International Perspectives of the United States Healthcare System

Sherryl W. Johnson, Ph.D.
Professor
Albany State University
504 College Drive
Albany, Georgia 31705
USA

Abstract

This article includes the perspectives of twenty -seven immigrants from fourteen countries on the U.S. healthcare system. The Mandala and Cultural Explanatory models are used as theoretical frameworks. Structured interviews were utilized to obtain information on occupation, education, family structure, satisfaction, strengths and limitations of the U.S. healthcare services. International comparisons of the U.S. healthcare system and approximately ten (10) countries are also included - based on feedback form the respondents.

Introduction

The World Health Organization defines health as "not merely the absence of disease or infirmity, "but "a state of complete physical, mental and social wellbeing (Constitution of the World Health, 1947). A society's wellbeing is often assessed by the health of its citizens. The United States has often been referred to as a melting pot – with citizens from all parts of the world – that have assimilated into the American way of life. Even so, in terms health, the United States has made great strides in some areas – such as technological innovations and advances in medicine. Yet, there is still less optimism in relation to cost and access issues. The impact and increase in chronic diseases has also adversely affected the U.S. healthcare system. In 2009, the percentage of non-institutionalized adults who reported their health as fair or poor ranged from 6% of those 18- 44 years of age to 29% of those 75 years and older. The ranking was five times as high among persons living in poverty (Health United States - Chartbook, 2010). Chronic conditions such as heart disease and cancer continued to lead the death rates. In 2007, one quarter of all diseases were from heart disease and 23% were from cancer (Health United States - Chartbook, Special Feature on Death and Dying, 2010).

In 2008, national healthcare expenditures in the United States totaled $2.3 trillion, a 4.4% increase from 2007. The average per capita expenditure in health in the United Stated was $7,700 in 2008. Accordingly, the United States spends more of its gross domestic product (GDP) on health than any other major industrialized country. In 2007, the United States devoted 16% of its GDP to health, compared to 11% in France and 10.8% in Switzerland – other countries with high GDP shares. Even so, extended life expectancy has not been noted in the United States – in relation to other industrialized countries that spend less. The general life expectancy for males and females was 77.9 in 2007 (Health United States - Chartbook, Healthcare Expenditures, 2010).

Specifically, the United States spends 40% more per capita on healthcare than any other western industrialized nation. However, the United States remains the only industrialized nation in the world that does not provide a basic health benefit package to all its citizens. Despite the high level of spending on healthcare, millions of Americans are disenfranchised, especially ethnic minorities who experience many barriers to the healthcare system (McIntosh, 2002). As recent as 2008, 35% of personal healthcare expenditures were paid by private health insurance. Consumers paid 14% out of pocket and 40% from public funds such as Medicare and Medicaid (Health United States - Chartbook, Healthcare Expenditures, 2010).

Theoretical Framework

Despite the cost of healthcare, health seeking perspectives, health practices, and access issues are often varied based on a wide range of indices. One author supports the notion that culture can provide a heightened and broader view of the United States healthcare system (MacLachlan, 2006). The World Health Organization's Alma Declaration (1978) also placed emphasis on the social dimensions of health by focusing on primary healthcare – e.g. community ownership and participation. Different communities have different values. Thus, community health offers a mechanism for the integration of cultural values into healthcare (MacLachlan, 2006).

Using the integrative model, Hancock and Perkins (1985), described the 'Mandala of Health' as a way of understanding and remembering that an array of factors influence health, culture and community (lifestyle, personal behavior, psycho-socio economic environment, sick care system, human biology, physical environment, work, spirit, body and mind). The interplay between culture and health is truly complex and warrants consideration of a kaleidoscope of causes, experiences, expressions and treatments for a plethora of human ailments (MacLachlan, 2006). Polit and Hungler (1993) described the role of culture and viewpoints from an ethnographic perspective. They identified ethnography as a branch of human inquiry associated with the field of anthropology – that focuses on a culture (or subculture) of a group of people; with an effort to understand the world view of those under study.

Yeo, Meiser, Barlow – Stewart (2005) examined how the cultural explanatory model has assisted health professionals in understanding how culture affects access to screening services, communication of diagnosis and management of the treatment regimen. Higginbottom (2006) indicated that no concordance in therapy can be recognized unless dissonance between the patient and the provider is minimized using the explanatory model. In this model, the patient's viewpoint is critical to understanding and explaining health practices and behaviors. Culhane-Pera, 2001, reported that applied ethnography or focused cultural studies can help professionals work toward the national goal of reducing health disparities and ultimately improving the quality of health.

Methodology

Structured interviews were conducted with individuals who had migrated to the United States. Eighteen open – ended questions that were posed to the individuals regarding the United States healthcare system (prior to the implementation of the Affordable Healthcare Act of 2010) were utilized in the assessment. Question content related to: nationalities, occupation, education, family structure, personal health insurance, health services, impression of the U.S. healthcare system, health system likes, health system dislikes, international comparisons, improvements needed, governmental responsibility for the uninsured, individual responsibility for the uninsured, services for uninsured, services for illegal immigrants, cost of services and healthcare technology. All of the individuals were interviewed in a place where they normally conducted their daily affairs – e.g. work, home or school. The results of the interviews included individuals from various nationalities. The individualized results appear in the analysis.

