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Qualitative Comparison of the United States and United Kingdom Healthcare Systems

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QUALITATIVE COMPARISON OF THE UNITED STATES AND UNITED KINGDOM HEALTHCARE SYSTEMS

A Master's Thesis

Presented to

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In Partial Fulfillment

Of the Requirements for the Degree

Master of Science, Health Promotion and Wellness Management

By

Rachel Cazzaniga

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ABSTRACT

The United States and United Kingdom healthcare systems vary based on their public access, financial dependence, health outcomes, gross domestic product, and much more. The systems have continued to grow with different focuses of importance in the quality of care that is being distributed to their populations. The U.K. universal healthcare system represents their value of accessibility and affordability, while the U.S. privatized system(s) represents their value of economic growth. The study provided a qualitative analysis of the systems' differences by integrating real world experiences and perceptions of the systems from individuals that have encountered and interacted as a patient in both the U.K. and the U.S. models. Participants had lived in each country for at least one year and recruitment was conducted by a snowball method. An interview guide was used to structure each interview, and were recorded, transcribed and analyzed via a phenomenological approach. Participants identified main themes of wait-time differences, financial relief and financial burden variances, and a need for growth within each system. The quality of care received was shown to be dependent on the prioritization of accessibility, affordability, and availability of the individuals interviewed.

KEYWORDS: accessibility, affordability, universal, privatized, comparison, insurance

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INTRODUCTION

Overview

The United States and United Kingdom have been studied based off their vastly different healthcare systems for years, with extensive research and ongoing investigations to attempt to pinpoint reasonings as to why healthcare system basics cannot be similarly replicated within the different environments. The two healthcare systems not only vary in the delivery of their health insurance availability, but the health outcomes of their populations, the gross domestic product (GDP) towards healthcare, health accessibility to vastly different populations, and the medical and technological abilities of the different countries. The comparison begins with the view on the ability to expand the systems within their targeted populations. The United Kingdom has one of the largest public sector systems with universal healthcare to all citizens through the country's taxation process. Opposingly, the United States has the largest private network with estimates of ~9% of gross income attributed towards healthcare taxing in 2008. Additionally, the United States incorporates a compilation of many different systems, so no one overall model can be studied (Trudeau 2019). The United States population has shown great interest in wanting to direct their own care due to the financial subsidy from public and employer-sponsored programs- U.S. healthcare consumers have lacked the opportunity to understand and modularize their healthcare experience. Differing in the United Kingdom, individuals have grown from their "one size fits all format", allowing for their system become more complex (Ham 2005). The difference between having an overall system and multiple different systems has shown disparities in the ability to access care and usage of economic and political power within the respected government agencies. Having two different healthcare systems means there will be a

result in different perceptions of care as well as different health outcomes and governmental cost allocations- for instance, the life expectancy rate in 2020 for the United States was 77.3 years of age and 80.9 for the United Kingdom; the mortality rate for infants per 1,000 live births in 2020 in the United States was 5.4 and was 3.6 for the United Kingdom; the health expenditure (percentage of GDP) in 2019 for the United States was 16.8 and the United Kingdom was 10.2; the domestic private health expenditure (percentage of current health expenditure) in 2019 for the United States was 49.2 and was 20.5 for the United Kingdom (DataBank 2022). While it is unfair to make a statement saying one system is better than the other, each country can learn from the other and apply what best fits their populations. It is also important to consider individual perceptions and experiences of interactions with each healthcare system. The individual perception and experiences allow for a qualitative approach to the study to incorporate and understand real experiences and feelings rather than the numbers and data that are typically presented in healthcare systems analyses.

Research Question

The following study was done to answer the following proposed research statement:

- Research Statement: The purpose of this research is to qualitatively assess individuals' perceptions of the United States and United Kingdom's healthcare systems.

Delimitations

The focus of the study was to understand the contrasting healthcare systems of the United States and the United Kingdom. Due to the great difference between the two countries' approaches to healthcare and the qualitative method of research, the study was delimitated by:

- Population being known due to the snowball method used for the collection of participants.
- Sample size chosen based on the unique participants accessible within the given location of the researcher and their availability.
- Unique participant characteristics including living in each country for a minimum of one year, have had a qualifying medical event/occurrence causing the use of each medical system, and knowledge of the difference between public and private healthcare systems.
- An interview guide created by the researcher to reflect the common trends found within the literature review and common perspectives within each culture.
- Qualitative methodology of research and analysis to increase perspective awareness and individual attributes to each system that makes them unique.

Assumptions

The following assumptions are the premise for the study:

- The United Kingdom healthcare system provides universal healthcare to all ordinarily resident within the country.
- The United States healthcare ideology is based on multiple privatized and public systems, thus causing disparities in the access to insurance and quality care.
- The United States accessibility to healthcare remains in a constant state on transition due to technological advancements, political reforms, and an aging population.
- The participants interviewed and studied will provide truthful responses that represent their personal attitudes towards each healthcare system with the use of their relevant experiences within each system.
    - Participants have relevant experience within each healthcare system for at least one-year time.
- The interview guide was effective at assessing personal perceptions and experiences of interactions with each respective healthcare system
- The interview guide asks relevant questions regarding the current state of the United Kingdom and United States healthcare systems.
- The participants are truthful in their responses during the interview process.

Definitions

Affordability: Inexpensiveness; The ability to afford.

Affordable Care Act (ACA): The healthcare reform act enacted in 2010 was designed to expand health coverage to uninsured Americans by expanding Medicaid eligibility, prevent insurance

companies from denying coverage because of a pre-existing condition, created a health insurance marketplace, and to ensure that essential health benefits are covered in plans. According to Healthcare.gov, under the ACA, if your income is 400% or above the federal poverty level (FPL), you may qualify for the premium tax credit in 2022; if your income is 150% or below the FPL, you may qualify to enroll in marketplace coverage (Healthcare.gov n.d.).

Health Insurance: Insurance that pays for medical and surgical expenses. Examples of health insurance programs include Medicare, Medicaid, and federal/state employee insurance plans.

Healthcare System(s): The generalization of the implied health models within each country. For example, a healthcare system is the United Kingdom's universal healthcare model and the United States privatized insurance plans.

Medicare: A federal health insurance program for those of the age 65+, specified individuals with disabilities, and individuals with end-stage renal disease. There are three parts of Medicare, and they are Medicare part A [hospital insurance] (coverage of inpatient hospital stays, care within skilled nursing facilities, hospice care, and some health home care), Medicare part B [medical insurance] (coverage of certain doctors' services, outpatient care, medical supplies, and preventative services), and Medicare part D [prescription drug coverage] (coverage assistance for prescription medications- this includes many vaccines/shots) (Medicare.gov n.d.).

Medicaid: Healthcare coverage for Americans who are low-income adults, children, pregnant women, elderly adults, and individuals with disabilities; Medicaid is administered by states and is funded jointly by the federal government and states; ~80.9 million people covered (Medicaid.gov n.d.).

National Health Service (NHS): “Government-funded medical and health care services that anyone living in the UK can use without being asked to pay the full cost of the service. These services include visiting a doctor or nurse at a doctor’s surgery, getting help and treatment at a hospital if you are unwell or injured, seeing a midwife if you are pregnant, and getting urgent help from healthcare professionals working in the ambulance services if you have a serious or life-threatening injuries or health problems (this might include being transported to the hospital (Full Fact Team 2017).

