

The Human Right of Health Care

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Abstract

In the United States, there is currently a health care crisis that is affecting tens of millions of Americans. In this research paper, our team will dive into what the specific problems are within our current healthcare system, explain their significance and effects through online research and personal interviews, and attempt to come up with a solution. From our analysis, we noticed several major unfavorable qualities of the current health system in our country: health care is very expensive; many Americans do not have health insurance or adequate insurance coverage; there is a lack of availability of services, culturally competent care, and holistic care; and the actual quality of our care is substandard compared to other developed nations. Our solutions to solve these dilemmas all revolve around a similar concept: the establishment of a government-controlled, socialized health care system called the United States Cooperative Health System.

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Background Information

Health insurance helps protect you against the high costs of medical care and is a deal with an insurance provider. You buy a package or contract, and if you seek medical attention the company offers to cover part of your expenses; many Americans get a health insurance policy through their employers.

Culturally competent care is characterized as care that values patient demographic diversity and cultural influences that influence identity and health services, such as language, modes of speech, opinions, attitudes, and behaviors. Communication barriers, race and ethnicity differences, low literacy, and other factors can contribute to the problem of different groups in our country not having equal access to health care or insurance. When it comes to language and communication barriers for example, “Spanish-speaking Latinos are less likely than Whites to visit a physician or mental health provider or receive preventive care” (National Academy of Sciences, 2006). This is why it affects Latinos by the type of health service they receive; having an interpreter is important for non-English speakers but, “less than half — 48 percent — report that they always or usually had one” (National Academy of Sciences, 2006).

A move within the current healthcare system is to start educating patients on changes in lifestyle and self-care to promote wellness. This may include diet, exercise, psychotherapy, relationship counseling, and spiritual counseling. As of right now, this type of care is not as prevalent or readily available as it should be. Another type of care is holistic healthcare and it is so important because it underlines the relationship between mind, body, and spirit. Although, you can visit your doctor when it comes to health advice, “the holistic approach is simply a way to find a balance between clinical medicine and a more general feeling of well being” (K, 2019). The goal is to reach optimal wellness where everything works the best it can, and, in holistic

healthcare, individuals take responsibility for their own degree of well-being and regular decisions are used to take responsibility for one's own wellbeing.

Methodology

Throughout this paper, the research team enables several different forms of research, consisting of online investigation and personal interviews with real people who have authentic experiences with our current medical system. When spending time exploring internet sources, our team made sure that each site we were gathering information from was a reputable and trustworthy source that would supply us with the most accurate and relevant information for our paper. When interviewing our respondents, we asked questions that assessed each mentor's credibility on the subject of health care, questions that gave us insight into the interviewees' past experiences with the current healthcare system, and questions that showed each professional's hopes for the future medical system in our country. Each mentor gave their unique position and perspective, presenting the team with a wider outlook on the current healthcare system and what it could look like in the future.

Introduction

Annually \$3.6 trillion is spent to prevent and treat chronic diseases in the USA according to the Centers for Disease Control and Prevention (2020). Comparing the life expectancies of other developed countries to the USA, we get to know that the quality of healthcare in the USA has lots of room to improve. Access to health care is the ability to obtain health services when needed, and the lack of adequate access for millions of people is a crisis in the United States. Access to health care has two major components: the first and most frequently discussed is the ability to pay and the second is the availability of health care personnel and facilities that are close to where people live, accessible by transportation, culturally acceptable, and capable of

providing appropriate care in a timely manner. This report will go into depth about how the socioeconomic status, race/ethnicity of a person also determines his/her health status in the population (Center for Disease Control and Prevention, 2020). Quality health care must be made accessible and free to all people living in the United States.

