Modern Healthcare: A Look at the Economics and Ethics of Medicine

An Honors Thesis (HONRS 499)

by

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Thesis Advisor
Dr. Najma Javed

Ball State University
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Medicaid, Medicare, Welfare, Social Medicine. We’ve heard the words, but do we know what they mean? As a creative thesis, I will teach a course that will take a look at these healthcare initiatives and the laws and ethics involved. In addition, a study of the relationship between poverty and healthcare in the United States and abroad will be considered and discussed. The imminent issues of modern healthcare will be addressed in a manner that college students interested in the improvement of our healthcare systems can understand and in a manner that will motivate students to delve more deeply into the world of medicine that stands behind the physicians and nurses. The course will be a discussion-based course that looks at book excerpts, movies, and interviews to better understand modern healthcare. Weekly journals reflecting reactions to discussion topics, one paper, and a final project will be included in the course.
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Honors Colloquium Advisor  
Ball State University
Introduction

Medicaid, Medicare, Welfare, Social Medicine. We've heard the words, but do we know what they mean? In truth, the average college student does not know about the world of modern healthcare. Since I'm interested in medicine and becoming a physician, I have shadowed many physicians. When I ask about their profession, they are usually very satisfied with their work, but their one complaint is that the "business" of medicine has really disillusioned them and has hindered their vision for a healthier tomorrow. So my next question was obviously, "What is the 'business' of medicine?"

This was the beginning of my journey through the moneyed medical maze that cannot be seen but is strongly felt by doctors, nurses, and patients.

Although I am far from being an expert, I have learned a great deal about the healthcare field, and I wanted to share this knowledge with fellow college students who are interested in the economical and ethical aspects of medicine. I have come to realize how closely the economical status of an individual relates to the quality of healthcare he or she receives. Here in the United States, one of the most advanced countries in the world equipped with excellent hospitals and staff, what is the first thing that happens when one goes to the emergency room, no matter what the ailment? Do you see a doctor or a nurse? No. Instead, a clerk comes and asks, "May we see your insurance card?"

Coming from an insured family, I have never had to worry about what would happen if I couldn't produce my nifty little yellow card that seems to be the magic pass to see a doctor; but I had to ask myself, what happens to the people that are not insured?

While interviewing a lady right in Muncie, Indiana, last year, I discovered one of the possible answers. The lady I was talking to holds a job that does not offer an
insurance plan and she does not make enough money to buy a private plan. In addition, she makes too much money to qualify for government aid. Therefore, when an accident occurred and she was treated at Ball Memorial Hospital, she was handed the bill to cover herself. On her salary, however, there is no possible way that she will ever be able to pay the several thousand dollar debt that she now has with the hospital. So what does she do? The sad answer is “nothing.” All she can do is make a small monthly payment with her meager income after she buys food and other living necessities. In essence, from now on, she will never have that extra $100 to splurge on that new outfit she wants or the new accessory she would like to put in her new Habitat for Humanity home.

After listening to her story, I can only ask, “Is this fair?” A hard-working woman is in debt for the rest of her life simply because she does not have health insurance? Wouldn’t the doctors of yesteryear who accepted payment in the form of chickens, pigs, and vegetables be surprised to hear that? What happened to the theory that medicine was to simply heal the ill, not heal the ill and then put such a financial burden on them that they almost can’t handle the stress.

With the knowledge that even people in the U.S. who have a low economical background struggle with affordable healthcare, the next obvious question was “So what about the poor in third-world countries? What about their health?” Since I have traveled to Ecuador twice on medical service trips, I have witnessed first-hand the affects of lack of healthcare on the poor indigenous people who live in mountains of Quito. We saw many patients who had never seen a doctor in their entire lives, let alone a highly qualified American surgeon who could drain, clean, and correctly medicate a growing abscess.
With a little research, I was able to find several books that focused on the issue of health and poverty in the U.S. and internationally. With these in hand, I knew I wanted to share this knowledge with others, and so I decided to see if I could teach an honors colloquium for my honors thesis on modern healthcare. The plan was to share what I had learned about the "business" of medicine and the travesty of the poor to students who are interested in the improvement of our healthcare system and the improvement of healthcare conditions globally. My goal is to inform and motivate because knowledge is the predecessor of action. If I can convince one person of the great need of change in our healthcare system, maybe that one person will be instrumental in making that change, and a healthier future for the world can begin.
Colloquium Plan