Residents: An individual and/or group of people who reside permanently within a specified area.

State-funded: A service/program/etc. that is funded/supported with state dollars.

Uninsured Medical Costs: Medical expenses that are not covered by insurance. For example, an out-of-pocket payment for a doctor’s visit without the use of health insurance.

Universal Healthcare: “All people have access to health services they need, when and where they need them, without financial hardship…. Full range of essential services, from health promotion to prevention, treatment, rehabilitation, and palliative care.” (World Health Organization n.d.).

US Centers for Medicare and Medicaid Services (CMS): Federal agency within the United States department of Health and Human Services that houses the Medicare and Medicaid programs.

Significance of Study

The significance of the study is to gain an overall understanding of the United States and the United Kingdom healthcare systems from individuals that have experienced both systems-

using qualitative research to contradict or support secondary and tertiary literary research. The collection of first-hand data from individuals who have experienced both healthcare systems gives the study the opportunity to include ideologies and real-world experiences to better gauge how realistic and truthful secondary and tertiary data is in describing the outcomes of the healthcare models. Finally, the study purposefully includes an extensive literature research to allow for the previously researched data regarding the healthcare systems to show the volitation of the perceived care in comparison to the given perspective of individuals analyzed in the qualitative research.

LITERATURE REVIEW

The following literature review dives into the details of the United Kingdom's and the United States' healthcare models provide insight as to how they are structured, perception of care, overall quality and health outcomes, and correlation of financial status on availability, accessibility, and affordability of healthcare. The main goal of the literature review is to provide detailed understanding of the common trends within each healthcare system. To do so, each country is studied separately before creating and analyzing a comparison of the two. The detail of the literature review created a template for a qualitative research analysis to be conducted further on, which better allows the perception of the individuals studied to be understood. It is important to consider that each country's availability of research and data varies based on the reporting systems as well as the truthfulness of those with firsthand knowledge and experience. With this, each article, blog, journal, statistics, and report chosen to be included in the literature is selected based on its level of reliability, validity, and ability to present evidence-based reasoning behind statements being made.

United States

The United States has been known for its continuous political transition and inability to stabilize a united healthcare system due to the constant back and forth between parties (Andress 2016). The continuous change has led to the middle class and low-income populations struggling to afford health insurance and healthcare or to keep it (Gordon 2022). This is due to fluctuations in general living expenses along with job loss and changing standards to be within certain

programs (Gordon 2022). To begin with where the current "model" of healthcare stands within the United States, it is split into two generalized systems- public and private health insurance.

Public health insurance includes Medicare and Medicaid programs. The Medicare program is set to cover insurance measures for those of the age 65 or older, and those below the age of 65 with long-term disability or end stage renal disease. For the 2020 enrollment for Medicare, there were around 62 million beneficiaries enrolled (Meredith 2021). Medicaid, on the other hand, has criteria that varies based on the state one lives in but has standard criteria that low-income pregnant women and infants are to be covered (and the child until the age of 18), low-income families, the blind, and individuals with disability (Tikkanen et al. 2020). Medicaid enrollment is higher than Medicare, with around 75 million Americans enrolled. The private insurance plans within the United States consist of employer plans or private plans bought directly by an individual. What this means, is that within a career in the United States, the employer at the company/organization must offer the employees some form of a health insurance coverage plan. If a person in the United States opts to privately buy their own insurance plan, they have the privilege to do so. A major influence and additional factor in the continuous transition of the United States healthcare systems comes from the Affordable Care Act (ACA). The focus of the ACA was to expand the availability, accessibility, and affordability of healthcare and insurance to the populations in need in the United States. The most known influence of the ACA was Medicaid expansion, which has shown progress of the extension to over 32 million uninsured Americans (Cusick et al. 2021). The ACA provided many services to Americans, some of them being the protection of patients with preexisting conditions from being denied coverage, essential women's health coverage (such as mammograms, prenatal care, and screenings for cervical cancer), improved access to prescription drugs, and young adults to stay

on their parent's insurance plan until the age of twenty-six (Cusick et al. 2021). Along with this, from 2013-2017, there were 19,200 fewer deaths among low-income, older adults due to the implementation of this act (Cusick et al. 2021). The three main failures that have been identified in the United States healthcare system are cost, lack of coverage, and health outcomes (even after the ACA was put in place).

In 2018, the United States spent 16.9% of its Gross Domestic Product (GDP) on healthcare expenditures (which is 90% higher than the Organization for Economic Co-operation and Development [OECD] average); price levels of healthcare resources and services are 28% higher than the OECD average for health-related goods; still within 2018, 27.5 million Americans were still uninsured (8.5% of the population) and is expected to grow to be 35 million Americans uninsured by 2028; the mortality rate for preventable cause were 175 per 100,000 in comparison to the OECD average of 133 per 100,000; the OECD stated that the socioeconomically disadvantaged were at a higher risk within the United States in relation to healthcare services and preventable deaths; the United States has 4.8 deaths per 1,000 live births in comparison to the OECD average of 3.5 per 1,000 live births (Supanick 2021).

United Kingdom

To start, all residents within the United Kingdom are entitled to the public health care coverage that is provided through the National Health Service (NHS). The main source of funding to allow the United Kingdom to be able to provide this is through taxation; other funding for this healthcare coverage plan comes from those who use the NHS as a private patient or through copayments. While all residents have access to this care plan, they also have the option of private insurance as well. 10.5% of the United Kingdom opts-in to use their own preferred

supplemental insurance plans to be able to receive more rapid access to the care they have elected for (Thorlby 2020). The initial enactment of the countries universal healthcare coverage stems from the Beveridge Report, which covers the purpose and use of free healthcare along with additional benefits to be had from universal care. According to the Beveridge Report, free healthcare will eliminate unemployment, eliminate illness, eliminate poverty, and improve education (Thorlby 2020). Along with this, in 1946 the National Health Service Act had required the Minister of Health within the United Kingdom to provide a comprehensive, free health service to replace out-of-pocket payment and voluntary insurance; all ordinarily resident- one who is lawfully and voluntarily settled within the United Kingdom as "part of the regular order of their life for the time being, whether for a long or short duration" (Gov.UK 2022)- were automatically entitled to this service, such as their current universal healthcare program (Thorlby 2020). For the general cost spending of the United Kingdom in terms of the OECD standards, the United Kingdom spent 9.8% of their Gross Domestic Product on health care and 79.4% of this was for the NHS services provided to all residents of the United Kingdom (public insurance services) (Thorlby 2020).