The High Costs of Care

One key component of the problem with the United States healthcare system is its actual cost, to the individual and to our country. As reported by Bloom (2017), “average annual costs per person hit \$10,345 in 2016.” On top of this astonishing figure, our country spent over \$3.6 trillion in 2018 through the healthcare system (Peter G Peterson Foundation, 2020). While these numbers are quite shocking, the situation is only getting worse. In less than eight years, Americans can expect our national expenditures to rise to \$6.2 trillion and our average personal costs to \$18,000 (Peter G Peterson Foundation, 2020), greatly outpacing the expected inflation rate. With all this spending, we should be able to expect a well-functioning system, but the sad fate is that we cannot. While the US spends the most in gross dollars and as a percent of our GDP, 16.9% in 2018, we fall short to other countries in reaction to how well our healthcare system performs (Tikkanen & Abramsm, 2020). Among the other 10 developed countries in the Organization for Economic Co-operation and Development (OECD), America has the lowest life expectancy, the highest suicide rates, the highest chronic disease burden, the highest rate of obesity, and the highest rate of avoidable deaths (Tikkanen & Abramsm, 2020). The actual quality of our medical system will be discussed later in this paper in more detail, but, focusing solely on the sheer cost of healthcare, there are many contributing, preventable factors that inflate the price so incredibly high.

According to the Peter G Peterson Foundation (2020), the primary causes of this phenomenon are expensive medical technology, administrative complexities, and the monopolization of hospitals. As our society grows more and more mechanically and technologically advanced, we can complete more complex tasks with ease. This is an amazing trait for the betterment of our world, but it does tend to be expensive. As this new, innovative tech diffuses into the healthcare field, specialists can more easily treat their patients at the same time as making the same patients' medical bills much more costly. According to Skinner (2013), "it's not just 'technology' that is driving our rising health-care costs; it's the type of technology that is developed, adopted, and then diffused through hospitals and doctor's offices." Skinner (2013) also goes on to describe that our country "pays for nearly any technology (and at nearly any price) without regard to economic value." There are likely many medical instances where a physician or a specialist uses a machine that is costing the patient and insurance provider much more than another method of treatment that may be just as effective and this needs to be addressed in our healthcare system.

Additionally, dealing with insurance providers is a significant part of most doctors' workdays. Specifically, in 2019, over half of all US physicians spent 10 to 24 hours a week on administrative paperwork and about 18% spent more than 25 hours (Kane et al., 2019). Doctors must spend their precious time dealing with many insurance providers instead of caring for their patients.

The next issue addressed is the amalgamation of hospital systems across our nation, which may sound good, but can lead to a decrease in competition and, subsequently, an increase in prices. When all the hospitals in one area are run by the same company, this company can inflate their prices because their consumers have little opportunity to go to a cheaper hospital

elsewhere. On the contrary, when hospitals are separately run, there is a rivalry to have the lowest prices and the highest quality of care. To add on to this problem with hospitals, many other aspects of the healthcare system are monopolized: two companies dominate 92% of the \$24.4 billion annual dialysis center industry and another two companies have ownership over 75% of the \$1.5 billion annual IV solution industry (Baker, 2019). Because these individual companies are so overreaching and powerful, they lack the necessary competition that our market needs to function well and lower prices for consumers.

Building on these three contributors identified by the Peter G Peterson Foundation (2020), Blue Cross Blue Shield (2020) identifies additional causes of the heightened cost of health care as prescription drug costs, chronic disease treatment prices, and the effects of harmful lifestyles adopted by many Americans. As stated by The Commonwealth Fund (2017), the rapid increase in prices for prescription drugs is due to the complete lack of competition in the market because “a manufacturer of a brand name product can go to a generic manufacturer who’s ready to go into competition and pay that manufacturer not to go into competition.” With nobody to compete with, these brand name product manufacturers can charge absurdly high prices for their products, costing the consumer, the insurance company, and the American government more and more each year.

