12-11-2013

Differences Between Healthcare Systems in Costa Rica & the United States and How Those Differences Affect the Overall Quality of Healthcare

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Differences Between Healthcare Systems in Costa Rica and the United States and How Those Differences Affect the Overall Quality of Healthcare

Carlie Decker

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I.) Introduction

Since the legislation of the Patient Protection and Affordable Care Act (PPACA) on March 23 of 2010, many things have changed for United States citizens. Under this new law, thirty-four million American citizens will receive subsidies that will partially or entirely pay for their health insurance (Manchikanti et al., 2011). However, it is estimated that the PPACA will raise taxes $699 billion dollars by 2019 (Manchikanti et al., 2011).

Costa Rica, which seems to be one step ahead of the United States in terms of health care reform, also imposed several tax hikes to pay for its well-known partial-universal healthcare policy. Following the establishment of the Costa Rican Social Security Fund (Caja Costarricense de Seguro Social or CCSS), paid for by these tax hikes, the quality of health care has dramatically increased (Clark, 2002). Many lower income citizens have full coverage insurance, provided by the government, which pays for doctor’s appointments, hospital visits, and pharmaceuticals. In addition to this, Costa Rica’s biodiversity and somewhat stable economy has made the country an ideal location for medical research, providing citizens with innovative medical technology and medications (Park, 1995). Unfortunately, these tax increases can no longer keep up with the monetary demands of CCSS and other health reform sectors (Leff, 2011). Because of the similarities between Costa Rica’s health care system today and the direction the United States health care system seems to be heading in the future, Costa Rica may serve as a guideline for upcoming United States health care reforms.

This thesis seeks to examine the opinions of United States citizens and Costa Rican citizens regarding key healthcare issues (health insurance, access to
pharmaceuticals, medical licensing requirements, and medical research) that impact health care systems as a whole. It seeks to pinpoint moral beliefs as well as political opinions concerning the aforementioned issues in order to identify what aspects of the healthcare system citizens are most pleased with and what aspects of the healthcare systems citizens are most concerned with.

II.) Research Methods

Interviews were conducted in both Costa Rica and the United States and further web-based research was completed during the completion of this thesis.

A.) Subject Recruitment

At the start of this thesis, I intended to seek out ten subjects from Costa Rica and ten subjects from the United States. Prospective subjects had to meet preliminary qualifications in order to be considered for the study. These qualifications included being between the ages of twenty and sixty-five, having a general knowledge of the healthcare system, speaking proficient English, and having citizenship in either Costa Rica or the United States.

Subjects were recruited using a brief oral script, inviting them to participate in a study assessing moral beliefs regarding health insurance, pharmaceuticals, medical licensing requirements, and medical research. Subjects from Costa Rica were recruited during a two-week medical mission trip I participated in at the end of April 2013 and the beginning of May 2013. Interviews were completed within patient booths at various pop-up clinics across San Jose. Subjects from the United States were recruited
throughout the months of September and October at several isolated locations on Western Michigan University’s campus.

Prior to completing an interview, subjects were required to sign an informed consent document. A brief amount of time was spent going over the consent document and answering any questions before the interview began. Figure 1 outlines the demographics of all participants interviewed.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Race</th>
<th>Primary Language</th>
<th>Private or Public Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.R. 1</td>
<td>30</td>
<td>Hispanic</td>
<td>Spanish</td>
<td>Private</td>
</tr>
<tr>
<td>C.R. 2</td>
<td>38</td>
<td>Hispanic</td>
<td>Spanish</td>
<td>Private</td>
</tr>
<tr>
<td>C.R. 3</td>
<td>55</td>
<td>Black</td>
<td>Spanish</td>
<td>Private</td>
</tr>
<tr>
<td>C.R. 4</td>
<td>29</td>
<td>Costa Rican</td>
<td>Spanish</td>
<td>Private</td>
</tr>
<tr>
<td>C.R. 5</td>
<td>55</td>
<td>Costa Rican</td>
<td>Spanish</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 1</td>
<td>20</td>
<td>Middle Eastern</td>
<td>English</td>
<td>Public</td>
</tr>
<tr>
<td>U.S.A. 2</td>
<td>27</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 3</td>
<td>53</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 4</td>
<td>55</td>
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<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 5</td>
<td>21</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 6</td>
<td>20</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
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<tr>
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<td>20</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 8</td>
<td>20</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
<tr>
<td>U.S.A. 9</td>
<td>21</td>
<td>Caucasian</td>
<td>English</td>
<td>Public</td>
</tr>
<tr>
<td>U.S.A 10</td>
<td>21</td>
<td>Caucasian</td>
<td>English</td>
<td>Private</td>
</tr>
</tbody>
</table>

