as much as those in the US, but they are awarded other benefits
    - Under Medicare, physicians have malpractice insurance
    - Medical records are digitized
    - The cost of a medical degree is half of what it costs at a public university in the US (Reid, 139)

**Out-of-pocket Model**

- Personally financed medical care where "the rich get medical care; the poor stay sick or die," there is no established system to assist with the costs (Reid, 19)
- In rural parts of India, China, Africa, and South America, residents usually go their entire lives without visiting a doctor

    - They often have access to a village healer who uses traditional medicines that may or may not help a patient with a condition (Reid, 19)
- In the United States, those who are uninsured reflect the out-of-pocket model of health care

Healthcare in developing countries

- Two primary patterns of health care spending can be identified
    - In one scenario, the government pays for more than half of the health care spending, but the funds come from foreign-aid and charity sources
    - The other scenario is that all the money spent on health care is spent on wealthy people and government officials, and access is often restricted to the capital city (Reid, 145)
- Regarding prescription drugs, patients still must pay out-of-pocket
    - But clinics may not have steady access to the drug in question, meaning that even if you can pay, it might not be available (Reid, 147)
- The life expectancy in developing countries is much lower than in developed countries
    - There are substantial deaths from diseases that have been eradicated in developed countries, such as leprosy, malaria, smallpox, and polio (Reid, 147)

Compared to the USA

- Comparable patterns can be seen in the United States for those that are uninsured
- Uninsured Americans are more likely to get sick and stay sick
- They are more likely to die from injuries sustained in accidents
- And they do not have access to early diagnosis for deadly diseases like cancer and heart disease (Reid, 149)

Anecdote

- The author visited a clinic in a rural area with complaints of shoulder pain and stiffness
    - The prescribed treatment regimen was prayers, herbal oils and ointments, and massages in accordance with the ancient sages of yoga (Reid, 143)
- The author was prescribed Ayurveda which does not heal, but it believes in the energy of the body and the prescribed treatments balances your energy
    - Your body works to heal itself (Reid, 157-158)
    - After weeks of participating in traditional medicine, the author did not have shoulder pain and his range of motion increased (Reid, 161)
    - Was not a cure but improved the condition
        - A point of overprescription in the US and other developed countries

- When interviewing doctors in India, the author found that Western medicine and traditional medicine exist
    - The Amji Clinic, the Tibetan herbal doctor, Dr. Tenzin, cannot charge people for prescriptions, instead he makes his living by selling homemade medications (Reid, 155)
    - The Canadian Clinic exists an hour from the Amji clinic and doctors like Dr. Khunde treat patients with western medicine (Reid, 155)
    - There is a mutual respect between these two medical professionals, and they often submit referrals to each other
- In the United States, we created the National Center for Complementary and Alternative Medicine (NCCAM) to investigate the effectiveness of traditional therapies like acupuncture and homeopathy
    - This organization was created to decide whether health insurance should cover such remedies
    - Still, many developing countries look for healing in Western and traditional medicine (Reid, 154)

**Conclusion**

Key points:

- Social determinants of health are factors that influence an individual's access to healthcare that are not directly medically related
- Beveridge is healthcare paid by taxes, no medical bills
- Bismarck model offers healthcare coverage through taxes and insurance is offered through an employer, but plans cover everyone
- National health insurance model has private providers, but healthcare is completely covered by the government through taxes
- Out-of-pocket model there is no system to help with medical care costs
- In the USA, we have a mixed-model system that has components of each healthcare model
- For that reason, healthcare spending in the USA is high without reflecting better quality care provided because there is no uniform system that health coverage follows

Beveridge, Bismarck, National Health Insurance, and out-of-pocket models control access to medical care and define the sophistication of the care received for communities across the globe. Although many developed countries have different health care systems, such as France and Canada, they are successful because their core values support the idea that every resident of the country deserves fair and appropriate health care. In the developing world, healthcare reform is urgent as care is inaccessible because there are no health insurance options offered to citizens. Additionally, the United States health care system incorporates each type of health

care model into its health care system, however, insurance organizations in the United States are for-profit meaning that offering the basic human right of adequate medical care is not the driving factor, money is. In the next episode, I will define US health care and explain how our GDP spending on health care should not reflect the health disparities that exist in the US today. Thank you for listening to this episode of the *Comparative Healthcare* podcast.

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Episode 2

**Intro**

Hello everyone and welcome back to the *Comparative Healthcare* podcast. Just to recap the last episode, I covered different healthcare models and how they compare to each other. I talked about Bismarck, Beveridge, national health insurance, and out-of-pocket models. Hopefully those names ring some bells. Social determinants were also defined. In this episode, I will give an overview of the US healthcare system. Alright, let's get into it then.

**Healthcare System**

Like the first episode, I will define the different aspects of our healthcare system because it is unique. So, in the United States healthcare reform is a hot, yet controversial topic. Here, we have a healthcare system that is considered a mix of the models from the first episode.

- Bismarck-under 65, patient is offered insurance through an employer and pays a copay (Reid, 20)
- Beveridge-Native Americans, military personnel, and veterans have doctors that are governmental employees in government-owned clinics and never get a medical bill, Veteran Affairs (Reid, 20)
- National Health Insurance-US Medicare, near-universal participation, and low administrative costs (Reid, 20)
- Out-of-pocket-uninsured, pay the entire bill and visit doctors less frequently (Reid, 21)

We are also entirely unique from other countries because healthcare is different for separate classes of people and there is heavy reliance on for-profit insurance (Reid, 21). The United States healthcare system does not promote a plan that is available for all which creates health disparities between social classes (Johnson 2021).

**History of US Healthcare**

- Initially, national health insurance was proposed in 1915 by the American Association for Labor Legislation (AALL). This program was suggested to provide medical care, sick pay, and funeral expenses to lower-paid workers, but it was not backed by the American Medical Association (AMA) or the American Federation of Labor. It failed (Bodenheimer & Grumbach, 182).
- In 1943, the Wagner-Murray-Dingell Bill was proposed as an expansion of social security. Under this bill, employers and employees would contribute to the federal social insurance trust fund in the form of a salary withholding. This money would pay health providers and offer a no-payment form of health insurance. Those who were eligible were those who paid into social security—the working class and the retired who contributed before retirement. After President Truman's election, his support of this bill motivated the AMA to organize an expensive campaign that defeated the bill (Bodenheimer & Grumbach, 182-183).
- In 1965, Medicare and Medicaid became integrated in the US healthcare system. Medicare is coverage for people over 65 who had contributed to social security, whereas Medicaid is a public assistance program funded by general federal and state taxes (Bodenheimer & Grumbach, 183).
- After Medicare and Medicaid, many thought the US was en-route to a national health insurance model, as many developed countries started with coverage for portions of the country that then extended to everyone. In 1970, the Kennedy-Griffiths Health Security Act was proposed to cover the entire US population. Physicians would be paid by the federal government, the working class would stop contributing to Medicare, and Medicaid recipients would be included in this model and Medicaid would be phased out. Opposition from the AMA and the private insurance industry defeated this system (Bodenheimer & Grumbach, 184).
- President Nixon then changed the landscape of national health insurance in the US by moving it toward the private sector. The Nixon proposal mandated employers to purchase private health insurance for their employees (Bodenheimer & Grumbach, 185). This supported the expansion of the private health insurance industry whose main concern is profit, not providing adequate healthcare.
- Healthcare reform is a continuous topic that plagues the politics of the United States. Maybe if governmental officials worried less about profit and more about the people they claim to represent, real, positive change could begin.