Next, there are many diseases such as cancer, heart disease, obesity, and arthritis, classified as chronic diseases, that “are among the most common, costly and often preventable of all health problems” (Blue Cross Blue Shield, 2020). Our national spending on these diseases is incredible. In 2003, the US spent \$128 billion on arthritis and related conditions; in 2008, \$147 billion was spent to treat obesity in our country; in 2010, \$157 billion was spent on cancer treatments and over \$315 billion on heart disease (Blue Cross Blue Shield, 2020). With these

treatments taking up 86 percent of all U.S. healthcare costs (Blue Cross Blue Shield, 2020), there needs to be a vigilant effort to curb the development of these diseases through preventative care; these ailments are largely the direct cause of unhealthy lifestyles that we as an American public partake in. If we can tackle these public health issues at their root causes, we can likely expect to see a significant drop in these immense national costs.

Lack of Holistic Health Care

Holistic healthcare is complete or total patient care that takes into account an individual's physical, emotional, social, economic, and spiritual needs; his or her response to the disease; and the effect of the disease on the ability to meet self-care. It is important to have a holistic approach to health care because it takes everything into account. According to K (2019), having a holistic approach, “usually focuses on the cause of symptoms, not the reduction of symptoms” and investigates how to prevent symptoms.

When it comes to suicide, Wikipedia Foundation (2020) says, “in 2018, there were 48,344 recorded suicides, up from 42,773 in 2014.” Contributing to that problem, “surging death rates from suicide, drug overdoses and alcoholism, what researchers refer to as ‘deaths of despair’, are largely responsible for a consecutive three year decline of life expectancy in the U.S” (Kight, 2019). If a person is trying to defeat a certain type of addiction or depression, a holistic drug and alcohol rehab program will analyze all the influences affecting the lifestyle of an alcoholic and see if improvements could be made. Because of this reason, holistic health care will increase that person's likelihood of staying off drugs in the long run (K, 2019). For example, if anyone has taken to opioids as a means of avoiding a traumatic existence, a holistic therapist would explore ways of de-stressing and creating a healthier lifestyle.

In most cases, people are looking for these holistic options because they are often unhappy with regular medicine; they see alternative therapies as providing greater personal flexibility and power of health care decisions (Astin, 1998). As a result, according to BBC (2014), “suicide risk reduced after talk therapy” and “talk therapy sessions can help reduce the risk of suicide among high-risk groups.” For example, a 1994 survey of physicians from a wide variety of medical specialties (in Washington State, New Mexico, and Israel) found that over 60% recommended alternative therapies to their patients at least once in the previous year, while 38% recommended alternative therapies to their patients at least once in the previous month (Borkan et al., 1994). However, as reported by Astin (1998), Forty-seven percent of these physicians have reported using alternative therapies themselves, while 23 percent had integrated them into their practices.

The fact that only 23 percent incorporated these alternative holistic methods into their daily practice contributes to the problem of rising rates of suicide and different types of addiction. Certain measures need to be taken since most of the alternative therapies depend on relaxation and stress management. They can help relax your emotions, alleviate anxiety, and improve your general sense of well-being and wellbeing. Many physicians, cancer nurses, and researchers are involved in the notion that you can improve your health through optimistic feelings (Cancer Research UK, 2018).

The Quality of Care

A lack of resources in healthcare settings has serious consequences for the quality of patient care and the professional work environment for nurses, therapists, and other healthcare providers. Having more health system resources available and making better use of the resources are two approaches that can suffice the needs of workers and meet patients’ expectations. As

reported by HomeCEU (n.d.), many healthcare facilities either are not ready or have a lack of supply for emergency situations. According to HomeCEU (n.d.), some contributing factors to this are not having the crash cart stocked and ready, medicines and other miscellaneous items not being available on the spot, and having the patients wait extended periods of time to get the product. Not having the code sheet of the patient ready and not having the proper dosage of emergency medicines ready to go in the crash cart are also contributing factors. These are the critical situations where a microsecond of time makes a huge difference in what the outcome for a patient is. Other general problems many healthcare facilities face are not having a proper system for communication or documentation, technology issues, and short supply of medical equipment.