Because most of my time was spent in the poorest of communities while I was in Costa Rica, most citizens had little formal education and few could speak English. As a result, I was only able to recruit five participants from Costa Rica instead of ten. As indicated above, all ten interviews were completed in the United States.
B.) Interview Procedure

Each subject was asked to answer questions about their demographics, health insurance, pharmaceuticals, their physician, and medical research. Their responses were recorded on my iPad and were coded numerically preceded by the acronyms C.R. or U.S.A. in order to identify in which country each interview took place. This allowed for accurate results and confidentiality. Each interview took about twenty minutes to complete, with time allotted for answering any questions subjects had at the conclusion of the interview. A list of all the questions participants were asked to respond to has been included in the appendix.

After all twenty interviews were completed, the recordings were analyzed and brief notes were taken. All recordings and notes were stored on my password protected iPad and computer. Following the completion of this thesis, all recordings and notes will be transferred to a flash drive and will be stored in a locked cabinet in Dr. Geiser’s office located at 3933 Wood Hall for three years.

C.) Risks and Costs

This study is considered very low risk because all data is confidential. Some minor risks involved with this study included mild discomforts when answering questions and slight time inconveniences. In order to minimize all risks, subjects were repeatedly reminded that they could refuse to answer any question they did not feel comfortable with. Interviews were also kept short, only lasting twenty minutes, in order to reduce any risks related to time inconveniences.
D.) Benefits

Although there were no direct benefits for subjects completing interviews, there were several indirect benefits. These included an opportunity for subjects to voice opinions concerning the cost of health insurance, the accessibility of pharmaceuticals, and the quality of healthcare they receive. Furthermore, policymakers, physicians, and pharmacists will gain insight on the thoughts and opinions of the citizens they seek to serve.

III.) Results

This section includes the results of interviews conducted in both the United States and Costa Rica in terms of opinions on health insurance coverage, access to pharmaceuticals, quality of physicians, and medical research. This section will also include things I observed while in both countries as well as information I obtained through web-based research.

A.) Health Insurance Coverage

The Costa Rican Social Security Fund (CCSS) was first enacted by the Constitutional Court in 1949 under Article 21 that protected the right to life. Under this Article, the constitution recognized “life as the most important good that can and should be guaranteed by the legal system” (“Global Health Observatory Data Repository”). The General Law of Health, passed in 1973, went even further, pledging the right to healthcare provisions and deemed the health of the population an interest guaranteed by the State.
The CCSS today can be divided into five different insurance coverage types: 1) employee-employer coverage, 2) self-insured, 3) indirectly insured under a relative, 4) insured through pension payments, 5) insured by State due to severe inadequate funds (“Global Health Observatory Data Repository”). It is also important to recognize that under the CCSS, an individual may choose to remain uninsured in which case he or she will still have access to emergency medical services. In contrast to this, citizens in the United States will be required by law to have some sort of health insurance starting January 1, 2014 under the Patient Protection and Affordable Care Act (PPACA). Although the PPACA seems to be relatively similar to the CCSS in terms of the breakdown in coverage type, the distinction of mandatory health insurance is enough to drastically decrease the effectiveness of an already flawed system.

Under the PPACA, more Americans will receive government-funded subsidies to help pay for their healthcare coverage using already-scarce tax resources (Manchikanti et al., 2011). Those who do not qualify for these subsidies will be forced to pay out-of-pocket for coverage they cannot particularly afford, having less money to spend on other things. However, the greatest fear of all is the notion that taxes will be raised nearly $700 billion by 2019 in order to pay for the PPACA (Manchikanti et al., 2011).