With most of the conversation revolving around the United Kingdom healthcare system being their public health model, they still do have the privatized model available and offered to individuals who reside there. As mentioned before, ~10.5% of U.K. residents chose to opt-in to their own, private insurance. Some of the most common/popular insurance companies that cover United Kingdom residents include, but are not limited to, BUPA, AVIVA, AXA, Medicare International, and Freedom Health Insurance (Chang et al. 2015). BUPA is the largest healthcare insurance company in the United Kingdom, with an affiliation with over 400 accredited hospitals; this carrier is an alternative to the tax-funded NHS program, with extensive coverage

for a variety of health related/medical expenses, from dental care to cancer (Chang et al. 2015). AVIVA is the sixth largest insurance company in the world- being based in in Great Britian- with over 53 million customers and coverage for all major types of health-related medical expenses and access to the top hospitals, treatment, medical specialists and pharmaceutical medicines (Chang et al. 2015). Next, AXA is a French insurance company, and the health insurance aspect of the insurance company is known as AXA PPP Healthcare, with access to life, health, and other insurance (Chang et al. 2015). Medicare International is a program that offers *full* coverage for chronic conditions (example: diabetes) and coverage for comprehensive check-up procedures (example: specialist's fees, general visits), and are known as one of the best United Kingdom health insurance providers (Chang et al. 2015). Finally, Freedom Health Insurance was stated by the authors of *The UK Health Care System* to be "one of the best providers of medical, sexual, aesthetic healthcare in the UK" (Chang et al. 2015). While these are a handful of the more commonly known health insurance providers in the United Kingdom, these few examples don't include all that is offered to the UK public.

While the National Healthcare System is free at the point of use to the permanent residents of the UK with cost allocations being provided by general taxation (covering 85% of the total health expenditure), the NHS provides services to special classes of people at a free or low-rate cost. The first category of a special class of people would be those of older age, for example those of the age 65+ who are able to receive free influenza vaccinations, nursing care being free for those in nursing homes, free sight tests for those over the age of 60+, etc. (Chang et al. 2015). Another sector of people would be those with a disability, who are helped by a Disability Living Allowance (DLA) and Attendance Allowance (AA); the regulation for assistance would be those with a disability causing the individual to need assistance with

personal care, mobility, or both (Chang et al. 2015). The provided support from these regulations allows for financial support of extra costs associated with individuals' mobility, supervision, and personal care. The personal care component is payable by three different rate options- low, medium, and high. Low rates are for those who are of the age 16+, require only basic assistance with basic bodily functions that require attention for activities for some portion of the day (Chang et al. 2015). The medium rates are for individuals who require more frequent assistance or consistent supervision throughout the day in order to avoid injury to themselves or others, and the high rate is for those who fall within the medium rate need level but also require this assistance at night (Chang et al. 2015). Moving on to the rate options for mobility, there are two options for this, which are lower and higher. The lower rate of assistance is for individuals who can walk, but supervision and guidance are necessary for unfamiliar roots and the outdoors; the higher rate of assistance is for those who are unable to walk or virtually unable to walk (Chang et al. 2015). The personal care and mobility components fall under the Disability Living Allowance (DLA) and moving on to the Attendance Allowance (AA), this is what includes people over the age of 65 with the personal care need (not mobility), which rates mimicking the medium and higher rates of DLA (Chang et al. 2015).

While there has been proven success in providing affordable, accessible, and available care within through this countries healthcare system, a major area of concern for the United Kingdom is their growing shortages of medical providers/doctors. The reasoning behind the shortage has not been clearly defined, but there has been reasoning to believe it is due to the lack of compensation for the number of hours of hard work the medical providers/doctors put in with working within the NHS. A way to combat this has been by providing incentives to trainees and returnees to attract professionals to enter the field (or back into the field) in the areas of shortage

(Thorlby 2020). Another potential cause of this is due to rising health issues and exhaustion from the providers, which is why the incentives are important- especially for those currently within medical schooling. To wrap up the model of the United Kingdom healthcare system, to ensure quality insurance in the care being provided, the Care Quality Commission regulates health and social care throughout their system.

Comparison

After conducting reviews of research studies and generalized information about each country's healthcare system, it becomes obvious that the gap between low-income and high-income adults with access to general health care and health insurance is significantly larger within the United States than in the United Kingdom due to many factors, but with a large emphasis on the failure to have one, overall "system" or "model" and having multiple different systems, privatized and public, in place of the universal system represented within the United Kingdom (Choi et al. 2020). Choi et al. studied the comparison between the 10^{th} percentile and 90^{th} percentile of income in each country and rated the prevalence of health outcomes due to income-health-gradient studies, showing the following results (10^{th} percentile vs 90^{th} percentile income rating): functional limitations for the U.S. was 78.5% vs 39.6% and 57.8% vs 30.9% for the U.K.; high inflammation for the U.S. was 42.6% vs 25.9% and 33.6% vs 24.8% for the U.K.; diabetes for the U.S. was 29.0% vs 11.7% and 14.5% vs 6.0% for the U.K. (Choi et al. 2020). The United Kingdom showed clear rates of less disparities between the 10^{th} percentile vs the 90^{th} percentile, which positively correlates to their populations access to healthcare services and the cost of the services available. Along with this, the United States showed to have higher costs and GDP spending due to the Americans perspective on medical treatments and the usage of

prescription medications for treatment. Americans tend to opt-in to the more expensive procedures while the United Kingdom patients will opt-out and prefer alternative methods, leading to a reduced overall healthcare cost that allows for the NHS to reduce GDP spending and have a universal healthcare system (Bergen 2018).

The British ideology of their system is that healthcare is a basic human right, as shown through their public healthcare system with a universal baseline of care for all those within the U.K. population; the United States healthcare system, though, is widely perceived and shown to be a privilege to U.S. citizens with access to privatized insurance- apart from the limited population who receives access to Medicare and Medicaid plans (Trudeau 2019). With the consideration of American employers paying employees for their specified healthcare package, the general average United States citizen pays roughly 5% of their gross income for uninsured medical costs; the United Kingdom's average is 4% higher (meaning roughly 9% of gross income per the average United Kingdom citizen) (Trudeau 2019). Something to keep in mind is that while the United Kingdom average citizen pays more in gross income towards uninsured medical services, all citizens are being provided universal healthcare while a large percentage- 8.6% or roughly 28 million (Starkey et al. 2022)- citizens of United States citizen have zero access to healthcare services and insurance due to the high costs and prioritization of privatized insurance. According to Chris Ham in his 2005 article, *Money can't buy you satisfaction,* he states that while both countries' populations have dissatisfaction with their specific healthcare system, the United Kingdom has higher rates of their population acknowledging that the system works "well" and with less belief that their system needs to be completely rebuilt, in comparison to the United States responses (Ham 2005). Along with this, Ham also mentions how in a study done by the World Health Organization (WHO) in 2000, the United Kingdom's healthcare

system performance ranked 18th out of 191 countries, and the United States ranked 37th (Ham 2005).