Before I had received permission to teach an honors colloquium, I had already spoken to several doctors and patients and discovered some personal stories about the world that is working behind what we see at the hospital. I had also seen a movie called "John Q" that inspired me even further to delve into the mystery of modern healthcare. With a sister who is a nurse, I have always been updated on new laws that are instituted and hear the complaints about how lawmakers should actually have to work in a hospital and see the affects what they do so blindly in a congressional meeting far away from the people who actually carry out their mandates. Then I traveled to Ecuador and saw firsthand the connection between poverty and healthcare or rather no healthcare at all. These events inspired me to tell others about what I had learned, and after a few chats with Dr. Joanne Edmonds, I received permission to teach a healthcare colloquium.

With this ahead of me, I had to do complete a little more in depth research on the topics at hand and narrow down the many ideas in my head. After looking at many books, I decided that I wanted to use half the semester to talk about the United States’ healthcare system and some of the effects it has on various populations across the country. I also wanted to compare it to a developed country that practices social medicine, the other prominent healthcare system, and I found an excellent article on a comparison of the U.S. and Canada. Then, I wanted to spend the final weeks of the semester looking at healthcare issues around the world. Using a book that contained a large collection of articles, I chose to look at Haiti, Africa, Peru, Russia, U.S.-Mexico border, Cuba, El Salvador, and Ecuador.
After reading several different articles about the current issues in the U.S. and abroad, I discovered how closely the economic, political, and medical arenas are connected. Therefore, I decided to really focus on health and poverty and have this theme run through the entire semester.

Throughout the semester, we will read book excerpts from Health and Poverty and Dying for Growth: Global Inequality and the Health of the Poor and discuss the readings. I will also bring knowledge from my research of other books and personal interviews to the discussions. We will use online resources to look at current laws, statistics, and healthcare forms. We will also watch two movies—“John Q” and “The Doctor”—which will add another venue of media and information to the class.

A journal containing thoughts, reactions, and outside research will be collected every week from each student. A large paper over a healthcare system of any country not discussed in class with a specific look at the connection between health and poverty will substitute for a midterm exam, and a final creative project will substitute for a final exam. Class grades will be based on class attendance, participation, and the quality of work on the above assignments. I am also planning a healthcare volunteering activity for the students as I feel that experiencing needs firsthand is one of the best learning opportunities. I also hope to have a few other activities throughout the semester to learn more about healthcare from different perspectives and avenues.

Overall, the class is designed to inform a college student about modern healthcare in a manner that he or she can understand, instigate global thinking on the relationships of economics, politics, and health, and motivate action in any way that a student feels he or she can contribute to the modern healthcare world.
Research

Currently, "The health problems that afflict 90% of the world’s population receive less than 10% of the world’s medical research. As a result, more than 8 million children in less developed countries die each year from measles, diarrhea, malaria, pneumonia, and malnutrition, conditions that are both preventable and treatable (Mbugua 499)." In addition, 584,000 women die every year due to complications during pregnancy or childbirth, and "almost 90% of those deaths occur in Asia and sub-Saharan Africa and less than 1% in the developed world (Mbugua 496)." "In developed countries such as the United States, the maternal death rate from pregnancy complications is as low as 1 in 4,000, but in developing countries more than one woman dies every minute from complications associated with pregnancy (Mbugua 488)." These statistics are both shocking and saddening, and the situation in developing countries is worsening each year because of four main healthcare delivery problems: transportation difficulties, physical risks and dangers to healthcare personnel, ineffective and corrupt government bureaucracies, and suspicion of the motives of high-income industrialized countries. On top of that, there is a lack of government funding going towards national healthcare in developing nations and many times, foreign aid money designated for healthcare is being directed elsewhere (Mbugua 488).

While developed countries, such as the United States, do not see the mortality rate that developing countries witness daily, a large part of this is because of the political turmoil found in places such as Kenya, Afghanistan, Russia, and Kosovo, just to name a few (Mbugua 487-488). Politics is directly related to the economics of a country which in turn is directly related to the healthcare provided for the people. During a time of
political turmoil, governments decide to increase military spending and they make cuts in funding in healthcare. It is obvious, however, that they have not considered the ratio of spending to deaths in both the military and healthcare. In 1995, global spending on the military was $864 billion dollars, but there had been only an estimated 23 million military and civilian deaths from war during the years 1945-1993. On the other hand, global spending on prevention and control of AIDS, tuberculosis, and malaria was a mere $15 billion, but there had been 150 million deaths from these diseases since 1945 (Mbugua 488).