While both the CCSS and the PPACA have their flaws, citizens of Costa Rica as well as the United States would agree that, in some ways, the acts are successful. When asked about the moral obligation to provide health insurance to those who could not afford it, all Costa Rican citizens interviewed agreed that health insurance should be provided. In contrast to this, only about half the United States citizens interviewed believed there was a moral obligation to provide health insurance.
and U.S.A. 4 noted that there was a difference between having access to health insurance and having access to health care. From this statement, we can conclude that some Americans believe there should be clinics for individuals with a lower income to receive treatment at low cost without the monthly burden of paying for health insurance. While clinics like this do not exist in the U.S.A., they are not uncommon in Costa Rica and other third world countries. Physicians, nurses, and students will often volunteer several days a week at a medical clinic, at which anyone can get treatment whether or not they have health insurance. Clinics like this are often set up by non-profit organizations based out of the United States, such as International Service Learning and Hope Imaging. Prescriptions and minor procedures are paid for by donated funds while anyone requiring major medical attention is sent directly to the closest emergency room, ensuring a safe yet cost effective alternative to traditional medical care.

With the help of organizations like these, village triages could be set up across the United States and free care could be given to American citizens as it is to individuals from other countries. This would certainly help combat the need for mandatory health insurance and tax incentives could be provided to physicians and nurses who contribute their time to benefit the greater good of society.

While all participants interviewed had either private health insurance from Costa Rica or private health insurance from the United States, excluding participant U.S.A 1, affordability seemed to differ markedly between the two countries. In Costa Rica, a reasonably healthy individual can be insured for as little as $60 a month (Connolly, 2002). Monthly premiums in the United States cost nearly four times this amount, averaging $215 per month. Many would contribute this large cost difference to the
difference in the cost of living between the two countries however this does not provide a concrete excuse for the excessive cost of private health insurance in the U.S. The average cost of a one-bedroom apartment in the U.S ranges from $700-$950 a month whereas the average cost of a one-bedroom apartment in Costa Rica ranges from $400-$500 a month (“Cost of Living in San Jose, Costa Rica”). A similar consumer price index difference can be seen in the cost of groceries, clothing, and transportation. Although a cost difference can be observed, the difference is not nearly as extreme as it is in terms of the cost of monthly health insurance premiums.

Most of the American participants interviewed credited this cost difference to the quality of health care between the two countries. When asked how the quality of health care in the United States compared to the quality of health care in Costa Rica, nearly all American participants assumed their country to be far more advanced than Costa Rica in terms of health care. Contrary to this belief, T.R. Reid explains in his book, The Healing of America, that Costa Rica is rated just above the United States in an overall ranking of healthcare systems, which includes distribution of health care, quality of health care, and responsiveness of health care services (Reid, 2009). However, the United States was ranked first in the amount spent on health care per patient whereas Costa Rica was ranked 50th.

If not for the highest quality of health care, what exactly do these high-priced monthly premiums pay for and why is Costa Rica exempt from these costs? One assumption is that high prices are turning high profits for those who work in the health care system. It is no secret that physicians are some of the highest paid professionals and pharmaceutical companies make billions in annual profits. However, the United States
also has some of the highest administrative costs because of the complex legal paperwork involved in treating each patient. Not only does the U.S. have far more laws governing its health care system, the country also requires physicians to purchase high cost malpractice insurance. This explains why licensed physicians in the U.S. make much more than licensed physicians in Costa Rica. These overhead costs drive the price of patient visits up in the same way the cost of rent at a conveniently-located restaurant would drive up the cost of a meal.

As stated in the article, *Bitter Pill*, by Steven Brill, CEOs of so-called non-profit hospitals can make six or seven figures annually while marking up the price of standard lab tests 400 times (Brill, 2013). When questioned about these excessive price inflations, many hospital financial officers will refer to the chargemaster. The chargemaster is a hospital’s internal price list and rarely does this list seem to reflect any sort of mathematical cost calculation. While not everyone is forced to pay chargemaster list price for medical care, those without health insurance are the individuals who typically face chargemaster costs (Brill, 2013).