Qualitative Research

Qualitative research has lacked in the study of healthcare systems, for both the United States and United Kingdom. A major benefit of qualitative research is that it allows for personal perspectives and the understanding of facts and data by their quality rather than the quantity of something produced. Due to the lack of qualitative research provided in the comparison of the healthcare systems, growth within the systems is limited to the quantitative research that is available which limits the ability to undergo comprehensive development of the overall methodology and ideology that is already established. For example, being able to consider underlying issues or concerns that are represented in the collection of interviews and through phenomenology. One of the few studies available using qualitative research collection and a meta-analysis perspective regarding the healthcare systems evolution was conducted in 2019, titled *Clinical performance feedback intervention theory (CP-fit): A new theory for designing, implementing, and evaluating feedback in health care based on a systematic review and meta-synthesis of qualitative research,* researchers found that feedback interventions in healthcare environments are so complex and are limited to quantitative research, thus leading the interventions to operate on missed opportunities and have many reasons for failure (Brown et al. 2019). Feedback interventions are essential in healthcare systems as they provide knowledge of results for the performance/action and/or behavior of individuals- comparison of the United States and United Kingdom healthcare systems relies on the quality of outcomes and the behavior and perspective of the individuals within the systems. Without this, there is limited

opportunity for growth and development of successful models. The result of the researcher's qualitative analysis on feedback interventions allowed for them to identify how feedback works in practice, factors that influence its effects in a usable and parsimonious manner, explanations as to why interventions are effective or ineffective, generation of predictions about what makes feedback interventions effective or ineffective, and applicability to other quality improvement strategies (Brown et al. 2019). To summarize, the use of qualitative research allowed for the quality of specific healthcare interventions to be identified which thus helps guide and assist the quantitative nature of the interventions and their ability to develop over time.

METHODS

The study was conducted to further the research and understanding of the United States and the United Kingdom healthcare models from a qualitative perspective of individuals that have experienced both systems. All methods that were conducted in the study were approved by the International Review Board (IRB) (see Appendix A) (IRB-FY2023-63)- the IRB group is formally designated to review and monitor studies that involve human subjects. While the research within the given study is still representative of a qualitative study, the IRB process was conducted due to communication with human subjects regarding their personal experiences, to be further used and analyzed.

> This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

Participants & Sampling Procedure

Participants were recruited using snowball technique- through connections of peers, their peers, etc. The researchers contacted the participants via phone and email to establish a connection and initiate the steps leading up to the interview. All contacted individuals are known acquaintances that have previously lived in the United Kingdom for at least one year. Each of the contacted individuals were asked if they had further connections that would fit the guidelines of the study. Once a list of all potential participants was gathered, inclusion criteria was verified (had lived in the U.S. and U.K. for at least a year respectively and had at least one urgent, emergency or chronic condition requiring medical attention in both countries) to ensure the

validity and reliability of the response provided in the interview. As samples were verified, interviews were then scheduled with each participant.

Data Collection

Interviews were conducted via Zoom (Version: 5.12.0 [11129]). Zoom interviews were recorded with the camera turned off for both the researcher and the participant along with auto-transcription to ensure data recollection and transcribing of the conversation was available for analysis later within the study. All participants were explained the purpose of the study and were asked to electronically consent to the use of their responses in an analysis of the two healthcare systems within a master's thesis by electronic signing a consent statement sent individually to each participant via email prior to the meeting. Once consent was received from the participants, scheduled Zoom interviews were sent out via email and the interviews were then conducted. The interview guide (see Appendix B) was created to assess the personal experiences and perceptions of each participant. The interview guide will be followed for each participant and not deviated regardless of the responses provided. The participants will be encouraged to explain their reasoning behind each response and as well encouraged to detail their personal experiences, as there is no right or wrong answer regarding their responses.

Consent Statement. The intent of the consent statement (see Appendix C) provided to participants prior to the interview was to provide the description of the researcher, explain any potential risks and benefits, provide the time involvement, explain the process of the interview, the participants rights, the thesis chairs and researchers contact information, and, finally, provide the researcher with an electronic signature as documentation of agreement to allow the research to further use their responses anonymously in this study. The consent statement providing the

clarity of anonymity in the responses of the participants also allowed for participants to be aware that they were able to answer questions truthfully without any potential repercussions.

Interview Guide. The interview guide (see Appendix B) was created to assess the personal experiences and perceptions of each participant with the healthcare systems. The interview guide was followed for each participant and did not deviate regardless of the responses provided. The participants were encouraged to explain their reasoning behind responses while detailing their personal experiences.

Analysis Methods

Once all interviews were conducted, each recording was reviewed and each interview was transcribed, not verbatim yet to capture each theme of the respective participants' responses. The transcribed interviews were then assessed in a phenomelogical approach to capture commonalities of themes. With the use of Excel Microsoft 365 (2022), each theme was quantified by how many times it was documented and how many unique participants endorsed each respective theme. Quotes were also pulled from interviews to highlight each respective theme. Themes are expected to coincide with the interview guide and what is known from literature and was loosely based around the individual perspective of the United States and United Kingdom healthcare systems, experiences regarding quality and importance of care towards the individual perspective, and the social effect and the realism portrayed within the already conducted studies on each healthcare system.

The researcher developed the questions throughout the process of the literature review and analysis of content that related to the main objectives of the study. To identify the qualitative goal of the study, it was important to create questions that enforced descriptive commentary and

feedback by those interviewed. The creation and format of the questions began with a more generalized focus- working towards gradually increasing the depth and detail of the questions and responses. For example, asking for general knowledge on either healthcare system. The researcher then asked wanted to create questions that allowed for more personal responses, thus allowing the participants to analyze their personal experiences within the systems and how it had shaped their perspective on healthcare quality. The researcher also included questions that allowed participants to reflect on how they personally feel the general public would view specifics of each system after living within each.

Participants were asked to explain the healthcare systems from their own personal experiences and opportunities- allowing the researcher to learn about each system from experienced personnel. The priority and focus on the individuals' experience allowed for a comparison of the two countries due to provided first-hand knowledge and experience, rather than conducting a meta-analysis approach with what is portrayed in social media or within past research- which would have prevented the researcher from acknowledging perspectives outside of what was available and presented to the general public. Acknowledgement of their own medical history also played a role in the interview process as everyone interviewed had a different experience and/or condition, allowing for a variety of experiences to be shown.

RESULTS

The purpose of the given research was to create a qualitative comparison of the United States and United Kingdom healthcare systems to allow for further analysis of the quality of care from individuals perspectives with experience within both populations. All participants within the study reviewed and signed the consent statement (see Appendix C), which allowed the researcher to use their responses in the results, analysis, and conclusion of this study. Each participant had lived in each country for a minimum of one year, many living in both countries for multiple years; each participant had a medical event occur that caused the use of each healthcare systems at least once- most had at least two medical events per country; each participant had knowledge of the differences between each system. All interviews were recorded via Zoom (Version: 5.12.0 [11129]) with cameras turned off and auto transcription was turned on and documented.

Demographics

Three participants were identified in the research conducted within this study. Two of the participants were male, and one participant was female. Each participant had lived within the United Kingdom for at least 10 years, and each participant had lived within the United States for at least 3 years- each participant was originally from the United Kingdom and moved to the United States for a period or permanently, all with valid healthcare insurance. All participants were over the age of eighteen and had a minimum of one healthcare experience outside of a primary care visit within each healthcare system.

Interview Breakdown

All questions asked within the interviews allowed for individual perspectives to be shared and generate a qualitative understanding of the differences and similarities between each healthcare system. While all questions were beneficial in understanding the qualitative perspective of individuals who have experienced both healthcare systems, there were a few questions that stood out, gave repetitive/similar answers between interviews, or provided commentary that stood out amongst others. On the other hand, there were a few questions that while they added to the fluency and direction of the conversation, they did not provide enough insight to allow for clear or identifiable responses that would benefit the analysis of this research- these questions were question 9 (please explain, to the best of your ability, the process of getting billed and/or paying for the care you received from each system) and sub-question 1 (why is one [population; U.S. or U.K.] generally healthier than the other).