As reported by Schuster et al. (2005), much of the interest in quality of care has developed in response to the dramatic transformation of the health care system in recent years. New organizational structures and reimbursement strategies have created incentives that may affect quality of care. Although some of the systems are likely to improve quality, concerns about potentially negative consequences have prompted a movement to assure that quality will not be sacrificed to control costs. The concern about quality arises more from fear and anecdote than from facts: there is little systematic evidence about quality of care in the United States. We have no mandatory national system and few local systems to track the quality of care delivered to the American people. More information is available on the quality of airlines, restaurants, cars, and VCRs than on the quality of health care.

Lack of Cultural Competence

The nation's increasing diversity brings opportunities and challenges to the creation and delivery of culturally competent services for health care providers, health care systems and

policy makers. Cultural competence is described as the ability of providers and organizations to provide health-care services that meet patients' financial, cultural, and linguistic needs. A culturally responsive healthcare system can help increase patient outcomes and quality of care and can also reduce racial and ethnic inequalities in treatment. Types of approaches for pushing the health care sector towards these targets include delivering appropriate instruction for health providers on cultural competency and cross-cultural problems and developing measures that reduce institutional and linguistic obstacles to medical care.

According to Georgetown University (n.d.), “people who do not have a regular doctor or health care provider are less likely to obtain preventive services, or diagnosis, treatment, and management of chronic conditions.” As reported by (Georgetown University, n.d.), the proportion of the nonelderly population that does not have a usual source of care, classified by race, are 30% of Latinos, 19% of African Americans, 21% of Asians, 19% of American Indians, and a mere 15% of white people. Health insurance coverage is also a primary determinant of health care quality. Higher proportions of minorities than white people have no common source of care and do not have health insurance, and Black people, Hispanics and some Asian populations often seem to have lower health insurance coverage compared to whites, with Hispanics facing more barriers to health insurance than any other group (National Institutions of Health, 2017). Blacks and Hispanics are also less likely to receive care in emergency rooms than whites and lack health care continuity. Analysis of racial and ethnic differences in access to and use of health services between 1977 and 1996 illustrates that the gap between Hispanics and whites has not narrowed over time (Fiscella et al., 2002). In our incredibly diverse nation, nobody should be at a medical disadvantage because of the color of the skin or their place of origin.

Problems with language and communication can also lead to patient dissatisfaction, poor comprehension, and poor quality of care. Spanish-speaking Latinos are less satisfied with the care they receive and more likely to report general health problems than English speakers (Georgetown University, n.d.). According to the U.S. Census Bureau (2002), of the 37 million adults in the United States who speak a language other than English, 18 million people (48%) do not speak English very well. This leads to language and communication barriers may change the value and quality of health care received; for example, Spanish-speaking Latinos are less likely than white people to visit a physician or mental health provider, or to receive prenatal services, such as a mammography examination or an influenza vaccination (Fiscella et al., 2002). The availability of interpreters may also affect the use of health services.

The 1992 National Adult Literacy Survey found that 40 to 44 million Americans do not have the necessary literacy skills to function daily (Kirsch et al., 2002). According to Kirsch et al. (2002), elderly people typically have lower levels of literacy, and less access to formal education than younger populations. Older patients with chronic diseases may need to make multiple and complex decisions about their conditions. Low literacy can affect, for example, the ability of patients to read and understand instructions on prescription or medicine bottles, health education materials, and forms of insurance. Furthermore, Georgetown University, (n.d.) claims that “those with low literacy skills using more health services, and the resulting costs are estimated to be \$32 to \$58 billion which ranges 3 to 6 percent in additional spending on health care.