In order to combat these price inflations, the government should look into malpractice reform and come up with cost-effective administrative plans. Doing so could decrease the overall cost of health insurance.

**B.) Access To Pharmaceuticals**

Prior to my travels to Costa Rica, I was under the impression that the country had far more pharmaceuticals available without a prescription than the United States did. In actuality, Costa Rica and the United States adhere to similar
processes of obtaining pharmaceuticals. In both countries, patients are first required to see a physician and obtain a prescription where they are then sent to a pharmacy in order to receive their medication. As stated in previous paragraphs, the cost of insurance eliminates the possibility of seeing a physician for many. Because of this, I assumed participants would want more pharmaceuticals available without prescription, eliminating the need to see a physician and reducing the overall cost of drugs. However, this did not seem to be the case. Participant C.R. 1 was the only individual that believed that antibiotics should be made readily available without prescriptions, this way those “who cannot afford to see a doctor can still receive treatment” (Interview C.R. 1).

Although the unlimited availability of antibiotics seems harmless because they do not typically possess addictive qualities, this is not necessarily true. Frequent intake of antibiotics could lead to the creation of “superbugs” when consumption is not particularly necessary. The idea behind the creation of a super-strain begins with a mutation of a well-known species or the transfer of DNA between two individual bacteria (Im, 2006). This change in genetic makeup causes the antibiotic to be enzymatically inactive once within the cell or causes an alteration in the binding site to which the antibiotic would adhere. While the “development of resistance in inevitable following the introduction of a new antibiotic”, resistance can be further facilitated when antibiotics are taken incorrectly to treat viruses (Im, 2006). Doing so allows dormant bacteria to pass on their resistance to pathogens. Participant C.R. 4 also reflected the fear many have of creating a “superbug” during the interview, stating that “patients need to see a doctor because they do not know what treats what” (Interview C.R. 4).
In addition to mutation and recombination of bacteria DNA promoted by the overuse of antibiotics, several participants expressed the possibility of supporting addiction by making more drugs available without a prescription. Participant U.S.A. 2 affirmed the importance of prescriptions by indicating the many drugs lead to dependence and should therefore be controlled by a physician. Participant U.S.A. 5 and C.R. 3 also championed for the requirement of prescriptions, stating that people already abuse drugs under the current pharmaceutical restrictions and if we were to make these drugs more easily accessible, the problem would worsen. In addition to this, participant U.S.A. 6 pointed out the flaws in the current regulation system, saying that addicts are able to get small prescriptions from several different physicians in order to get their fix. These addicts are known as “Doctor Shoppers”, “patients who receive painkiller prescriptions from multiple doctors without informing the doctors of their other prescriptions” (Melville, 2013). In order to combat these “Doctor Shoppers”, the US Department of Justice distributed funds to pharmacies across the United States in order to set up prescription monitoring programs, however Kentucky and West Virginia are the only two states requiring the use of these programs today (Melville, 2013). If the government were to require physicians and pharmacies to take part in prescription-monitoring program, “Doctor Shopping” would be prevented and prescription drug abuse rates would begin to decline.

While prescription drug abuse is still evident in Costa Rica, as indicated by participant C.R. 3, no prescription-monitoring program has been created in order to combat this problem. However, because Costa Rica’s healthcare system is slightly different than ours, one can assume that “Doctor Shoppers” are not as troubling as they
are in the United States. In order to see a physician in Costa Rica, a patient must wait in line for several hours because making appointments is not customary in the Country. This makes the acquisition of several prescriptions for one drug much more difficult than in the United States. Nevertheless, it is still important for physicians to fully understand a patient’s prescription history before signing on the dotted line. For this reason, I would still recommend that Costa Rica employ a prescription-monitoring program as well.