The lack of prioritization in global spending is affecting millions of people including those in developed nations. While some countries have decided to go to a healthcare system that administers equal healthcare to everyone, the United States still works on the four-pronged healthcare system. There is “Medicare for the elderly and disable, Medicaid for low-income/public assisted individuals and persons with certain disabilities, employment-subsidized coverage in the workplace, or self-purchased coverage available through private insurance companies (McPhee 4).” Unfortunately, there are many in the U.S. who fall in a category between qualification for Medicaid and being able to afford insurance and they work at a facility that does not offer the employment-subsidized healthcare coverage. Therefore, they don’t purchase health insurance and if something happens, the result is that they are indebted to a hospital for years to come. Recent statistics have shown that even though the “United States spends over $3,000 per person, per year… [there still exists] one in four persons who are uninsured or without adequate health insurance coverage (McPhee 7).” A poll in 1999
showed that 24.2 million American workers were uninsured and 8.7 million workers' children were also uninsured (Blumberg and Nichols 51).

Because of this discrepancy, many have called for a healthcare reform to make the U.S. more like the social healthcare system of Canada. “Half of all hospitals in Canada are privately owned, and physicians are both salaried and reimbursed. Doctors receive a fee-for-service payment while government sets the fixed annual budgets for hospitals. Canadians are free to choose their doctors and the hospitals they use. Each person is issued a health insurance identification card by the province in which he or she lives. Most important, access to care is equally distributed and guaranteed regardless of individual income (McPhee 13).” Many Americans would rather have this system since many insurance companies mandate the doctors that a person can go to or since some can’t afford insurance and end up with large medical bills. “A Harris poll [showed] 10% of Americans think their system works ‘pretty well’ as compared to 56% of Canadians holding the same view of their own system. The same poll indicated 61% of Americans would trade the U.S. health care system for the Canadian system, while only 3% of Canadians would trade for the U.S. model (Leslie 71).” While Canada has had some controversy over their system since this pole was taken, there still exist many Americans who would prefer Canada’s system. One reason is that Canada is less strict on prescription medications and overall, medicine is a lot cheaper in Canada. “The allergy reliever Claritin is a good example. In Canada, where Claritin is sold without prescription, a month’s supply costs U.S. $17. In the United States, where Claritin is a prescription-only medicine, a month’s supply costs U.S. $60 plus the doctor’s fee for the visit to obtain the prescription (Mgubua 491).” Therefore, “a growing number of
Americans, particularly those on fixed incomes, cross the border into Canada or Mexico to fill their prescriptions because they can purchase many drugs at as little as half the price they would pay in the United States (Mgubua 490).

While politicians battle the pros and cons of healthcare reform, the uninsured are continuing to suffer. Observational studies have shown that there is actually a connection between health insurance and health other than the quality of care one receives in a hospital. For example, a “landmark study by Ayanian and colleagues documenting lower survival rates, conditional on stage of diagnosis, among uninsured women with breast cancer than among privately insured women with the disease...suggested] that health insurance improves the outcomes (Levy and Meltzer 185).” In addition, “consider the relationship between health insurance status and health around age 65. Health status improves markedly at that age, when people become eligible for Medicare. This finding seems to suggest that health insurance has a positive effect on health (Levy and Meltzer 186).” Due to the “increase in the number of uninsured individuals and the alarming increase in the transfer of uninsured and underinsured patients from private for-profit hospitals to public/charity hospitals, a phenomenon known as ‘dumping’ (Rice 104),” public hospitals are so large that there are issues with the patient to nurse ratios causing a decrease in quality care to each patient. The large transfer of uninsured patients from private hospitals to public hospitals has occurred because some “private for-profit hospitals have delayed treatment or flatly refused to treat uninsured or underinsured individuals and, as a result, death or permanent disability has occurred (Rice 104).” With these statistics, it is hard to ignore the connection between health insurance and health.
Having realized the connection between health insurance and health, there have been many studies conducted on sectors of society that fall below the insured middle-class American worker. In particular, it is important to notice the research completed on one of the most affected areas of society that is coincidentally the sector that is able to do the least to modify or better its situation, and that sector is the children of our nation. There have been several interesting studies on children from low-income families, African-American children in particular, and the results are both shocking and distressing.