**USA Situation**

US healthcare regulation

- "The United States lacks a central government entity that regulates health care" (Johnson, 342). "Many different federal agencies, as well as the states and private businesses, are involved in the regulation and operation of health care" (Johnson, 342).

US spending

- The US spends more on health care costs than most other countries, but this is due to higher prices of prescription drugs, medical procedures, hospital stays, etc (Johnson, 348).
- GDP-Currently, the US spends $4.3 trillion (about $13,000 per person in the US) dollars on healthcare which is 18.3% of the country's Gross Domestic Product, or GDP (CMS.gov).
- For reference, Germany spends the most on healthcare than any other European country and they spend 432 billion Euros which is $461 billion USD (Europa.eu) while also offering the same healthcare plan to all its citizens.
- One source I found stated that the Office of the Actuary at the Centers for Medicare and Medicaid Services predicts that US GDP spending on healthcare will reach 20% by 2024 which seems likely as the amount of spending increases every year (McCarthy).
- The GDP increase is driven by the recovery of the US economy after the 2008 recession, an increase in the number of people insured by the Affordable Care Act, and growing numbers of older individuals. Prescription drug costs have also increased significantly as there are new, expensive treatments for Hepatitis C, cancer, and multiple sclerosis (McCarthy).
- Just adding to the uniqueness of the US healthcare system, private insurance spending should remain constant with the implementation of high deductibles and copayments (McCarthy). Further contributing to separation of healthcare access between classes—the rich can afford it and the poor cannot.
- Despite spending more on healthcare than other wealthy nations, the US still performs poorly on certain health measures like maternal mortality, suicide, preventable hospital admissions, and life expectancy. We are still plagued with many of the problems of developing countries.

Why spending more is getting us less?

- As I mentioned in the first episode, there are various social determinants of health such as race, gender, neighborhood, work, or education. These factors play heavy roles in the

American healthcare system because we do not have a system that offers the same healthcare to everyone, like other developed countries.

- In *Understanding Health Policy,* the authors start with anecdotes that show how there is healthcare excess and deprivation in the US. A man named James Jackson lost his Medicaid benefits because of state cutbacks. He started experiencing abdominal pain and waited over a week to go to the hospital. Upon arrival, doctors diagnosed him with a perforated ulcer and septic shock, and he died. He died because he was afraid of the cost of his medical care. Consuelo Gonzalez started experiencing back pain and it was alleviated with drug-store acetaminophen. She went to her physician to make sure it was not anything more serious and she was prescribed a stronger medicine to be taken 3 times a day. Consuelo ended up with a bleeding ulcer that required hospitalization or $24,000 to her health insurer. An excess of healthcare caused her more troubles than her original problem (Bodenheimer & Grumbach, 1-2).
- Contributions to expensive healthcare: inflation, rise in doctors' salaries, inappropriate or ineffective care, and administrative waste (Bodenheimer & Grumbach, 93-94). Because the US has a mix-model system, there are administrative branches that review insurance claims, bill patients, do insurance marketing, and then those that oversee clinical services.
- I mentioned the different administrative costs in the first episode, and they are often lower than those of the United States because all patients have the same medical care and medical care is viewed as a fundamental human right. Healthcare is not considered another form of revenue and expenditure, the priority is people's health, thus there are less administrative sectors for reviewing claims, denying claims, and billing patients. Instead, health insurance is more universal and equal, eliminating excess administrative costs and reducing the amount the country spends on healthcare.

How to control costs

- Healthcare costs can be controlled with a regulatory or competitive strategy. Both of which will be necessary in the US due to the various health insurance options.
- Under social medicine, health insurance is often funded by taxes or another implementation of the government. This is how Social Security works to fund Medicare Part A. Changes in healthcare expenditures can only happen if there is a change in legislation that changes the tax amount—this is a regulatory strategy (Bodenheimer & Grumbach, 99).
- A competitive strategy targets employment-based health insurance, which you guess it, also exists in the US. With this strategy, the goal is to encourage price-sensitive purchasing by the employer and the employee (Bodenheimer & Grumbach, 100).
- For clarity, I am going to tell a story that helps us understand this strategy. A man named Giovanni works at an auto company and has Blue Cross health insurance that covers most services from whichever provider, with no deductible. He does not know

how much the health plan costs because his employer pays the total premium. He talks with his friend in the employee benefits department if the cost of the health insurance offered worries the company. The friend replies that it is expensive, but the premiums are tax deductible for the company. If instead the company paid its employees more money to cover additional health expenses, that is taxable income, whereas health coverage is not (Bodenheimer & Grumbach, 100). The catch-22 of this scenario is that the employer negotiates a premium for health insurance that not only offers good coverage for employees, but also reduces the taxes that the company owes each year. The employee is less likely to expect a higher wage because healthcare costs are covered by employer-based health insurance.

Quality of Healthcare—Real Problem in the US

- Access to care varies within the United States by social class and can be further influenced by neighborhood, education, and work. Those who are middle class and above often have good coverage through their employers and they can afford deductibles and copayments. Those below middle class are often uninsured or struggle to find doctors that accept Medicaid. To receive quality care, you must have access to care—something the US struggles to amend (Bodenheimer and Grumbach 111-112).
- Under Medicaid, physicians are paid on a fee-for-service basis, meaning that the state pays the provider for the services received by a patient. Oftentimes, this motivates doctors to run more tests, perform more surgeries, etc. This contributes to the large number of surgeries that the US performs in comparison to other developed countries (Bodenheimer & Grumbach, 113).
- Conversely, if physicians are paid on a capitation basis, they are paid regularly on behalf of the beneficiaries of the health insurance plans. This helps to reduce healthcare costs because there are less inappropriate or unnecessary services provided.
- Once again, the greediness of the United States contributes to the poor quality of healthcare that is offered.