C. The Physicians and the Hospitals

Becoming a licensed physician in Costa Rica takes six years of studying at a Costa Rican University followed by one year of social services at a state hospital and several years of residency (“Costa Rica”). In contrast to this, becoming a licensed physician in the United States requires a four-year undergraduate degree followed by four years of medical school and three to five years of residency training depending on specialty. In terms of time-education requirements for physicians, Costa Rica and the United States do not seem to differ much. However, the consensus in the United States seems to be that physicians who are schooled in countries other than our own are unqualified and receiving treatment from them is dangerous. This was reflected in the interviews conducted in the United States when most participants assumed health care was poor in Costa Rica when compared to health care in the United States. And yet, when participants were questioned on whether or not they trusted their physician, all Costa Rican participants said yes while Participant U.S.A. 2 and Participant U.S.A. 8 indicated that they do not entirely trust their physicians.
One explanation for this lack of complete confidence can be attributed to the limited amount of time Americans spend with their physician during a typical appointment. The American participants interviewed said they spend on average about 15 minutes with their physician while Costa Rican participants claimed to spend about 40 minutes with their physician. In addition to this, several American participants also indicated that they spend much more time with a nurse during a typical appointment then a physician. Participant U.S.A. 2 explained how she often feels as though her physician cannot make an accurate diagnosis when spending such little time with her, often doing little more than discussing symptoms (Interview U.S.A. 2). In order to improve the overall quality of health care and mend patient-physician relationships, physicians should be sure that all patients feel completely comfortable with the diagnosis they have been given regardless of the amount of time it takes. As indicated by the interviews completed, most patients would like to spend about thirty minutes with their physician each appointment, though this could vary from patient to patient. Although this could result in longer waiting times, patients in Costa Rica have indicated that longer waiting times can lead to stronger patient-physician relationships and ultimately a better overall quality of healthcare.

D.) Medical Research

While conducting medical research is often proven to be beneficial to the greater good of society, ethical implications often stand in the way. Animal testing and stem cell research are two common moral obstacles that inhibit progress of medical research but lack of sufficient funds can also deter medical research progress. Because the CCSS and
PPACA spend so much in federal tax dollars when offering government assistance to those who cannot afford health insurance, there is not much money left over to fund other government projects, such as medical research. Because of this medical, researchers are forced to allocate funds from other sources. Most often, this money comes from nonprofit organizations or private companies. In fact, it was estimated that “75% of U.S. clinical trials in medicine is paid for by private companies” (“Who Pays for Science?”).

However, great fear is rooted in the belief that these private companies have an agenda other than to benefit the greater good of society. Participant U.S.A. 2 complied with this fear, stating that often pharmaceutical companies will present results of their studies in a way that makes their product seem more successful at treatment than it actually is in order to make more money. For example, if a company paying for research could directly benefit from a string of successful trials of a certain drug, they may “influence the study’s design or interpretation in ways that subtly favor the drug they would like to market” (“Who Pays for Science?”). In order to combat this problem, the FDA should monitor experiments funded by private companies more heavily and consumers should ask their own questions about the studies before fully accepting the results.

While lack of sufficient funds for medical research exist in Costa Rica and the United States, this monetary shortage seems to be much more apparent in the United States for several reasons, the first being our need to be number one. Whether it’s the military, education system, or even our entertainment industry, the United States has a drive to be number one. And although America has not yet lost its technological edge over the rest of the world, it has come at a large price for taxpayers and ethical standards.
Another reason why the United States has suffered more from the inability to pay for medical research has to do with the preexisting amount of scientific published journals written by American researchers compared to those written by Costa Rican researchers. Of the 3,000 scientific journals published in 2009, 40% were written by the United States while those written by Costa Rica were almost negligible (Herper, 2011). This indicates that the United States has been spending much more in medical research than Costa Rica for several years.