Sadly enough, the “progress toward improving the health of children, especially those who are poor, has slowed. The percentage of low birthweight births has not decreased since 1980; immunization rates among children have declined while the incidence of measles, mumps, and rubella has increased... Moreover, in 1990 we witnessed a decrease in the nation’s infant mortality rate, but 9.1 deaths per 1,000 births is still higher than 21 other industrialized nations. Poor children are at a greater risk than nonpoor children for developing chronic and disabling conditions (Copeland 131-132),” and unfortunately, it seems that poor African-American children are seeing even more drastic affects of insufficient healthcare than poor white children.

The National Center for Health Statistics (NCHS) has shown that “the black infant mortality rate (IMR) was 18.6, more than twice the white IMR of 8.1. Black children (under age 18) are more than twice as likely (4.8%) as their Caucasian counterparts (2.1%) to have self-reported health status as ‘fair’ or ‘poor.’ Similarly, black children with chronic illnesses are more likely to experience limitations of activity (inability to participate in or perform in age-appropriate play, educational activities or
self-care) than non-black children (5.6% v. 5.0%) (Kelley, Perloff, Morris and Liu 187).” After seeing these statistics, it is interesting to note the reason for the disparity of health between black and white children. The NCHS found that “for children under five years of age, whites had a mean of 7.6 visits per year [to the doctor], while black children had 4.6 visits (Kelley, Perloff, Morris and Liu 187).” Distressingly enough, in the case of an African-American child from a low-income family compared to a white child from the same circumstances, the black child will face a greater challenge in receiving quality healthcare. It is a travesty to note that race is still an issue in our society today and it is being reflected in the health of innocent children.

While the U.S. is struggling with many healthcare issues, developing countries are also battling healthcare reform. While it is impossible to delve into the deep problems that exist in the healthcare systems of the world due to the political and economical struggles of different nations and peoples, it is worthwhile to look at a few developing nations and consider their struggles for a better quality of health and life. For the purpose of understanding a little of the global inequality and health of the poor, Russia, Africa, Haiti, and Peru stand as good examples to examine the worldwide need for better healthcare provision.

Firstly, Russia’s healthcare system has seen multiple changes since World War II as different Russian leaders have taken control. From social medicine to the privatization of healthcare, many options have been tried but none have succeeded and the disparity between the few wealthy and the multiple poor is growing exponentially. While a select few of Russian society have access to quality healthcare, the majority of Russian citizens
are impoverished and unable to afford medical treatment. These inequalities are being reflected through several venues.

First of all, the mortality of especially men and children has shown the great need for better healthcare. “For males ages 15-24, the annual death rate in 1981 stood at 258.7 per 100,000 population... By 1993, the rate climbed to 289.3. For males ages 45-54, the 1981 death rate was 1,586.2 per 100,000 population, ...but then surging upward to 2,173.4 in 1993 (Field, Kotz, Bukhman 158).” “At present rates, about half of all males now aged 16 will not reach the official retirement age of 60 (Field, Kotz, Bukhman 159).” As for children, “during the Soviet years of 1980-1991, the mortality rate varied between 10.4 and 11.6 per thousand births. Then from 1991 to 1994 mortality grew very rapidly, rising by 38 percent... (Field, Kotz, Bukhman 157).”

Secondly, the spread of infectious diseases has shown the lack of necessary healthcare to the Russian public. “Diphtheria, for example, which has almost disappeared in most wealthy countries, has seen a spectacular rise in Russia. In 1989, there were 603 reported cases of diphtheria in Russia. In 1993, a total of 15,229 cases were reported. In 1994, 39,703 cases were reported... (Field, Kotz, Bukhman 159).” In addition, “the incidence of childhood measles, fairly stable in 1990-92, increased almost 300 percent between 1992 and 1993. That of whooping cough rose 63 percent during the same period. Tuberculosis is also re-emerging as a widespread health menace. The incidence of tuberculosis in Russia was relatively stable in 1990-92, but rose by 11 percent in 1993. Deaths from tuberculosis, which fell continuously until 1989, rose by 4 percent in 1990, 3.6 percent in 1991, and 15 percent in 1992. ...The impact of tuberculosis on children provokes special concern, and in 1993, compared with the
previous year, there was a 12.7 percent increase in the number of children suffering from active tuberculosis. Most frightening of all is the rapid rise in the number of cases of multi-drug resistant tuberculosis. Meanwhile, other infectious diseases are also on the rise, including hepatitis B, cholera, typhoid, anthrax, salmonellosis, and syphilis (Field, Kotz, Bukhman 159).”