**Examples of disparities**

- The following episodes will explore different groups within the USA and how healthcare access, cost, etc is different between those groups.
- Just for overview, I will mention some examples that will be developed in following episodes. In an article that explains health disparities by race and ethnicity explores lots of health disparities. Black, Hispanic, and American Indian and Alaskan Native fare worse than white people in the majority of examined measures, interestingly, black people do have some better screening experiences for things such as cancer but still have a higher mortality rate from cancer than white people. Conversely, Asian people fare better or the same than white people across the same examined measures. People of color are at

a higher risk of COVID-19 infection and of suffering from healthcare disparities such as hospitalization, death, and negative social and economic impacts.

**Conclusion**

Key points:

- The USA has examples of every healthcare system with the same country
- Examples include the VA, Medicare, the uninsured, and insurance through employers
- US healthcare is not regulated
- US GDP spending is high with poor healthcare quality
- Social determinants of health contribute to the poor access to healthcare for the homeless, unemployed, or those living below the poverty line
- Without a uniform healthcare system, social determinants of health are more inhibitory
- Healthcare costs can be regulated with a regulatory or competitive strategy

Thank you for listening to another episode of the *Comparative Healthcare* podcast. The primary focus of this episode was to define and describe the complexities of the healthcare system in the United States which leads us into the next few episodes about specific healthcare disparities. Thanks again.

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Episode 3

Hello everyone, I'm your host, Georgia, and welcome back to the *Comparative Healthcare* podcast. Last episode we talked about the US healthcare system—its structure, spending, and a sneak peek into the healthcare disparities that exist here. In this episode, I am going to discuss the health disparities that affect the transgender community and how our healthcare system is not structured to resolve these problems. With that short introduction, let's get right into it.

**Intro**

- I first want to begin by defining the term transgender
    - As stated in the Protecting and Advancing Health Care for Transgender Adult Communities article, "'Transgender' is an umbrella term used to describe people whose gender identity and/or gender expression differ based on the sex they were assigned at birth. The transgender community is not a monolith. Transgender people have diverse sexual orientations, gender expressions, and gender identities, and transgender identities do not depend on physical appearance or medical procedures." (Medina, 1)
- Discrimination, violence, stigma, and social and economic factors affect the physical and mental health of transgender individuals
- They suffer from more chronic conditions like higher rates of HIV/AIDS, substance use, mental illness, and sexual and physical violence (Medina, 1)
    - I will explore these further in this episode
- More recently, the COVID-19 pandemic exacerbated this existing healthcare disparities
    - Especially transgender people of color
- What the US needs to bridge this healthcare gap is nondiscrimination laws and inclusive policies

**Mental health barriers**

- The transgender community is a high-risk population for mental and physical health problems (Medina, 2)
    - They face regular harassment and discrimination
    - Underserved by the American medical system
    - The 2019 Behavioral Risk Factor Surveillance System (BRFSS) data show that 3 in 5 transgender respondents report poor mental

    - Elevated rates of asthma, regular smoking, and HIV among transgender populations make them more prone than cisgender individuals to experiences a severe case of COVID-19
        - Just a relevant fact
        - Isolation during the pandemic exacerbated mental health problems
        - Gender-affirming care was curtailed during the pandemic
- Minority stress- "minorities within a society, stigma, prejudice, and discrimination create a hostile and stressful social environment that can contribute to mental health problems such as depression and anxiety and drive higher prevalence of unhealthy or high-risk behaviors" (Medina, 4)
    - Center for American Progress survey of members of the LGBTQI+ community found 2/3 of trans individuals have experience some form of discrimination
    - Includes verbal and physical harassment
    - Increase for Black, Middle Eastern, and American Indian populations (Gruberg)
- On a chemical level, this stress causes dysregulation of cortisol (Medina, 5)
    - Affects metabolism, mood, cardiovascular health, and immune system health
- Gender-based violence and hate violence
    - Considered a social determinant of health
    - Physical violence --> minority stress --> mental health consequences (Medina, 7)
    - Reported killings are increasing annually with Black and Latina transgender women overrepresented among victims (Medina, 8)
    - Fear of victimization

**Social determinants of health**

- As stated in the first episode, social determinants of health are factors that infleunce healthcare quality and access but are not directly related to health risks or problems
- Racism, sexism, and transphobia all influence access to healthcare (Medina, 9)
    - High rates of poverty
    - Medical care is unaffordable
    - Disrupt in continuity of care
    - Discrimination by medical providers
    - Family rejection
        - Higher rates of domestic abuse than cisgender individuals (Medina, 10)
- Unsafe, degrading environments --> hide identity, change behaviors to avoid stigma/discrimination is a public health problem unique to disparities between trans and cisgender people (Medina, 9)

**Barriers to economic security**

- Systemic and institutional discrimination

- 1 in 4 transgender respondents reported a household income less than $25,000 annually (Gruberg)
    - Contributes to poor health
    - Exacerbates mental and physical ailments
    - Can not afford care/gender-affirming care
- Reliance on employer-provided coverage creates barriers for populations vulnerable to unemployment or employment discrimination (Medina, 11)
    - Transgender community being one of those populations
- Leads to labor market exclusion and lower rates of insurance (Medina, 12)

**Housing insecurity**

- Homelessness is exacerbated by labor and housing market discrimination, lack of legal protections, and family rejection (Medina, 12)
- Low annual income makes healthcare unaffordable but also makes rent and mortgage payments impossible
- Homelessness is associated with high rates of drug use, depression, anxiety, and suicide (Medina, 13)
    - The healthcare disparities between trans and cisgender individuals are not just a healthcare issue
    - These problems are connected to other barriers like discrimination in the workplace or housing market, family rejection, etc.
- Unsheltered transgender people are more likely to have police interactions and be sent to jail or prison than sheltered transgender people (Medina, 13)
    - Those numbers increase for Black unsheltered transgender individuals
    - Unable to house medications properly, no access to gender-affirming care

**Medical system hostility**

- Refusal of treatment and verbal or physical harm are common against transgender patients by healthcare professionals (Medina, 15)
- Racist and sexist hostility is inseparable from transphobia
    - Rather than offering alternative medical treatments or assistance, transgender patients are at a higher risk of being institutionalized or recommended for the criminal legal system prematurely (Medina, 15)
- Medical hostility has led to reliance on the black market and informal networks for gender-affirming care (Medina, 15)
    - Unregulated substances and potential legal consequences feel safer than engaging with healthcare providers
- Medical systems must earn transgender people's trust if they want to curve health disparities