In addition to this, the United States is also considered to be the unhealthiest country, with more than 33% of the adult population being obese (“Adult Obesity Facts”). Because of this, there will be a higher demand for medical research to keep its inhabitants alive and well. In comparison, Costa Rica does not even make the list of the top 28 unhealthiest nations because of their nutritious cultural diet of beans and rice (“Obesity Statistics-Counties Compared”). However, most of the research being done in the United States targets finding cures for infectious diseases or cancer while little research is geared towards improving general health. Although it is important to find cures for diseases like HIV and cancer, focusing on a way to improve the general health of the population would decrease the need for medical research and reduce the cost of health care. In addition to this, participant U.S.A. 2, participant U.S.A. 4, and participant U.S.A. 5 indicated that they would prefer medical researchers to focus on obesity, illustrating their compliance with this idea.
IV.) Conclusion

In order to create a more effective health care system, reform must take place to improve health care coverage, access to pharmaceuticals, patient-physician relationships, and effective medical research. By using the Costa Rican Social Security Fund as a guideline, as well as taking opinions from both Costa Rican citizens and American citizens, I was able to make suggestions on how to reform the current health care system with regards to these four distribution areas.

In order to increase the number of individuals receiving adequate health care without drastically increasing taxes, the government should first offer tax incentives to physicians and nurses who volunteer their time regularly at nonprofit clinics aimed at treating individuals without health insurance. Health insurance coverage would also increase if the overhead costs for physicians and hospitals were to first decrease. Initiating malpractice reform and coming up with cost-effective administrative plans could decrease these costs.

In terms of accessibility of pharmaceuticals, participants expressed a need to place more limitations on drugs with addictive properties. One way of doing so included enforcing the use of a patient-prescription history program by all physicians. Doing so would eliminate “Doctor Shoppers” and give physicians further insight on their patient’s pharmaceutical history.

Patient and physician relationships could easily be improved if physicians would spend more time with each patient, making sure patients are satisfied with their appointment. Spending more time with patients would limit the amount of patients a
physician could see in a day but it could also prevent misdiagnosis and may increase the overall health of society.

Lastly, should medical researchers focus on finding ways to promote general health throughout the country instead of finding cures to specific diseases, the overall health of society would improve. This would lead to decrease the total amount spent on health care and could ultimately reduce the cost of health insurance and pharmaceuticals.

Based on the results of the participant interviews, there are several ways in which both the Costa Rican health care system and the United States health care system is failing. And while no system is entirely perfect, the World Health Organization demonstrates that some are better than others. Using studies like this one, we will be able to get a more accurate picture of what is working and what is not working for the citizens the government aims to serve.
References


Appendix A: Oral Recruitment Script

Verbal Speech Requesting Participation

Hello! My name is Carlie Decker and I am a student at Western Michigan University. I would like to invite you to participate in an interview for a study I am completing for my honors thesis in order to graduate from the Lee Honors College. This study seeks different opinions and moral beliefs regarding health insurance, pharmaceuticals, medical licensing requirements, and medical research. The opinions and beliefs of participants’ in Costa Rica will be compared to those of participants’ in the United States. If you are interested, you will be able to review the interview questions prior to signing the consent form, which allows you to participate in this study. The interview will take about 20 minutes and will be recorded in order to ensure confidentiality and accuracy of data. Your name will not be used in the study and your responses will instead be coded numerically. Are there any questions?
Appendix B: Consent Document

Consent Document
Dr. John Geiser, Principal Investigator
Carlie Decker, Student Investigator
Differences Between Healthcare Systems in Costa Rica and America and How They Affect the Overall Quality of Healthcare

You are invited to participate in a study researching thoughts and opinions on four bioethical issues; health insurance, access to pharmaceuticals, medical licensing requirements, and medical research. This study is being completed by Carlie Decker, an undergraduate student at Western Michigan University, with the supervision of Dr. John Geiser, her faculty mentor.

This consent document will outline the purpose, the procedures, the risks, and the benefits for those participating in the study. Should you give your consent after reading this document, know that you are still able to withdraw at any point in the study. You will not suffer any prejudice or penalty by your decision to stop participation. Please read this document carefully and feel free to ask any questions.

What are we trying to find out in this study?
This study examines opinions and moral beliefs regarding health insurance, pharmaceuticals, medical licensing requirements, and medical research. The opinions and beliefs of participants’ in Costa Rica will be compared to those of participants’ in the United States.

Who can participate in this study?
To be eligible to participate in the study, you must be a United States citizen or a Costa Rican citizen between the ages of 20 and 65 years old. All participants must speak English in order to ensure an accuracy of data.