Lack of Availability of Services

Access to healthcare is a key factor for a population to be in good health. According to a Rural Health Information Hub (2019), access to healthcare in America is defined as “the timely

use of personal health services to achieve the best possible health outcomes.” Ideally, residents should be able to conveniently and confidently access services such as primary care, dental care, behavioral health, emergency care, and public health services. As stated by Healthy People (2020), “access to healthcare is important for overall physical, social, and mental health status; disease prevention; detection, diagnosis, and treatment of illness; quality of life; preventable death; and life expectancy.”

There are several factors that affect people from getting access to the healthcare system and one of them is limited appointment availability. Believe it or not, many healthcare organizations offer a typical set of office hours for patient visits, but, for the working adult or parent, a clinic that is open between 8 a.m. and 6 p.m. is not always useful. Patients need convenient office hours that allow them to visit the doctor outside of their work or school schedules. Two more factors that harm people’s ability to get access to health care services are the place they live and clinical shortage issues. As of 2020, 57.8 million people live in rural areas and these individuals face a litany of challenges, ranging from where they live to having enough doctors to provide care. “Remote geographic location, small size, limited workforce, physician shortages, and often constrained financial resources pose a unique set of challenges for rural hospitals,” According to Heath (2018), even when a patient has access to a provider and can schedule an appointment, transportation barriers can keep patients from seeing their clinicians. Patients who are physically unable to drive, who face financial barriers, or who otherwise cannot obtain transportation to the clinician office often go without care. As reported Heath (2018), approximately 3.5 million patients go without care because they cannot access transportation to their providers and transportation is a critical social determinant of health that has recently gained nationwide attention. Oftentimes, patient care access issues are not about getting a foot in

the door. Instead, it is about getting a foot in the right door. While it is essential for healthcare organizations to remove obstacles barring patients from getting to the office, it is equally important for organizations to make sure patients are getting to the right type of facility. This is especially critical as health systems begin to integrate alternative treatment sites into their repertoires. Patients can choose to access care at an urgent care center, a retail clinic, a micro hospital, a freestanding emergency department, and numerous other emerging treatment facilities, but individuals without health insurance have less access to healthcare services.

Lack of Insurance Coverage

One of the biggest issues within our current healthcare structure is that there are so many Americans that are currently uninsured and so many of those whose insurance coverage does not cover their medical needs. Just two years ago, there were almost 28 million nonelderly people living without health insurance in the United States (Tolbert et al., 2019), making up 8.5% of our country's population (Berchick et al., 2019). While these figures represent a small minority of the people living in our country, this is still tens of millions of people that have struggled and will continue to struggle to be able to receive health care. Many of these uninsured peoples have families with at least one employed member, are people of color, and are of low-income status according to Tolbert et al. (2019). For these groups of people, health insurance is too costly so they are forced to go without it, and, subsequently, the uninsured "have worse access to care than people who are insured" and "are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases" (Tolbert et al., 2019).

Additionally, 20% of uninsured adults made the decision to not receive medical attention or care because it would have been too costly for them (Tolbert et al., 2019).

One of the many shortfalls of our current multi-payer healthcare system is that there will always be those who are left out due to complications with cost. In Florida alone, the average monthly insurance payment is \$449.84 for this year, totaling an annual \$5,398.08 spent on health insurance alone (Price, 2020). The lowest average monthly insurance payment for 2020 is \$285.51 in Rhode Island and the highest is \$662.87 in New York (Price, 2020). This shows us that this is an issue facing the entire nation. Wherever you are in the US, you can expect to have to spend hundreds of dollars a month and thousands per year solely on health insurance, which may or may not cover your actual medical needs. On top of this amount that some can already not spare for health insurance, the average deductible for 2019 was \$1,655, as reported by Leonhardt (2019). Before those who are insured can reap the limited benefits of their insurance, they will likely have to pay more than \$1000. With these respective costs in mind for health insurance and deductibles under this insurance, it is easier to comprehend that there are so many Americans who have strictly limited options when it comes to accessing quality health care.