    - Examples of being unsuccessful: conversion therapy, HIV public health responses, and the classification of transgender identity as a mental disorder (Medina, 15)

**Access to adequate care**

- Lack of cultural competency
    - 1 in 3 transgender people reported having to teach their doctor about transgender people to receive appropriate care (Gruberg)
    - 15% report being asked invasive or unnecessary questions about being transgender (James)
- Worry about judgment and having to explain their identities
- Not surprisingly, in a TransPop report, only 20% of transgender respondents reported being very satisfied with the healthcare they receive (Meyer)
    - For cisgender heterosexual respondents, this value is 45%
- Interestingly, over 50% of medical schools lack curricula about health issues and treatment of LGBT patients beyond HIV (Medina, 16)
- Insurance denial for gender-affirming care (Medina, 18)

**Legal protections in healthcare**

- SOGI is sexual orientation and gender identity
- In 2020, President Biden signed an executive order to enforce laws that prohibit sex discrimination to prohibit discrimination based on sexual orientation and gender identity (SOGI) (Medina, 19)
    - Employment, housing, healthcare, education, and credit
- Recommendations of the authors from the article titles *Protecting and Advancing Health Care for Transgender Adult Communities:*
    - Federal agencies should fully implement executive order across government (Medina, 20)
        - Include healthcare, health insurance, and provision of services
        - Accurately reflect the law
    - Reverse the Trump administration's broad religious exemptions (Medina, 20)
        - Important due to increased rate of consolidation among hospitals affiliated with Catholic systems
            - Transgender-exclusive ethical and religious directives
            - 1 in 6 hospital beds are in Catholic hospitals
    - Engage in rulemaking to strengthen nondiscrimination protection in Centers for Medicare and Medicaid Services regulations (Medina, 22)
        - Include examples on what it means for covered entities not to discriminate based on SOGI

        - Behaviors that could trigger review
    - State and federal regulatory bodies adopt affirmative coverage language (Medina, 24)
    - Improve Medicare coverage (Medina, 24)
        - Explicitly prohibit SOGI discrimination
    - Explicitly clarify protections for transgender patients in healthcare (Medina, 25)

**Beyond nondiscrimination legal protections**

- Staff training on cultural competency (Medina, 33)
    - Reduce invasive questions
    - Improve healthcare provider education on patient care
- Increase funding for community health centers (Medina, 33)
    - Provide urgently needed and affordable care to LGBTQI+ populations
    - Increase HIV-related awareness programs
- Policies to prevent violence against transgender people (Medina, 34)
    - Federal policymaking
    - Address housing insecurity, criminalization, victimization

**Conclusion**

Key points:

- Transgender individuals face discrimination in their everyday lives, and can still experience this is healthcare settings
- There are various barriers to healthcare for the transgender community: mental health, lack of cultural competency, job insecurity, and housing insecurity
- Medical schools lack appropriate education on transgender health
- Not only are legal protections necessary but societal changes must be made to promote trust between trans patients and doctors

Thank you for listening to this episode of the *Comparative Healthcare* podcast. In this episode, I explained transgender healthcare disparities when compared to cisgender patients. In the next episode, I will explore racial healthcare disparities that plague the US healthcare system. Again, thank you for listening.

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**James, S. E. & et al. (2016). T*he Report of the 2015 U.S. Transgender Survey*. Washington, DC: National Center for Transgender Equality, 2016.**

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Episode 4

Hello everyone, I'm your host, Georgia, and welcome back to the *Comparative Healthcare* podcast. Last episode we explored healthcare disparities between trans and cisgender individuals and how healthcare quality and access look different for the transgender community. In this episode, we will be exploring more healthcare disparities, but this time we will be focusing on race. There may be some connections that you notice between this episode and the previous and I will recognize those points in the following episodes when I interview professors with specific training in fields related to race, gender, and sexuality. With that being said, let's begin.

**Intro**

- For minority populations, the lack of health insurance is the most significant factor that contributes to healthcare disparities
- Minorities "...constitute one-third of the US population but make up more than half of the 50 million people who are uninsured" (DHHS, 2)
- The National Health Disparities Reports (NHDR) documented that "minorities often receive poorer quality of care and face more barriers in seeking care including preventive care, acute treatment, or chronic disease management" (DHHS, 3)
- Colorism, or skin tone stratification, is when people's life chances and outcomes are associated with their ethnoracial identity and their skin tone (Monk)
    - Black people are stratified further by their skin tone
    - Colorism has determined if people can enter social clubs or even church and the "brown bag test" was often used whether it was with a legitimate brown paper bag, or a door painted a shade of brown

**History**

- Racism has existed in the US since the inception of the country
    - Began with American Indian genocide
    - Just want to mention that I use the term "American Indian" because that is how indigenous people are called in US legislation
- Continued racism but against black people with slavery and Jim Crow laws

    - Still have implication today
- Like I already mentioned, the "brown bag test" was used for skin color stratification, but the history of race in the US is even more complex
    - Especially in relation to healthcare
- Skin tone importance originated during slavery as light-skinned black people were treated better by white people and often seen as more aesthetically appealing and intellectual (Monk)
    - Stems from the idea that light-skinned individuals are more European than African
    - Interestingly, some light-skinned multiracial people often desire darker skin so they cannot be mistaken for white
        - Implies a social boost but also loneliness
        - Discrimination and skin tone discrimination increased the incidence of cardiovascular disease
            - Not only is healthcare access influenced by race, but disease prevalence is too
- Ingroup colorism may have more significant effects on health than other discrimination because it comes from other group members (Monk)
    - Individual has their guard down
    - More unexpected
    - Example of why discrimination must be analyzed as multidimensional

**Institutional Racism**

- As we all know, and like I already mentioned, racism has existed in the US since the arrival of colonizers
- Since the 1980s, US policies have given more power to state governments which allows them to create policies and practices that are not race-neutral (Brown)
- Structural racism is associated with high infant mortality, myocardial infarctions, functional limitations, and other health conditions (Brown)
- COVID-19 is another example of racial healthcare disparities
    - More black people died from the COVID-19 pandemic than white people (Wrigley-Field)
        - The number of white people that die from inaccessible healthcare, that is how many black people died from COVID-19 (Wrigley-Field)
            - Even more die from inaccessible healthcare
        - Significant enough that the racial mortality gap will widen
    - COVID-19 risks have been minimized, social distancing, wearing masks, etc., but social institutions warrant attention for contributing to racial health disparities