What is one positive and one negative attribute of each healthcare system? This question guided the participants to think about their experiences within each healthcare system and then allowed them to begin critically thinking about their true experiences, by naming negative and positive attributes within each system. Within every interview conducted, each participant provided the same answer to the asked questions regarding naming one positive and one negative attribute about each system: The United Kingdom is free care that is provided as a right to everyone, thus relieving stress regarding being able to get care if needed, but this then led to increased wait-times that many times can deter individuals from seeking care if they need it. Opposingly, it was the exact opposite for the United States where the positive attribute was the short wait-times and the time sensitive treatment of healthcare being provided to individuals, but the financial burden associated with this care causing limited accessibility to care within this

population and the reluctance to seek care due to the overwhelming cost associated with healthcare services.

What are your thoughts/feelings towards universal healthcare? Within the universal healthcare system, the common thoughts/feelings revolved around the financial relief experienced with being able to access care when you need it, and a sense of gratitude towards knowing that if you are ill or injured, you will always have the option to go receive healthcare services as you are not held back by the overwhelming burden that can be financial stability. With this said, since everyone ordinarily resident within the United Kingdom has accessibility and affordability of healthcare, the drastic increase in wait-times to see providers causes a lessened desire to want to use the services. As quoted by one of the participants, the universal healthcare system is:

> Healthcare paid for by your taxes, and you have the right to it, but therefore there's long waitlists and it's not as financially influenced.

The participant mentioned above was stating how the perception of healthcare within the United Kingdom is that everyone has a right to this service, and everyone will be provided with this service, but at the cost of increased wait-times to be able to receive the actual care and reduced influence by the healthcare workers to provide initial treatment if it is not deemed 100% necessary at that point in time.

What are your thoughts/feelings towards private healthcare? The interviewed participants generally mentioned how private healthcare allowed for more specialized services and quicker access to necessary care, but the financial burden was overwhelming. Although the availability for healthcare in a more privatized system increased, the accessibility and

affordability reduced the positive feelings and general liking towards this type of system. To state directly from an interview:

> It is really expensive. People that are in a position where they can't afford it (healthcare services), they may not go and get it because, 'insurance covers some of it but doesn't cover all of it, if you can't afford medical insurance, or your job doesn't offer medical insurance, what am I going to do?'- where in the U.K., you walk in, you know it's going to be taken care of (cost of services). It may take you longer, but you still know you are going to be taken care of and it is not going to financially break you. Whereas the U.S., if you are in a place of privilege... you can bear the financial and mental costs...the system benefits those who have means and privilege, and that's problematic.

Essentially, the financial burden of accessing care trumps the increased availability if you are not in a financial bracket that can cover the extreme costs of healthcare services within the United States. If you have the financial means, or as mentioned above as "privileged", then the United States healthcare system is of your benefit as you will receive the care quickly, get the necessary treatments, and will have further access to specialty care.

Which system do you think is more efficient in delivering care to the general public? & Please explain, to the best of your ability, the quality of care you receive from each system. The response for these particular questions were mixed due to the varying capabilities of each system and the different strengths and weaknesses. For example, one participant stated that:

> There is more access here (U.S.) from an infrastructure standpoint as a patient, so if I need to go emergency care, primary care, or urgent, there is those options while in the U.K., it is one or the other (emergency care or primary care). The types of services are what's different...if you need surgery or you need a CT scan or something more complicated, it is a lot easier and a lot quicker in the U.S. than it would be if I was in the U.K. because of the structure of the system itself.

And similarly, another participant also mentioned the willingness to provide care in the following statement:

> I would say that the U.S. are more likely to do additional tests and get things done while you are there at the E.R. (emergency room) because of the fact that it gets covered by costs while the U.K. are more reluctant to do so- they triage, they'll make sure you're ok, and then go see a major physician and then go through the consulting process whereas here (U.S.) insurance covers that (services).

With this being said, it may seem as though the United States was showing favor towards delivery of care, but participants also mentioned the capabilities also have a strong correlation to the funding and affordability of healthcare within both populations. One participant said that:

> I know that back home (United Kingdom), it's a very sympathetic view on the healthcare system, and it's not that they are not doing a very good job because they are not able to, but because they are under-staffed or just simply don't have the facility to help and to hold enough patients. In the U.S., it feels like whatever your budget or insurance allows will dictate the standard of your healthcare.

It is not that one system is "better" at delivering care than the other. The United States has a greater drive to provide direct treatments during initial visits such as scans and preventative testing because cost is a driving factor- insurance or out of pocket costs are paying for the services, not the tax dollars. On the other hand, the United Kingdom delivers quality care to the population, yet they are more resistant to provide additional testing's as the payment for the use of these services is through the tax dollars that are funding the system, which is not an unlimited supply of money.

Analysis of Notable Features

Through the collection of data, the researcher created a Microsoft Excel spreadsheet to manually track, through the use of the recorded interviews and transcriptions, features that were mentioned within each interview multiple times; these notable features helped analyze what was important to each participant and also had a high presence and influence as these features were

mentioned by each participant many times. For the analysis of the United Kingdom, notable features mentioned were the wait-times experience within the universal healthcare system, the increased accessibility of healthcare, the financial relief, and experiencing the commonality of multiple patients being present in hospital rooms (multiple beds). The frequency of each of these features being mentioned through each interview is shown in Figure 1. On the other hand, for the analysis of the United States, notable features mentioned were the financial burden associated with a privatized healthcare system, being provided with care quickly and being provided treatments in initial visits, the negative stigma that is associated with the United States healthcare system, receiving attentive treatment by providers (providers focusing on the individual rather than the multiple other patients that may be on their list to treat or within the waiting room). The frequency of each of these features being mentioned through each interview is shown in Figure 2. The importance of tracking these trends is it represents a general consensus of what truly stands out within each healthcare system. Such as, it is apparent that in the United Kingdom, the financial relief experienced with the use of a universal healthcare model is very clearly present and an influence on the quality of care that is provided. Opposite of this, the financial burden within the United States healthcare system is clearly a trend that takes a toll on the overall quality of care that is delivered within this system. Each of these trends plays a role in the overall quality of care and general feelings of the healthcare systems, and also represents areas of growth that should be addressed.

Comparison. Relatively, the manual collection of notable features and trends allowed for a comparison to be completed, represented in Figure 3. Throughout the conducted interviews, the researched was able to conclude that within both systems, a staffing shortage is present- although for different reasons. The staffing shortage within the United Kingdom generally associated with

the lack of compensation provided to healthcare workers. In the United States, the staffing shortage more closely correlated with the education training and willingness of individuals to work within healthcare. A participant clearly mentioned the staffing shortage in the following statement:

> Based on the actual healthcare workers, I feel like in the U.K. the healthcare workers don't get paid for their services like they should, but that's just because of how it's funded. Over here (U.S.), I know there's always been a battle with nurses but you're getting more of a salary and more pay over here (U.S.) than back at home (U.K.).