Analysis

The analysis consisted of interviews of individuals with fourteen nationalities: Liberian, Hungarian, Philippine, Nigerian, Cuban, Jamaican, Indian, Syrian, Bohemian, Canadian, Thai, Japanese, Ghanaian, and Italian. Most of the individuals were interviewed in their workplaces or schools (students). Their viewpoints on the United Healthcare System appear in Tables 1 (Demographics), Table 2 (General Impression of the U.S. Healthcare Services) and Table 3 (Roles and Recommendations Regarding Healthcare System).

Table 1 - Demographic Information

Nationalities / Gender	Fourteen Nationalities; Males -18 (67%); Females - 9 (33%)
Occupation	Professors (5); Students (5); K-12 Teachers (3); Store Clerks (2), Nail Technician (2); Self Employed (1); Medical Doctor (1), RN(1), Correctional Officer (1); Bookstore Manager (1); Convenience Store Manager (1), Journalist (1); Medical Assistant (1); Navy Optician (1), Subway Artist (1)
Education	Student (5); Bachelors Degree (5); Ph.D. (4); Masters Degree (3); Associates Degree (3); Less than High School (2); M.D. (1)
Family Structure	Relatives in the home (100%)
Personal Health Insurance	Yes – 23 (85%); No – 4 (15%)
Reported Health Services Utilized	Private Physicians, Hospitals, General Clinics, Emergency Rooms, Dental Services and Public Health Services

Table 2 – General Impression of the U.S. Health Services

Satisfied With Services	Yes* – 25 (93%); No – 2 (7%) *Cost mentioned as a limitation despite satisfaction
Overall Impression of Services	Positive – 13 (48%); Negative – 13 (48%); Neutral – 1 (2%)
Identified Services Liked	Yes – 26 (96%); No – 1 (4%) Likes: Technology, Resources, Accessibility, Immediate Care
Identified Services Disliked	Yes – 26 (96%); No – 1 (4%) Dislikes: Cost; Process without Insurance; Wait Time
International Comparison of US Health System	U.S. better than 9 countries: Hungary (cost higher); Nigeria (no payment no service; limited access); Philippines (less technology); Jamaica (quality less); India (pay as you go; longer waits in emergency room); Thailand (sanitation issues); Ghana (less capacity); Italy (caters to upper class); Cuba (care for the powerful) Countries (3) with quality that is equal to/ or surpasses the United States: Canada (universal healthcare system; no lawsuits; doctors paid similar fee); Ghana (similar competence as U.S.); Jamaica (exemplary service); Syria (universal healthcare; low prices)
General System Improvements Needed	Universal Health Care to Decrease Cost; Ability to Choose Doctor Despite Insurance Plan; Decrease Staff Shortage (RNs), Faster Service, Equal Assess; More Affordable Care for the Less Fortunate

Table 3 – Role and Recommendations Regarding Healthcare System

Governmental Responsibility to Provide Healthcare to All	Yes – 25 (93%) ; No – 2 (7%)
Willingness to Support of Healthcare for All	Yes – 22 (81%); No – 5 (19%)
Services for Uninsured	Yes – 22 (81%); No – 5 (19%)
Services for Illegal Immigrants	Yes – 17 (63%); No 7 – (26%); No Comment – 3 (11%)
Cost of Services Too Expensive	Yes – 27 (100%)
Technological Innovations Needed	Yes – 24 (89%); No – 3 (11%) Yes for medical necessity, prevention, diagnosis, excellence No due to excessive cost/ exploitation

Summary

An overview of the findings allowed participants to reconstruct their personal outlook and associated health beliefs as described by Higginbottom, 2006. Spradley, 1979, also noted that cultural studies offer health professionals the opportunity to see health and disease through the eyes of patients from a myriad of cultures. Such studies can also provide a framework for understanding disparities in health based on limited social and economic resources that are necessary to sustain health (Schulz and Lempert, 2004).

Hellmann, 2001, stated that the concepts of health and illness are culturally defined. Other authors also discussed how an individual's life experiences can serve as a mediator between the individual and a health condition. While the United States health system has undergone significant reform, such as the recently implemented Affordable Healthcare Act to correct deficits, it is still known as the best quality healthcare system in the world (Romney, 2007). Most of the respondents expressed satisfaction with the United States health care system with the exceptions for costs and waiting times. Excessive cost was mentioned by 100% of the respondents. Other responses related to provider selection and shortage of healthcare personnel.

Williams and Torrens, 2008, identified the major players needed to make the needed fundamental changes to the United States healthcare system, as 1. patients and customers, 2. providers of services, 3 suppliers of services and goods, including pharmaceuticals, 4. insurance intermediaries, including Medicare and Medicaid, and 5. government as a regulator, planner, financier for research and training. Respondents were questioned regarding roles and noted the roles of both the individual and government.

The patient / customer dimension emphasizes the need to create an awareness and dialogue regarding culture and health (Brennan and Schulze, 2004). Prout, 1996, further noted that cultural ethnography can show how the effectiveness of therapeutic interventions can be influenced by a patient's cultural practices and how ethnocentric assumptions can impede effective health promotion (Kingfisher and Millard, 1998). The respondents readily compared the health systems in their homelands to the United States healthcare system. Efficiency and quality were noted. The lack of universal healthcare was mentioned as a limitation when compared to countries such as Canada and Syria. The lower health service prices in Italy were also mentioned. Cultural studies can be far reaching in relation to access to health (Schultz and Lempert, 2004), treatment compliance (Alverson, Alverson and Drake, 2000) and health seeking practices (de-Graft-Aikins, 2005). Similar studies can be used to further explore the Mandala and cultural exploratory model – with underpinnings in health cultural beliefs, and multivariate factors that influence health, overall wellbeing and the effective delivery of healthcare services.

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