        - Solutions include reparations, expanding social problems, defunding the police, and laws to combat educational and residential segregation (Wrigley-Field)
- "Dying of Whiteness" due to racism that has been integrated into US society
    - White men in Tennessee were the focus group of a study, and they were more likely to deny the expansion of Medicaid to prevent minorities from accessing healthcare (Metzl, 175)
        - In turn, more white people do not have access to affordable healthcare
        - When data was adjusted for the years that people would have lived if Medicaid was expanded, over 100,000 white lives would have been saved (Metzl, 176)
        - Racism negatively affects healthcare access for minority groups directly while racist ideologies prevent white people from considering their own benefits that could be derived from better healthcare access
- America elected President Trump despite him asking lower-income white people to choose less coverage and more suffering over a system that linked them to Mexicans and "welfare queens" (Wetzl, 187)
    - Why? Racism.
    - US voted for white nationalism and supremacy which ironically ensured that white people pay and suffer more for healthcare
    - "Whiteness" turned into a category of risk (Wetzl, 188)

**Racial Inequalities**

- Starting with pain control, white people are more likely to receive pain control medications (Bodenheimer & Grumbach, 25)
    - This is not due to health insurance but race
    - Latino and black patients receive poorer pain control
- Higher proportion of minorities are uninsured, uses Medicaid, or is poor, access problems are amplified in these groups (Bodenheimer & Grumbach, 25)
    - "African Americans and Latinos are less likely to have a regular source of care or to have had a physician visit in the past year" (Bodenheimer & Grumbach, 25)
- Racial and ethnic differences in healthcare are not always due to financial resources or insurance
    - African Americans and Latinos receive fewer services than white people of the same income or with the same insurance policies (Bodenheimer & Grumbach, 25)
- Disparities in quality of care for conditions such as diabetes, asthma, HIV/AIDS, cardiac care, and cancer
    - African Americans, Alaskan Natives, American Indians, and Latinos receive poorer quality of care than white people (Bodenheimer & Grumbach, 25-26)

    - Even worse health disparities for LGBTQ+ people of color
- Black and Latino neighborhoods have fewer practicing doctors (Bodenheimer & Grumbach, 26)
    - Black and Latino primary care physicians are more likely to locate their practices in underserved communities

**What accounts for these disparities that are not fully explained by insurance coverage and socioeconomic status?**

- Possible that cultural differences may exist that value medical care and attitudes towards seeking help differently (Bodenheimer & Grumbach, 26)
    - Related factor may be insufficient communication between doctors and patients of different racial, cultural, and language backgrounds
    - However, these possibilities do not completely account for racial health disparities
- Historically, hospitals were segregated or had segregated wards with inferior facilities and equipment (Bodenheimer & Grumbach, 26)
    - Also, racial barriers to entry into medical schools
- Overt racism is diminishing in healthcare, unconscious discrimination may influence access to healthcare

**Health Status and Race**

- Black people experience worse health than white people in the US (Bodenheimer & Grumbach, 27-28)
    - Lower life expectancy
    - Infant mortality rates are double of that of white people
        - Continues to wide
    - Mortality rates for black people exceeds those of white for 7 out of 10 of the leading causes of death in the US
    - Black men younger than 45 have 10 times the likelihood of dying of hypertension
        - Could partially be explained by social stressors related to race
        - Essentially, exacerbated by racism
- Native Americans also have poorer health than white people
    - Native Americans younger than 45 have higher death rates
    - Higher infant mortality rates
- Latinos and Pacific Islanders have great diversity (Bodenheimer & Grumbach, 28)
    - For example, health status varies between Cuban Americans and Mexican Americans
    - Health status also varies between Pacific Islander ethnicities

        - For example, Japanese Americans often are middle class whereas, Laotians are poorer
    - Still, Latinos have higher death rates of diabetes and acquisition of immune deficiency syndrome
    - Conversely, Asians have lower death rates in the US
- Healthcare inaccessibility is exacerbated by higher rates of poverty for minority groups

**Policy Changes**

- There have been initiatives taken to try to reduce racial health disparities
- Affordable Care Act
    - Signed by President Obama
    - Insurance coverage to more than 30 million people
    - Reduced health disparities by "investing in prevention and wellness" with "delivery of health care" and "prevention and wellness at the forefront of national policy" (DHHS, 7)
- Healthy People 2020 initiative
    - Track death, disease, and injuries based on race, ethnicity, gender identity, sexual orientation, disability status, special needs care, and geographic location (DHHS, 7)
    - Better understand and visualize healthcare disparities
- Let's Move!
    - Designed by First Lady Michelle Obama
    - Reduce childhood obesity by offering healthier foods in schools, encouraging healthy habits, and increasing physical activity (DHHS, 7)
- Despite these efforts, healthcare inequalities continue to proliferate, and policy change is required
    - Example being the adverse effects of COVID-19 on minority populations

**Reparations**

- Reparations is compensation to minorities that have been adversely affected by the historical racism of the US
- Amount considers the cost to the victims or gains to the perpetrators (Darity)
    - Things like slavery and the global effects on the living descendants
    - These authors state that they prefer the latter because it considers current wealth gap between black and white Americans
- Must measure the costs of slavery and racial oppression, consider unpaid wages to the enslaved, the financial gain of slaveholders, the price that the enslaved had to pay for their freedom, and the contribution of slavery to the nation's economic development (Darity)

    - Excess mortality caused by post-civil war violence and hate crimes
- Today, we see disparities in the housing market (Darity)
    - Smaller percentage of black people as homeowners
    - Home values are less because they are in black neighborhoods
    - Exacerbated by redlining and the denial of homeownership in the early 20th century
- Wage gap and workplace discrimination should also be considered (Darity)
    - The black-white wealth gap is due to cumulative, intergenerational wealth that was introduced by slavery and racism
    - Only benefitted white people
- The idea is that reparations should be estimated based on present conditions as a direct result of slavery
    - Rather than the "pay for what the ancestors did" mindset
    - Because racism is integrated into US institutions and affects things like healthcare access

**Conclusion**

Key Points:

- Minority groups do not have equal access to healthcare in comparison to white people
- Structural racism plagues healthcare and creates healthcare disparities
- Insidious discrimination contributes to differences in healthcare access, not just insurance coverage and socioeconomic status
- Higher rates of poverty can often be associated with poorer health of minorities
- Healthcare policy changes are necessary, and reparations are part of the solution

Thank you for listening to this episode of the *Comparative Healthcare* podcast. In this episode, I covered racial healthcare inequalities that plague the US healthcare system. I investigated various racial groups and noted how their health statuses compare to that of white people. The following episodes will be interviews with experts in the fields of transgender and racial health disparities. Again, thank you for listening.