Where will this study take place?
Interviews will take place at various pop-up clinics in Costa Rica, where the student investigator will be working as a volunteer for two weeks from April 28th till May 10th, or on Western Michigan University’s campus.

What is the time commitment for participating in this study?
If you decide to participate, the study should only take about 20 minutes. There will also be time for any questions should you have them.

What will you be asked to do if you choose to participate in this study?
If you choose to participate in this study, you must first sign this consent document. You will then be asked to complete a short interview about 20 questions long. You will also be asked to answer general demographic questions about your age, race, occupation, etc.

What information is being measured during the study?
This study measures the opinions and moral beliefs of individuals in Costa Rica and the United States and how these beliefs apply to the health care system. This study also seeks to measure how the two health care systems compare and contrast.

What are the risks of participating in this study and how will these risks be minimized?
There are very few risks associated with this study. All interviews will be recorded and participants will be coded with numbers rather than their names. All recordings will be password protected on my iPad and will be locked up on Western Michigan’s campus in Dr. Geiser’s office (3933 Wood Hall) on a flash drive at the conclusion of the study along with any notes taken from the recordings. Should a participant feel uneasy about any part of the study, a debriefing period will take place in order to assess any concerns and answer any questions.

What are the benefits of participating in this study?
There are several expected benefits of this study, including an opportunity to voice opinions and moral beliefs regarding the health care system. Furthermore, policy makers, physicians, pharmacists, and medical researchers will gain insight on the thoughts and opinions of the citizens they seek to serve.

Are there any costs associated with participating in this study?
There are no costs associated with participating in this study.

Is there any compensation for participating in this study?
There is no compensation for participating in this study.

Who will have access to the information collected during this study?
Those who will have access to the information collected during this study include Carlie Decker and Dr. John Geiser. Once this study is completed, it will be presented to a thesis board composed of Lee Honor’s College faculty and any other students who wish to sit in during the presentation.

What if you want to stop participating in this study?
Should you want to stop participating at any time during this study you will not suffer any prejudice or penalty.

Should you have any questions prior to or during the study, you can contact the primary investigator, Carlie Decker at 269-598-8515 or via e-mail at carlie.a.decker@wmich.edu or John Geiser, faculty advisor, at 269-387-5392. You may also contact the Chair, Human Subjects Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board (HSIRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.
I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

Please Print Your Name

___________________________________  ____________________________
Participant’s signature                  Date
Appendix C: Interview Questions

Interview Questions

- Demographic Questions:
  1. What is your age?
  2. What race do you most identify with?
  3. What is your primary language?
  4. Do you belong to an established religion? If so, can you describe it to me?
  5. What is your highest level of education obtained so far?
  6. What is your occupation?
  7. What is your marital status?
  8. Do you have any children? If yes, how many?
  9. Do you have any chronic health issues?

- Health Insurance Questions:
  1. Do you have public or private health insurance?
  2. Was it difficult for you to find an affordable health insurance plan? Please explain.
  3. Do you believe there is a moral obligation to provide health insurance to those who cannot afford it? Please explain.
  4. Do you believe it is an employer’s responsibility or the government’s responsibility to provide health insurance? Please explain.
  5. Do you believe health insurance should be required for all?
  6. What are your views on life support/life extension?

- Access to Pharmaceuticals:
  1. Where do you get your antibiotics?
  2. Do you see a doctor before taking any antibiotics?
  3. Do you take any medicine regularly, over-the-counter or prescription?
  4. If yes, are they affordable?
  5. Do you think it would be beneficial to have more pharmaceuticals available without a prescription? Please explain.
  6. What limitations should there be on pharmaceuticals? Please explain.

- Medical Licensing:
  1. How do you think the quality of health care in Costa Rica compares to the quality of health care in the United States?
  2. Do you trust your physician?
  3. How much time do you spend with your nurse during a typical doctor’s appointment?
  4. How much time do you spend with your physician during a typical doctor’s appointment?

- Medical Research:
  1. Do you consider your country to be up-to-date with the latest medical technology, vaccines, etc.?
  2. What medical issue do you believe researchers should focus on?
  3. What ethical implications do you believe interfere with medical research? Please explain.