Along with this, another similarity were the provided services within each healthcare system, with no notable difference in what can be treated and what forms of care are available to the populations. Third, each healthcare system is aware of changes that need to be made to better improve the overall quality of care to the general population, although there may not be action set in place to make these changes.

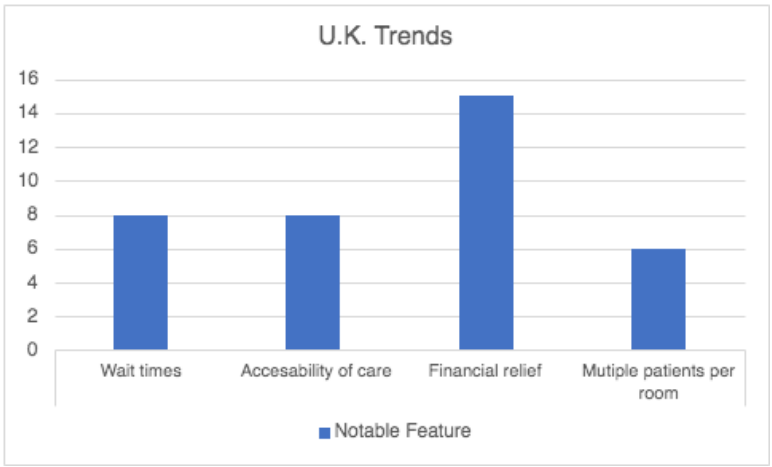

Figure 1: U.K. Notable Features Chart

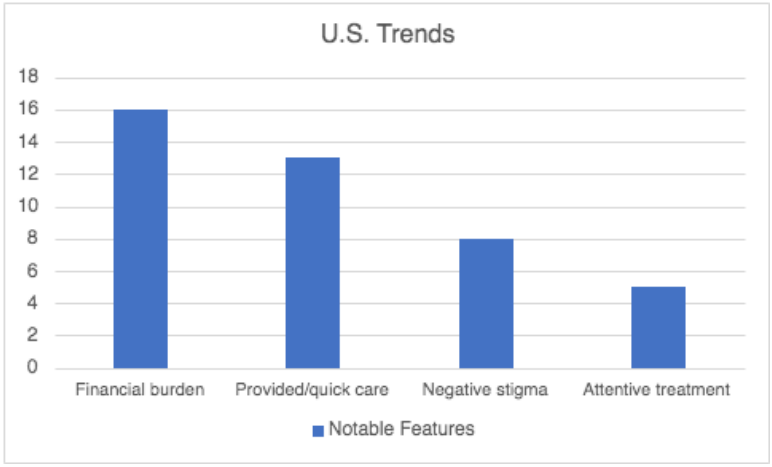

Figure 2: U.S. Notable Features Chart

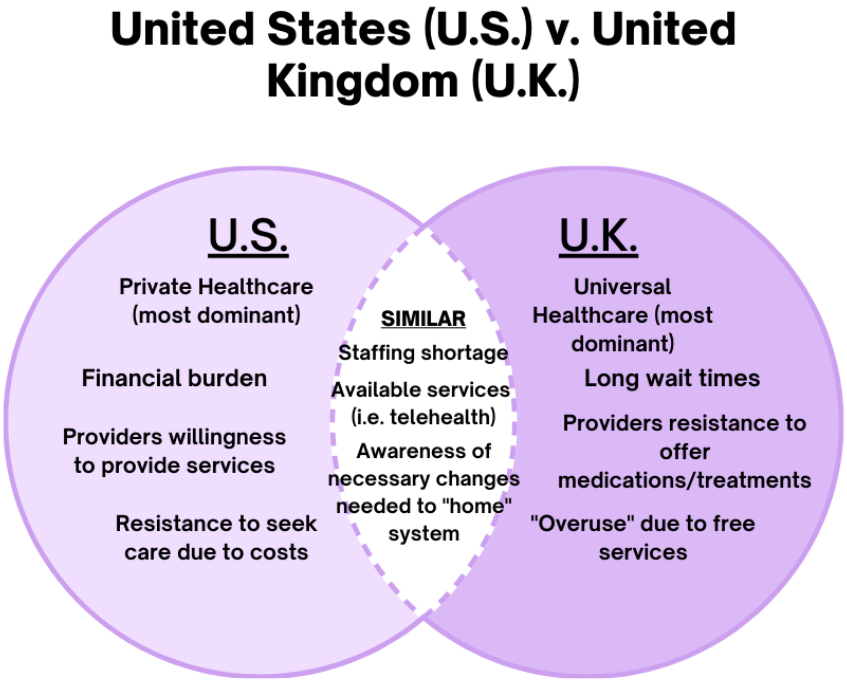

Figure 3. U.S. v. U.K. Venn Diagram

DISCUSSION

The purpose of the provided research was to provide a qualitative analysis of the comparison of the United States and United Kingdom healthcare systems to allow for the interpretation of individual experiences and perspectives rather than numerical data that is typically applied to interpret and represent the quality of the systems. The researcher's intent with creating a comparative study of two massive and vastly different healthcare systems was to gain a sense of clarity on the quality of care provided to individuals from the perspective of the individuals with the experience. The common trend when looking into research available on healthcare systems is that the research is either quantitative or filled with bias, causing the validity and reliability of actual perceived quality to be skewed. The researcher wanted to expand the available research to allow for an equal comparison and analysis to be done on the healthcare systems, which include both the numerical and qualitative findings.

A main theme identified by the researcher when their researcher was the opposed opinion explained about the general public population by all participants. What this means, is that each participant stated that a common trend in the United States is to have a negative perception towards the U.S. healthcare system and a common trend in the United Kingdom is to have a negative perception towards the U.K. healthcare system- there is no “side” to or population that has been or will be fully satisfied with the healthcare availability and quality that is offered to them. The researcher analyzed that when you see different opportunities and structures that have a perception of providing care in a different sense, it becomes difficult to fully satisfy populations that rage so widely in economic status, political perception, etc. For example, individuals of the United States population may perceive the United Kingdom as having a better

healthcare system because it is “free” to all, but they do not consider or are not aware of issues that the U.K. healthcare system faces, and vice versa. The United Kingdom may perceive the United States healthcare system as being better due to the reduced wait times and the commonality of treatments and medications being provided to patients, but they may not realize how expensive it truly is to get this care and how many members of the U.S. population do not have even a basic level of care, such as the U.K. has.

Another main theme identified by the researcher was the willingness to offer treatments, medications, and preventative methods between the United States and the United Kingdom healthcare systems. A common discussion within each interview was the willingness to provide certain care with the assumed reason by the participants being the financial funding of each healthcare system. Within the United Kingdom, their universal healthcare is funded by tax dollars- meaning that there will not be a major fluctuation in incoming revenue based on basic services being provided, and since the universal, free care is provided to everyone ordinarily resident, having long-term hospital stays, extensive use of medical equipment, increase production of medications, etc. will have a greater effect on the economic stability and availability of care that can be provided. In the United States, for every service that you receive, there is a cost associated to it that either the individual is paying, or their insurance is paying- the organization in which a person is getting care will not be impacted by the cost effects of providing services to patients such as preventative scans, providing medications, long-term hospital stays, etc.