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Interview Questions

Healthcare Disparities within the Transgender Community Questions

- Small introduction with the interviewee
    - Name, classes they teach, field they are experts on

1. I mentioned this in the background information episode, but how do you define the term transgender?
    a. Segue into healthcare disparities that particularly piqued my interest
2. I read a lot about transgender individuals being at high-risk for mental illnesses, why do you think that is?
3. Which healthcare institutions do you think contribute to this pattern? Or which institutions do we lack in the US healthcare system that would help with this mental health crisis?
4. Interestingly, transgender individuals have an increased likelihood of developing cardiovascular disease, asthma, and depression. What factors do you think are risk factors for these conditions?
5. Do you think "minority stress" may contribute to trans persons' fear of healthcare institutions? In an article I read this was defined as a theory "...that for minorities within a society, stigma, prejudice, and discrimination create a hostile and stressful social environment that can contribute to mental health problems such as depression and anxiety and drive higher prevalence of unhealthy or high-risk behaviors."
6. Does minority stress contribute to increased rates of suicide, depression, and/or anxiety?
7. In my research, I found that social determinants are non-medical factors that influence an individual's access to healthcare and the quality of care available. These factors are

neighborhood, family, socioeconomic status, sexuality, and various others. Which social determinants contribute to the healthcare disparities between trans and cisgender persons? Or better, which ones contribute the most significantly?

8. Because socioeconomic status is a social determinant of health, what barriers exist that prevent economic security within the transgender community?
9. Because of housing market discrimination and exclusion, transgender individuals experience high rates of homelessness and poverty. How do you think this contributes to healthcare disparities between trans and cisgender persons?
10. How can nondiscrimination protections change to help the transgender community?

- Additional questions that spark from conversation

Racial Healthcare Disparities Questions

- Small introduction with the interviewee
    - Name, classes they teach, field they are experts on

1. Through my research I have found that racism is a system. Which social phenomena significantly contribute to racial health disparities?
    a. Segue to social determinants of health and/or additional questions about the interviewee's response
    b. Relate to housing, education, employment, and other factors
2. Ethnic minority groups experience higher rates of hypertension, diabetes, asthma, and obesity. Does the US healthcare system contribute to these inequalities? If so, how?
3. Depending on the response, how did the factors mentioned contribute to the disproportionate impact of the COVID-19 pandemic on racial minorities?
4. Increased awareness of health disparities will help bring awareness to healthcare disparities but what policy changes do you think would make the most significant difference?
5. How are patient-provider relationships influenced by health disparities?
6. Do you think early education on preventative measures and healthy lifestyles effectively works to decrease healthcare disparities within ethnic or racial groups? Are they equally taught depending on community, neighborhood, etc.? Does that contribute to health disparities?
7. How do you understand implicit bias toward members of ethnic and racial minority groups? Do you think that contributes to health disparities? If so, how?
8. In the US, we have various ethnic and racial groups, each with their own views of healthcare. Do you think a more inclusive approach to medicine would help decrease some health disparities? Such as recognizing the benefits of both western and traditional medicine.

Episode 5

Hello everyone and welcome back to the *Comparative Healthcare* podcast. The couple episodes have been about healthcare disparities that exist in the US, and I wanted to supplement this information with an interview from an expert. In this episode, I will be meeting with Professor Shuster to discuss transgender healthcare disparities. So, let's begin with that.

**Conclusion**

Key points:

- Minority stress contributes to the higher incidence of mental illnesses in the transgender community and could potentially explain part of the reason why conditions like cardiovascular disease are more common in trans people
- There are numerous social determinants of health that impact a trans person's access to healthcare, Professor Shuster mentioned that race and class are major contributors
- We talked about inadequate medical school curriculum and how medical schools are wary of where and how to incorporate trans medicine, but Professor Shuster mentioned using examples of transgender patients, explicitly stating that some patients may not identify with their assigned sex, and using inclusive language
- Another interesting point mentioned by Professor Shuster is that they concede that federal policy change is necessary to protect trans people from discrimination, but that there also needs to be change established that does not allow for its reversal with the election of another president

Thank you for listening to another episode of the *Comparative Healthcare* podcast. This episode focused on trans healthcare disparities and was guided by a conversation with Professor Shuster. The next episode will be focused on racial healthcare disparities but with insight from another professor, so watch for the next episode. Thanks again for listening.

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Episode 6

Hello everyone, I'm your host, Georgia, and welcome back to another episode of the *Comparative Healthcare* podcast. Last episode you heard an interview with Professor Shuster to discuss trans healthcare and this episode we will hear from Dr. Hedges about racial healthcare disparities in the United States. So, let's get right into the interview.

**Conclusion**

Key points:

- Racial healthcare disparities are affected by various factors which shows the intersectionality of healthcare
    - These include access to health insurance, employment, neighborhood, and housing
    - These factors along with macro and microaggressions lead to the higher rates of hypertension, diabetes, asthma, and obesity seen in various ethnic groups
- COVID-19 is a modern example of high risk but low protection instances impacting racial healthcare disparities
- Implicit bias is integral to healthcare in the US, but Dr. Hedges that it exists in most institutions
    - She used the example of preschools
- Dr. Hedges does state that there is value to understanding and utilizing the benefits of both western and traditional medicine

Connection to trans health:

- Both mentioned that patients often must look a certain way and/or act a certain way to be taken seriously by medical professionals
- There is distrust between patients and medical professionals because of decades of trauma
- Doctors are on a pedestal, if they do not understand the specific needs of a patient, they often revert to saying that they are the doctor and know better than the patient
- Medical school education is not sufficient on transgender nor racial healthcare disparities
- Cultural and structural competency would improve healthcare disparities
    - Understanding and acknowledging implicit bias

Thank you for listening to another episode of the *Comparative Healthcare* podcast. In this episode, Dr. Hedges gave us some insight into the racial healthcare disparities in the US and what affects those disparities. Next episode we will explore healthcare in less wealthy countries and compare how spending is mitigated differently and better healthcare systems are implemented. Thanks again for listening.

Kristin Hedges

Associate Professor, Internship Coordinator

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Episode 7

Hello everyone, I'm your host, Georgia, and welcome back to the *Comparative Healthcare* podcast. The last few episodes have been about healthcare disparities in the US and interviews with experts in relevant fields. In this episode, I will compare the healthcare systems of wealthy and poor countries to re-establish the idea that we pay far too much for healthcare and receive poor quality of care in the US. With that being said, let's begin.