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Two more factors that harm people's ability to get access to health care services are the place they live and clinical shortage issues. As of 2020, 57.8 million people live in rural areas and these individuals face a litany of challenges, ranging from where they live to having enough doctors to provide care. "Remote geographic location, small size, limited workforce, physician shortages, and often constrained financial resources pose a unique set of challenges for rural hospitals," according to AHA (2020). Even when a patient has access to a provider and can schedule an appointment, transportation barriers can keep patients from seeing their clinicians. Patients who are physically unable to drive, who face financial barriers, or who otherwise cannot obtain transportation to the clinician office often go without care. As reported by AHA (2020), approximately 3.5 million patients go without care because they cannot access transportation to their providers and transportation is a critical social determinant of health that has recently gained nationwide attention.

Oftentimes, patient care access issues are not about getting a foot in the door. Instead, it is about getting a foot in the right door. While it is essential for healthcare organizations to remove obstacles barring patients from getting to the office, it is equally important for organizations to make sure patients are getting to the right type of facility. This is especially critical as health systems begin to integrate alternative treatment sites into their repertoires. Patients can choose to access care at an urgent care center, a retail clinic, a micro hospital, a

freestanding emergency department, and numerous other emerging treatment facilities, but individuals without health insurance have less access to healthcare services.

Solutions

To attempt to resolve the many problems of our current healthcare system, our team came up with an extensive plan for a new system in our country called the United States Cooperative Health System (USCHS). The general overview of this new system is that every person living in the US can receive free basic healthcare for necessary and/or urgent health care services and prescription drugs and American taxpayers will contribute a certain percentage of their income to fund this new structure. Additionally, private health insurance can be purchased for additional coverages not provided under the USCHS. This allows everyone to have access to health care, no matter their wealth, and still maintains the freedoms of those who wish to purchase supplemental private insurance.

The USCHS will be very active in the regulation, reporting, and monitoring of the many aspects of the healthcare system such as prices for services/pharmaceutical drugs, hospital profits, physician compensation, the use of certain equipment and machinery, and the quality of care delivered at each health care institution, etc. According to Twomey (2019), “The federal government should negotiate these prices [that reflect value and innovation] with drug manufacturers.” If our government could get involved in assessing the value of prescription drugs, the prices we would pay as a country would decrease significantly because there is so much artificial inflation of costs within the pharmaceutical drug industry. Again, because there is so much waste due to the utilization of expensive, inefficient technology in the healthcare field, government intervention to assess the value of automations used by physicians across the country could drive the nationwide cost of healthcare down. “Unlike many countries, the U.S.

pays for nearly any technology (and at nearly any price) without regard to economic value” (Skinner, 2013). By having a regulating system in place under the USCHS, we can eliminate so many of these unnecessary expenses.

In addition to basic and necessary care, the USCHS will fund an array of things: the establishment of more high-quality clinics in disadvantaged neighborhoods; a courier service for transportation to medical appointments when the patient is unable to provide their own transportation; Urgent Cares to be open and available 24/7 (like ERs); interpreters for every language established in every health care facility, made accessible through a video conferencing app; and holistic health care centers to be set up and run. Since there are so many people in the US that live far away from quality health care centers, there will need to be hundreds more clinics set up. Under these new offices, medical students would be encouraged to offer their services and gain experience under other medical professionals to better their learning. To aid in the transportation of patients to physicians, ridesharing individuals would be compensated for their services through the USCHS when they drive someone to their doctor’s appointment, the hospital, etc. There are similar programs already in place like Access Lynx, but these largely have a cost tied to them. When rides to health care services are free, more people are likely to go to their appointments. Holistic health care centers, as part of a larger health care center or as a separate identity, would offer services aiding in the physical, emotional, social, spiritual, and intellectual health of everyone in a community. A large aspect of these centers is that therapy would be provided free of charge and would be encouraged and normalized at early ages for children, curbing so many problems that would develop later in the children’s lives such as suicide, depression, anxiety, etc.