Continuing, another theme within the research collected was the differences in wait-times- the term that was most frequently mentioned among every interview was “wait-times”. In the United Kingdom, there is increased accessibility and affordability to healthcare, thus

influencing individuals within the population to use the care that is provided to them. Rightfully so, if an individual is feeling ill, they will go to a provider to get a sense of clarity regarding their health. While increased accessibility and affordability is a massive step in increasing public health and providing equality among healthcare, it has also led to unexpected downsides- a major downside being the wait-times that are experienced. Each participant mentioned more than once that, when using the U.K. healthcare system, the wait they experienced was exponentially greater than what they experienced within the U.S.; there is multiple beds (patients) per room within healthcare facilities, providers would be quick within the appointments, and to go to a facility it was expected that you would be there for a large some of time. One participant mentioned that, in some cases, it seemed as though they did not get the full attention of the provider as it was clear they had other tasks to complete and patients to see- as if they were not fully focused on the conversation between patient and provider. When using the U.S. healthcare system, since there is decreased accessibility and affordability, the availability is increased. There are less patients that can go get healthcare services or are willing to go get healthcare services due to the financial impact it would have, so there is less of a wait-time to be seen by a provider and those waiting for care within the facility.

Once the interview had concluded, 2 of the participants asked the researcher why they had chosen to due this study. One specific participant stated that when they received communication regarding the study and searching for potential participants, they said:

> I thought it was interesting because, I'm guessing you're American, correct? 'correct.' I just found it super interesting because I feel like it's always a controversial topic about the U.K. versus the U.S. healthcare, so I just found it interesting.

The participants alluded to the idea that an American student taking on the topic of United States versus the United Kingdom healthcare was shocking as it is something that many Americans tend to conclude their opinion based on quantitative results and economic standpoints- many American individuals like to keep the perception that the way their system is functioning is the best way. The researcher was also asked how their devotion to this topic initiated, and the immediate response of the researcher was due to the result of reading the book *The Healing of America* by T.R. Reid. This book dives into the differences between healthcare delivery all over the world and how the same diagnosis is treated, billed, and perceived by healthcare professionals around the world. Still within the post-interview conversation, participants also spoke on how this subject is something that should be analyzed in a qualitative manner. Representation of healthcare quality should not be fully centered on numbers, as the actual quality given from the healthcare system relies on the experience of those who used the services.

Limitations

Due to the process of a qualitative study conducted by the researcher with an emphasis on perceived experiences, limitations were identified throughout the implementation and analysis of the study. First, sample size led to a limitation due to the restricted, limited availability of those in proximity that meet the guidelines for participation in the study. Next, the use of snowball sampling method to gather participants to be interviewed led to common traits within participants such as similar personality traits and perceived importance. Also, the use of a non-validated interview guide reflected what was perceived as important by the researcher and the data collected prior to the qualitative analysis of the participants. Finally, the last limitation identified was that qualitative research conducted on the selected sample population and size

limits the ability to generalize the results to the larger population due to the specialized circumstances of the individuals analyzed.

Conclusion

The ability to collect and analyze qualitative data in regard to the United States and United Kingdom healthcare systems has allowed the research to understand the perceived experiences and quality of care received by individuals. Healthcare is not something that should be analyzed and concluded based on numbers- healthcare is an individual experience that focuses on the growth, health, and overall, right of the person who uses the services. The United States healthcare system reflects the focus on economic growth while also increasing and expanding the treatments and care provided to individuals within the given population. The United Kingdom healthcare system reflects the focus on healthcare being a right that is provided to all ordinarily resident within its country, ensuring care is affordable and accessible to everyone. Each system has very clear and different priorities, and the determination of success all comes down to individuals perceived important- accessibility, affordability, or availability?

REFERENCES

Andress, L. 2016. *Politics and public health.* SPH Politics and Public Health Comments. Retrieved October 22, 2022. <https://www.bu.edu/sph/news/articles/2016/politics-and-public-health/>.

Affordable Care Act (ACA). n.d. HealthCare.gov Glossary. Retrieved June 26, 2022. <https://www.healthcare.gov/glossary/affordable-care-act/>.

Bergen, C., Stivers, T., Barnes, R. K., Heritage, J., McCabe, R., Thompson, L., & Toerien, M. 2018. Closing the Deal: A Cross-Cultural Comparison of Treatment Resistance. *Health Communication*, *33*(11), 1377–1388: 10.1080/10410236.2017.1350917.

Brown, B., Gude, W. T., Blakeman, T., van der Veer, S. N., Ivers, N., Francis, J. J., Lorencatto, F., Presseau, J., Peek, N., & Daker-White, G. 2019. *Clinical performance feedback intervention theory (CP-fit): A new theory for designing, implementing, and evaluating feedback in health care based on a systematic review and meta-synthesis of qualitative research - implementation science*. BioMed Central. Retrieved August 20, 2022. <https://implementationscience.biomedcentral.com/articles/10.1186/s13012-019-0883-5>.

Choi, H., Steptoe, A., Heisler, M., Clarke, P., Schoeni, R. F., Jivraj, S., Cho, T.-C., & Langa, K. M. 2020. Comparison of Health Outcomes Among High- and Low-Income Adults Aged 55 to 64 Years in the US vs England. *JAMA Internal Medicine*, *180*(9), 1185–1193: 10.1001/jamainternmed.2020.2802.

Cusick, J., Cusick, J., Hananel, S., Seeberger Director, C., Seeberger, C., Oduyeru Manager, L., Oduyeru, L., Gordon, P., Gordon, P., Shepherd, M., Shepherd, M., Parshall, J., Gee, E., Sozan, M. 2021. *10 ways the ACA has improved health care in the past decade*. Center for American Progress. Retrieved December 9, 2021. <https://www.americanprogress.org/article/10-ways-aca-improved-health-care-past-decade/>.

Full Fact Team. 2017. *What is the NHS?* Full Fact. Retrieved July 4, 2022. <https://fullfact.org/health/what-is-the-nhs/>.

Gordon, D. 2022. *With inflation rising, medical costs hurt the middle class most, new report shows*. Forbes. Retrieved October 22, 2022. <https://www.forbes.com/sites/debgordon/2022/03/30/with-inflation-rising-medical-costs-hurt-the-middle-class-most-new-report-shows/?sh=3fb1df682088>.

Herbert, K. 2021. *What do we mean when we say "low-income?"*. Better Bike Share. <https://betterbikeshare.org/2021/03/18/what-do-we-mean-when-we-say-low-income/#:~:text=The%20easy%20answer%20is%20to,higher%20in%20Hawaii%20and%20Alaska)>.

Ham C. 2005. *Money can't buy you satisfaction*. BMJ (Clinical research ed.), 330(7491), 597–599: 10.1136/bmj.330.7491.597. [PubMed]

Chang, J., Peysakhovich, F., Wang, W., Zhu, J. 2015. *The UK Health Care System.* New York: Columbia University. Retrieved July 18, 2022. <http://assets.ce.columbia.edu/pdf/actu/actu-uk.pdf>.

Keisler-Starkey, K., Bunch, L.N. 2022. *Health insurance coverage in the United States: 2020*. Census.gov. Retrieved October 22, 2022. <https://www.census.gov/library/publications/2021/demo/p60274.html#:~:text=Highlights,part%20of%202020%20was%2091.4>.