**Intro**

- As established in episode 2, what the US spending on healthcare is more than any other developed country
- But Americans pay more for less
    - High maternal mortality, suicide, preventable hospital admissions, and life expectancy
- Because we do not have a healthcare plan for all-type system, GDP spending on healthcare is exacerbated by administrative costs
- Interestingly, countries like Costa Rica and Cuba have excellent healthcare systems despite being not as wealthy
- Just for comparison purposes, the US spends $4.3 trillion on healthcare, 18.3% of Gross Domestic Product, $13,000 per person

**Costa Rica**

Overview

- $61.8 billion USD (Columbia University)
- 7.56% of GDP
- $902 per capita
- Population is significantly smaller: 5.1 million

History

- 1941, Caja Costarricense de Seguro Social (CCSS) social security insurance for wage-earning workers (Columbia University)
    - Until 1975, CCSS extended coverage to people in rural areas, low-income, and vulnerable populations
    - By 2003, coverage was 89% of the population
    - In 2010, residents had to become members of the CCSS
    - Healthcare is a right, lead to universal health coverage

Caja Costarricense de Seguro Social (CCSS)

- Universal coverage in the public sector and has private coverage options as well (Columbia University)
- Constitution states that human life in inviolable, right to health is constitutionally protected (Columbia University)
- CCSS is responsible for financing, purchasing, and delivering personal health services in Costa Rica (Columbia University)
    - In its own facilities but can contract private providers
    - Long wait times but adequate quality
- 3 different regimes for different population (Columbia University)
    - SEM covers wage-earning population and dependents
    - IVM provides coverage and pensions for elderly, disabled, orphans, and widows
    - Non-contributive regime is coverage for individuals unable to contribute to the system
        - Low-income or disabled
- Employee contribution through a percentage of a paycheck (Columbia University)
- Non-contributive regime is financed by state through Fund for Social Development (Columbia University)
    - Also charges on electronic lotteries, tobacco, and liquor sales
- Voluntary, private health plans are still common (Columbia University)
    - Premiums are determined by the income of the applicant
    - Private healthcare is of quality comparable to high income countries
    - Private health services at private hospitals and ambulatory settings
- Has strong primary care but does not meet the demands of specialized treatment (Columbia University)

How does Costa Rica perform overall?

- Longer life expectancy (OECD)
- Lower prevalence of smoking (OECD)
- Fewer avoidable admissions (OECD)
- 70% of people were satisfied with the availability of quality healthcare (OECD)

- Long wait times for procedures, like I mentioned
- Still 20% of healthcare expenditure is out-of-pocket (OECD)

**Cuba**

Overview

- 11.7% GDP on healthcare (OECD/The World Bank)
- $1,186 per capita

History

- Since the Cuban Revolution, healthcare for all citizens has been an important concept (Cuba Platform)
- Before the Revolution, access to healthcare varied by social class (Cuba Platform)
    - Private clinics only accessible to those with resources
    - Public hospitals were underfunded, inaccessible, badly equipped, and corrupt
- In 1961, Cuban government created the National Health System, or SNS for its name in Spanish—El Sistema Nacional de Salud (Cuba Platform)
    - Phase out private healthcare and expand public services
- Today, healthcare is regulated and financed by the government (Cuba Platform)
    - Free of cost
    - Leveraged its strength in education and high number of doctors to focus on primary care access
    - Emphasis on prevention and need for costly "cures" is reduced

National Health System

- Outperforms all other countries in Latin America (Cuba Platform)
- In 2014, Cuba spent nearly $7,000 less per capita than the US (Cuba Platform)
    - Lower infant mortality rate
    - Higher life expectancy
- Current challenges (Cuba Platform)
    - Making care more comfortable
        - Some medical facilities have limited access to bedding, bandages, and basic resources
        - Dealing with chronic diseases such as cancer and diabetes
        - And diseases that affect the elderly such as dementia

Structure of the Healthcare System

- 3-tiered structure for organizing primary, secondary, and tertiary care (Cuba Platform)

    - Municipal authorities oversee community-based primary care levels
        - Includes consultations, family doctor visits
        - Strive to resolve 80% of cases
    - Provincially managed hospitals and centers of specialization
        - Treat sick patients, handle complications, rehabilitation
        - You can go right to this level, but system works smoothly and only 15% of cases reach this level
    - Nationally administered, specialized hospitals and centers for the treatment and study of diseases
        - Focuses on cures
        - Complications from serious illnesses
        - 5% of cases
- In addition to the SNS, the Ministry of Public Health (MINSAP) oversees epidemiological control (Cuba Platform)
    - Example is fumigation to minimize mosquito-borne diseases
    - Regulation of sanitations
    - Promotion of hygienic norms
    - Regulation and evaluation of imported and domestically produced medicines
- Due to trade blockade, Cuba has invested in a domestic biopharmaceutical and biotechnological sector (Cuba Platform)
    - Reduces the cost of importing medicines
    - Income from exporting medicines--$686 million USD in 2013

Outcomes

- World leader in doctors per citizen (Cuba Platform)
- Life expectancy falls in the range of Western, developed countries (Cuba Platform)
- Provides medical internationalism (Cuba Platform)
    - Sends brigades of doctors to other countries to assist after natural disasters
    - In 2014, Cuba made $5 billion USD by contracting out Cuban doctors to foreign governments, healthcare is Cuba's highest-earning export

**USA**

- Why can't the US reduce its spending on healthcare and provide quality care when less wealthy countries can?
- Mixed model system
    - Causes spending to increase due to administrative costs
    - Only developed country where a significant portion of the population does not have healthcare coverage (The Commonwealth Fund)
- Racism and other biases influence healthcare access

    - Obvious from life expectancy numbers when looked at by race
    - Lower life expectancy for minorities
- Highest obesity rate—double the OECD average (The Commonwealth Fund)
- Less-frequency physician visits (The Commonwealth Fund)
    - Due to low supply of physicians
    - Due to insurance coverage
    - Leads to more expensive treatments when preventative care is not taken seriously
    - People are discouraged from using the healthcare system

**Conclusion**

Key points:

- Poorer countries like Cuba and Cost Rica perform better in healthcare than the US
- Both offer a coverage plan for all residents which helps to reduce GDP spending on healthcare
- Cuba and Costa Rica have strong primary care sectors to promote preventative care
- Admittedly, they lack resources for non-communicable diseases like cancer and cardiovascular disease
- The use of public health ministries promotes sanitization and hygiene standards
- The US does not have a single, structured healthcare institution because health coverage varies from person to person

Thank you for listening to this episode of the *Comparative Healthcare* podcast. In this episode, we talked about how countries with economic barriers still outperform the healthcare system of the United States. I analyzed how the healthcare systems of Cuba and Costa Rica differ from that of the US and why the US cannot achieve equal access to quality healthcare under its current healthcare system. In the next episode, I will give my suggestions as to how to fix the US healthcare crisis, using information that I have explained in this podcast. Thank you again for listening.