Under the USCHS, there would need to be many systemic changes. Firstly, office hours for physicians would be extended to later weekday times and additional weekend times, and, with this, more medical students would be able to help doctors. Next, a comprehensive preventative care plan, called Nutrition and Physical Education (NPE), for all Americans would be developed, starting early in school, educating children how and why it is important to be physically active, to eat healthily, and to avoid drug and substance abuse. Each year, students would learn progressively more advanced information that they can relate to, with an emphasis on how they can lead healthy lives beyond school. Also, to curb discrimination in health care, discrimination law infractions would be strictly enforced by an additional government organization, weeding out the doctors that are part of the problem in our country. In addition to stricter enforcement of these rules, students pursuing medicine will be held accountable for their actions: racist or hateful actions in college and medical school will be tied to the student's name whenever they try to become a doctor and, after too many incidents, the student will be sent to a mental health assessment facility to evaluate their cognitive ability and the extent of their racial biases. Based on this determination, the student will be sent into a racial bias training program to attempt to rid themselves of their innate prejudices. After this, the student's mental health will be tested again to verify growth and their ability to provide equal treatment to all their future patients, regardless of their race, ethnicity, religion, sexuality, etc.

Implementation Plan

Our proposed solution will bring drastic changes to our current system. Firstly, a government agency will be established, named the United States Cooperative Health System, and will deal with every aspect of this new health care system: price regulation, systematic changes, logistics, etc. While the transition will not happen overnight, this governing body will work

closely with health experts, doctors, hospital systems, and private insurers to make sure that the development of a single payer system includes everyone and is set up to be efficient: cutting prices, increasing quality of care, decreasing administrative waste, etc. This new system will be funded through a healthy mix of additional income taxes and employer premiums, with income taxes becoming much more progressive than they currently are. While raising taxes sounds unfavorable to many Americans, this plan could save middle class families thousands every year. Since each individual in our country is already paying upwards of \$10,000 annually towards health care costs (Bloom, 2017), an increase in taxes would require most to pay much less towards a health care system that would be much more inclusive and effective than the present structure.

When figuring out how much this vast system would cost annually, there are several facets to analyze: how much the government would cover, how much money would be saved by switching to a socialized system, etc. As stated by the DecisionData Team (2020), if the United States converted to a universal coverage health care system (similar to our proposed USCHS) and the government covered about 80% of the nation's health costs, leaving medically unnecessary services to be covered by private insurers, government health care spending would have to rise to \$2.3 trillion, around \$500 billion less than the current US healthcare spending. Because the government would cover approximately 80% of the bill, \$1.9 trillion would be spent annually and taxes would have to cover \$562 billion more in healthcare spending, up from the current \$1.3 trillion (DecisionData Team, 2020).

The next step to calculate is how much taxes would increase for each taxpayer. According to York (2020), the total adjusted taxable income in the US for 2017 was

\$10,936,500,000,000 (about \$10.94 trillion), produced by 143,295,160 taxpayers. If our goal is to raise the revenue gained from taxes by \$562 billion, we could simply divide this number by \$10.94 trillion and get the percentage increase in everyone's taxes necessary for the establishment and annual operation of the USCHS, roughly 5.14%. This tax would work in a similar fashion to how current FICA taxes function: the employee and the employer would each pay 2.57% on every dollar that the employee earns. As reported by Peterson-KFF (2017), "the typical non-elderly family in the United States spends \$8,200 per year (11% of their \$75,025 income) on health." The impact of this new 2.57% tax on this typical family would be a decrease of \$6,324.61 or 8.43% of income spent per year on health care, assuming this family would not purchase any additional private coverage. While this tax raise may increase the amount spent annually on healthcare by the wealthy with taxable incomes above \$400,000, the top 1% according to Dam (2016), the large majority of Americans will benefit financially from the setup of the USCHS.

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