Medicaid.gov. n.d. *Keeping America Healthy*. Retrieved July 17, 2022. <https://www.medicaid.gov/medicaid/index.html>.

Medicare.gov. n.d. *What's Medicare?* Retrieved July 17, 2022. https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare.

Meredith Freed, A. D. 2021. *A dozen facts about Medicare Advantage in 2020*. KFF. <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>.

Norris, L. 2021. *ACA Medicaid expansion in Missouri [updated 2021 guide]*. healthinsurance.org. <https://www.healthinsurance.org/medicaid/missouri/#:~:text=Missouri%20Medicaid%20enrollment%20numbers&text=As%20of%20May%202021%2C%20enrollment,2013%2C%20with%201%2C064%2C287%20people%20enrolled>.

GOV.UK 2022. *Ordinary residence tool.* Retrieved October 22, 2022. <https://www.gov.uk/government/publications/help-for-nhs-to-recover-costs-of-care-from-visitors-and-migrants/settled-purpose-tool>.

Thorlby, R. 2020. *International Profiles of Health Care Systems*. Retrieved December 9, 2021. <https://www.researchgate.net/profile/Roosa-Tikkanen/publication/347011106_International_Profiles_of_Health_Care_Systems_2020/links/5fd7897292851c13fe865e6a/International-Profiles-of-Health-Care-Systems-2020.pdf>.

Tikkanen, R., Osborn, R., Mossialos, E., Djordjevic, A., & Wharton, G. A. 2020. *International Health Care Systems Profiles United States*. Home. Retrieved December 9, 2021. <https://www.commonwealthfund.org/international-health-policy-center/countries/united-states>.

Trudeau, N. 2019. *Across the pond: A comparison of healthcare systems in the US and UK*. Choate Public Health. Retrieved December 16, 2021. <https://publichealth.choate.edu/across-the-pond-a-comparison-of-healthcare-systems-in-the-us-and-uk/#:~:text=While%20Britain%20has%20one%20of,to%20the%20largest%20private%20networ

k.&text=In%20other%20words%2C%20the%20UK,gross%20income%20towards%20healthcare%20taxes>.

Trudeau, N. 2019. *Across the pond: A comparison of healthcare systems in the US and UK. Choate Public Health*. Retrieved June 25, 2022. <https://publichealth.choate.edu/across-the-pond-a-comparison-of-healthcare-systems-in-the-us-and-uk/>.

Supanick, M. 2021. *Private Insurance and Universal Healthcare: How Can Private Insurance Be Utilized within a Universal Healthcare System in the United States?* Southern California Interdisciplinary Law Journal, *30*(2), 551–585. [Google Scholar]

World Health Organization. n.d. *Universal Health Coverage*. World Health Organization. Retrieved December 16, 2021. <https://www.who.int/health-topics/universal-health-coverage>.

World Health Organization Global Health Expenditure Database. 2022. *World Development Indicators*. DataBank. Retrieved July 25, 2022. <https://databank.worldbank.org/reports.aspx?source=2&series=SP.DYN.LE00.IN&country=>.

APPENDICES

Appendix A: IRB Approval

To:
Melinda Novik
Public Health & Sports Med
Daniela Novotny, Allan Liggett

Date: Sep 30, 2022 4:38:45 PM CDT

RE: Notice of IRB Exemption
Study #: IRB-FY2023-63
Study Title: QUALITATIVE COMPARISON OF THE UNITED STATES AND UNITED KINGDOM HEALTHCARE SYSTEMS

This submission has been reviewed by the Missouri State University Institutional Review Board (IRB) and was determined to be exempt from further review. However, any changes to any aspect of this study must be submitted, as a modification to the study, for IRB review as the changes may change this Exempt determination. Should any adverse event or unanticipated problem involving risks to subjects or others occur it must be reported immediately to the IRB.

This study was reviewed in accordance with federal regulations governing human subjects research, including those found at 45 CFR 46 (Common Rule), 45 CFR 164 (HIPAA), 21 CFR 50 & 56 (FDA), and 40 CFR 26 (EPA), where applicable.

Researchers Associated with this Project:
PI: Melinda Novik
Co-PI: Daniela Novotny, Allan Liggett
Primary Contact: Rachel Cazzaniga
Other Investigators:

Appendix B: Interview Guide

Questions

1. Please explain, to the best of your ability, your knowledge on the United States healthcare system.
    1. What is one positive attribute that stood out to you regarding this system? One negative?
2. Please explain, to the best of your ability, your knowledge on the United Kingdom healthcare system.
    1. What is one positive attribute that stood out to you regarding this system? One negative?
3. What are your thoughts/feelings towards universal healthcare?
4. What are your thoughts/feelings towards private healthcare?
5. Which healthcare system has shown to be more beneficial for your care? Why do you feel this way?
6. What experiences have you had that have contributed to your thoughts on each system?
7. Please explain, to the best of your ability, the differences in wait times and appointment availability between the two systems.
8. Please explain, to the best of your ability, the quality of care you received from each system (from providers, from staff, and from treatment/diagnosis).
9. Please explain, to the best of your ability, the process of getting billed and/or paying for the care you received from each system.

The next questions are about how you perceive public health within the United Kingdom vs. the United States.

a. Why is one (population; U.K. or U.S.) generally healthier than the other?
b. Does the general population view healthcare in a more positive or negative light in either system?
c. Which system do you think is more efficient in delivering care to the general public?
d. Any further thoughts?

Appendix C: Consent Statement

Comparison of the United Kingdom and United States Healthcare Systems: Interview Process

FOR QUESTIONS ABOUT THE STUDY, CONTACT:
Rachel Cazzaniga
Rac99@live.missouristae.edu
(636) 675-6691

DESCRIPTION: You are invited to participate in a research study aimed at obtaining information about how individuals that have lived in the United Kingdom and the United States have experienced both healthcare systems and their respective perspectives of each system. The conversations will be recorded to be transcribed at a later date.

RISKS AND BENEFITS: The risks associated with this study are minimal but may include some discomfort in thinking about your health and medical experiences. Your identity and responses will be kept completely confidential. Your decision whether to participate in this study can change without consequence. There are no direct benefits to you other than assisting a graduate student in completing her thesis.

TIME INVOLVEMENT: The interview will last about thirty minutes.

PROCESS: Each interview will be conducted via Zoom, with your name, identity and any other personal information masked. You will be asked to use a pseudonym and to keep your video off. Only your verbal responses will be recorded and transcribed for data analysis. Any information you voluntarily reveal that may identify you will be coded during analysis.

PARTICIPANT'S RIGHTS: If you have read this form and have decided to participate in this research project, please understand your participation is voluntary and you have the right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled. You have the right to refuse to answer particular questions. Your individual privacy will be maintained in all published and written data resulting from the study.

Contact Information:

- If you have any questions, concerns or complaints about this study, its procedures, risks and benefits, or alternative modes of participation, you should ask the Research Thesis Chair. You may contact Melinda Novik at 417-836-3168 or melindanovik@missouristate.edu.
- If you are not satisfied with the manner in which this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a research study subject, please contact the Missouri State University Institutional Review Board (IRB).

SIGNATURE _____ **DATE** _____