Thirdly, the nutrition of the Russian poor is so lacking in the necessary nutrients that a normal individual needs that the health of the people, especially the elderly and the children, is greatly affected. “In a 1992 study of elderly persons receiving pensions, half the people surveyed reported losing five or more kilograms in the previous six months; 57 percent stated that they did not have enough money to buy food… Poor nutritional status has contributed to the re-emergence in some cities of long-for-gotten illnesses, including scurvy, pediculosis, and rickets. Some surveys show that more than 60 percent of mothers judge themselves unable to feed their children properly because food products are either unavailable or too expensive for purchase. In many cases, children suffer from a deficiency in vitamins, such as ascorbic acid and folic acid. In one survey, greater than 60 percent of children under age eight exhibited signs of nutritional deficiencies, and more than 7 percent suffered from anemia. …Furthermore, as people lack adequate nutrition, their immune systems perform poorly, and they become more vulnerable to other forms of infection, further compromising the health of the population (Field, Kotz, Bukhman 161-162).”

Next, a look at the healthcare problems in Africa, the world’s poorest continent, is essential. Political, social, and economic crises are the backdrop for Africa’s current battles with HIV, AIDS, STDs, other infectious diseases, preventable diseases
compounded while interim stays in ill-equipped state hospitals, and illness related to nutritional issues. As for the HIV and AIDS epidemics, currently “with just 10 percent of the world’s population, Africa is home to 70 percent of past and present AIDS victims in the world: 35 million people. An estimated 22 million African adults and more than 1 million children currently live with HIV/AIDS (Schoepf, Schoepf and Millen 107).”

Because of social acceptance, the promiscuity of men using lack of condom protection is spreading the disease. As children are conceived, many then carry the HIV virus and then suffer the symptoms later in life as the virus gives way to full blown AIDS. While foreign aid has been sent to help in the epidemic, it is unlikely that the situation will change until the social views of the people change, thus the disease will continue (Schoepf, Schoepf and Millen 107-108).

Another factor in the declining health of Africa’s poor is the declining access to health care. Considering that the trek to a hospital or other healthcare facility “is dependent on many factors, including proximity to the facility, transportation costs, ability to pay service and medicine fees, and sociocultural factors such as language, class, and gender (Schoepf, Schoepf and Millen 109),” many people end up unable to receive medical treatment because they cannot reach a healthcare facility. Then, sadly enough, if they are able to access a facility, chances are high that they will not receive quality care because “in practice, for the poor who do access state health-care facilities, nurses deliver most of the curative as well as preventative services, usually without physician supervision. [In addition], nurses’ patient loads have increased dramatically, even in poor rural and urban areas where many cannot afford services (Schoepf, Schoepf and Millen 111).” One statistic showed that “between 1980 and 1993, the number of people
per nurse in Senegal rose more than six times, from 1,931 to 13,174 (Schoepf, Schoepf and Millen 112).” Therefore, it is not difficult to see that a poor patient cannot receive the quality care he deserves even if he is able to reach treatment, and thus at times, resulting in the further health decline of that patient.

Aside from these factors, as with Russia, nutrition is also a factor for Africa’s poor population. Some experts argue that “nutrition may be the single most important determinant of health. Poor nutrition is synergistic with disease; that is, the presence of either increases the likelihood of the other. Indeed, the strongest predictors of child health are, first, broad, equitable distribution of food and primary health services... (Schoepf, Schoepf and Millen 112).” Unfortunately, the nutritional issues in Africa have given way to underweight children, malnutrition, and children’s stunted growth, and the cycle will continue until economic stabilization occurs (Schoepf, Schoepf and Millen 112-114).

As with Africa, the multiple political uprisings in Haiti are directly connected to the health of Haitian people. Studies have shown that “during the coup [d’état] years, [researchers] noted a marked increase in the proportion of patients with measles, tuberculosis, typhoid, and complications of HIV infection (Farmer and Bertrand).” The tumultuous political environment was the backdrop for the spread of measles because many were unable to receive the mandated vaccinations due to lack of national vaccine coverage for the poor. In addition, the coup years stopped attention on the water-protection efforts causing an increase in coliform counts which led to a typhoid epidemic. Unfortunately, HIV infections rose because HIV-positive soldiers and/or paramilitary
"attachés" raped multiple women resulting in HIV transmission and the birth of HIV-positive babies (Farmer and Bertrand 78-80).