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Episode 8

Hello everyone, I'm your host, Georgia, and welcome back to the *Comparative Healthcare* podcast. Over the course of this podcast, I have defined healthcare models, US healthcare, US healthcare disparities, interviewed experts, and compared healthcare systems of lower income countries. Using all this information, I will explain how to solve the US healthcare crisis in this final episode. This is going to be extensive, so let's begin.

**Intro**

- I am going to start with a brief recap of the healthcare system of the US
- Currently, it is a mixed model system (Reid)
    - Bismarck-under 65, insurance through an employer and pay a copay
    - Beveridge- Native Americans, military personnel, and veterans have doctors that are governmental employees in government-owned clinics and never get a medical bill
    - National Health Insurance-US Medicare, near-universal participation, and low administrative costs
    - Out-of-pocket-uninsured, pay the entire bill and visit doctors less frequently
    - Lacks a central government entity that regulated health care
- US healthcare spending is more than any other developed country with poor quality of healthcare
    - We are spending more but receiving less
- Private insurance spending remains constant with high deductibles and copayments
    - But this causes separation of classes, the rich can afford insurance and the poor cannot
- US healthcare is plagued by disparities

    - I covered racial and transgender healthcare disparities
- Racial healthcare disparities are exacerbated by the institutional racism that has existed since the inception of the country
- Insufficient medical training and education on transgender health dissuades trans individuals from seeking healthcare
- Lower income countries control healthcare spending by providing universal healthcare coverage and emphasizing preventative care

**Which model?**

- The best model to implement in the US is the National Health Insurance Model
- This model is a combination of the Beveridge and Bismarck models
    - Providers are privatized but the government pays for health insurance for all funded by taxes (Reid)
- Would reduce administrative costs because there are no offices that deny claims, no profit to be made, and there is a single payer covering everybody (Reid)
- US Medicare closely reflects the National Health Insurance model because it offers universal coverage to its participants
    - Medicare would need to be expanded to offer better coverage of consultations, procedures, and medications
    - Would no longer be for only low-income individuals, it would be for everyone
- Follow the demonstration effect that worked in Canada
    - Start with the implementation of universal coverage in one state and its success would inspire other states to adopt similar healthcare plans
    - Even if not initially successful, the offered coverage plan could be tweaked, and another trial basis could begin
    - Even if coverage differs slightly from state-to-state, each state's plan offers coverage throughout the country
- Healthcare would continue to be paid for with taxes and paycheck withholding but would contribute to a healthcare relief fund
    - So that when a person goes to the doctor, there are no medical bills
- If administrative costs are not reduced enough by a single, universal coverage plan, a program like the card of life in France could be implemented
    - The card contains your medical history and is scanned at medical facilities and automatically notifies the healthcare relief fund
- Healthcare will be operated under a public body on a non-profit basis
- Doctors are offered malpractice insurance and primary care is emphasized
    - GDP spending on healthcare can be reduced by encouraging frequent primary care visits to catch early stages of disease, update vaccinations, etc.
    - Less future spending on non-communicable diseases like cancer and diabetes
    - Motivate students to choose medical pathways

- Doctors are paid on a capitation basis; they are paid regularly on behalf of the beneficiaries of the health insurance plans
    - Prevents doctors from running more tests or performing more surgeries than necessary because they are paid on a fee-for-service basis

**Reparations**

- Even with the implementation of a different healthcare system, the US was built on racist policies
- Although I do believe that equal, universal access to healthcare will reduce future instances of racial healthcare disparities, reparations are necessary to promote equity
    - Health is influenced by factors other than health status, such as education, income, neighborhood, race, gender, etc.
    - Reparations will help reduce the disparities caused by social determinants of health
    - With universal coverage established, monetary reparations can be used to close education gaps, provide financial stability, and hopefully influence the destruction of redlining
- Although I do not know the exact value of reparations, I do think they are necessary and can be partially afforded with the money saved from the implementation of the National Health Insurance-like model
- Also, white people need to recognize that their anti-universal healthcare beliefs are not solely economically based, but also racially motivated

**Transgender Health**

- Along with an NHI-like model in place, it is crucial that transgender care and gender-affirming care are covered under the universal healthcare plan
- In addition to changing the healthcare model of the US, education must be modified accordingly
    - The emphasis on the importance of doctors and primary care physicians will hopefully motivate more people to choose medical career paths
    - This emphasis on education will be paired with changes to the medical school curriculum that include transgender health issues and sensitivity training to ensure patient comfort
        - Beyond only covering HIV/AIDS
- The idea is that racial and transgender health disparities will be reduced by rebuilding the trust between patient and doctor

**Improving Access to Healthcare**

- Yes, this model will reduce high healthcare costs, but there are other issues that plague the US healthcare system
- Telehealth services will also be extended
    - Reduce transportation barriers
    - Prevent the overuse of healthcare by providing at-home consultations that then could result in referrals
    - Access to some form of healthcare in rural areas that may not have a hospital or clinic
- Education on healthcare sites
    - Again, emphasize primary care as the first consultation
    - Referrals can then be made
    - Like Cuba, first-level medical visits are used to assess health, provide preventative care, and ensure vaccinations
- Training on cultural responsiveness
    - Reduce implicit bias
    - If someone fears that they will be mistreated, they will avoid the doctors

**Concession**

- Although this is not a step-by-step solution to solving all healthcare problems in the US, my research has shown that universal policies are not only cheaper, but better for residents
- The US is already setup to have proposed changes by state that could proliferate when successful
- Current US healthcare ranks us as a developed country with problems of the developing world
- Immediate healthcare reform is necessary

**Conclusion**

Key points:

- Implement a national health insurance-like model because healthcare will be universal and still funded by taxes and paycheck withholding
- If only implemented in select states, the demonstration effect would cause healthcare reform in the remaining states
- GDP spending would be reduced by eliminating some administrative costs and primary care emphasis
- Reparations will promote equity
- Healthcare reform will work to better the relationship between minority patients and doctors

- White people must let go of the idea that universal coverage makes people “welfare queens”
- Universal coverage will benefit everyone, including white people

Thank you for listening to the final episode of the *Comparative Healthcare* podcast. In this episode, I explained why I think the implementation of the national health insurance model paired with cultural responsiveness will better serve patients of every racial, cultural, and identity background. The healthcare crisis remains at the forefront of issues that characterize the US and change can begin now. Thank you for listening.

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