Again, as with Russia and Africa, malnutrition is an issue with the Haitian poor as the people can literally not afford the bread. Due to an increase in food imports and high taxation on the imports, the poor cannot afford the available food and thus go without, causing the same issues that were seen with the Russian and African poor (Farmer and Bertrand 85-86).

Lastly, a brief look at the heath care and the health of the poor in Peru will complete this quick perusal of global health. As with Russia, Africa, and Haiti, politics has played a great role in the health of the Peruvian poor. First of all, it is important to note that government mandates on the economy of Peru under President Fujimori caused such a drastic change in the monetary value of the Peruvian dollar that "from 1990-91, the population officially classed as 'poor' jumped from seven to 12 million (Kim, Shakow, Bayona, Rhatigan and Rubín de Celis 130)." With the increase of those classified as "poor," health deterioration was not slow to follow.

"A survey of 400 low-income households between June and November 1990 showed that rates of sickness increased 20.6 percent, while spending on the purchase of medicine fell 50.7 percent in the same period. By the end of 1990, the infant mortality rate reached 84 per thousand live births... As late as 1993, 36 percent of all infants received no prenatal care and more than half of all births were unattended by health services personnel (Kim, Shakow, Bayona, Rhatigan and Rubín de Celis 138)."

These issues led to the privatization of health care similar to the United States system. Unlike the U.S., however, the proportion of those unable to afford insurance and
the number of people who live in areas without medical assistance are so high that the health of the Peruvian society has for, the most part, not gotten any better (Kim, Shakow, Bayona, Rhatigan and Rubín de Celis 146-150).

From the healthcare system struggles of the United States to those globally, the connection between economics and provided healthcare is obvious. And especially with developing countries, the political arena is so closely tied to the economy that those who have no part in the making of laws are the ones that feel the harshest effects of mandates given by the small influential sector of society. As statistics have shown, the modern healthcare world nationally and internationally needs changes in the most desperate way. The need for more educated people in the healthcare field is growing because people knowledgeable in healthcare law, ethics, and practice are the ones that can be instrumental in changing the system so that the cycle of poverty and disease can be broken. While many believe that change cannot come, experts disagree. They say that “if a concerted effort is made on three levels (Mbugua 501),” the world can rise to the current global healthcare challenge. The three levels are the following: “At the macro level, the world must unite and national leaders must take responsibility to promote peace in their own counties and across national borders. …At the mezzo level, corporations and healthcare institutions must be driven more by humanitarianism rather than selfish economic gains. …[And lastly], at the micro level, individuals must take personal responsibility for their own health and mind their neighbors’ health, too (Mbugua 501).” Therefore, if everyone does his or her part in whatever sector of society he or she belongs, change can be accomplished and a healthier global society can be attained.
Bibliography


"SIISSE Indicadores Sociales." CD. Provided by Quito Eterno.


Reflection

It seems unbelievable that the semester is over and I have succeeded in teaching a class. My goal for this class was to educate others about the healthcare issues here in the United States and abroad as I believe that the basis of change is awareness of the problems that we face as a society. As a final synopsis, I had each student say what they had learned over the past weeks, and I was pleased to hear the facts that my students are taking away with them. The following are a few comments that I received:

“Surprising to me is how wealthy the United States is but how poor our population remains. The poor cannot afford proper health care. Unhealthy individuals are unable to get jobs that will sustain a family sufficiently. This creates a never-ending circle where poverty and illness intermingle to create a world where many have no hope.”

“Patients around the nation have suffered greater health problems or have even died due to patient dumping. This goes to show that even the health care system is all about money. Just because someone cannot afford to pay for a health insurance plan does not give us the right to deny them service.”

“Americans are responsible for a lot of the global issues we talked about…, [and] though America is ‘responsible,’ we all struggle to understand how we can personally be proactive and make a difference.”

Hearing these comments lets me know that I have achieved my goal in teaching this class. The disparity between the poor and the wealthy and the quality of healthcare that each receives is astonishing and the need for change in our healthcare system gets greater every day, and I can only hope that each of the students in my class will remember the class discussions and keep their motivation to make a difference. If each
of my students does his or her part to make a change in his or her surroundings whether that be by volunteering to help those in need, educating others about the healthcare situations we are facing, or advocating changes in healthcare laws, my hope is that a healthier future for the world can begin.