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NAME

C101_US vs Healthcare.mp3

DATE

December 20, 2025

DURATION

33m 16s

7 SPEAKERS

Nick Capodice
Hannah McCarthy
Sue Tolleson-Rinehart
Amélie Quesnel-Vallée
Orlando Bloom
Archival
Speaker7

START OF TRANSCRIPT

[00:00:02] Nick Capodice
You're listening to Civics 101. I'm Nick Capodice.

[00:00:06] Hannah McCarthy
I'm Hannah McCarthy.

[00:00:06] Nick Capodice
And you know what that music means, don't you Hannah??

[00:00:08] Hannah McCarthy
I can take a guess.

[00:00:11] Nick Capodice
Why, sure you can.

[00:00:13] Hannah McCarthy
You can. Well, I'm pretty sure this is Guile's theme from Street Fighter two. Which would mean this is another round of us verses where we see how the red, white and blue measures up against the rest of the world.

[00:00:26] Nick Capodice
You're absolutely correct. And today we will see how Guile and Balrog fare against Cammy, Abigail, Ed, and so many more. We're doing US versus healthcare.

[00:00:40] Hannah McCarthy
All right, so how did we measure up?

[00:00:43] Sue Tolleson-Rinehart
Oh, well, I'm sorry to say that if you looked at the 13 wealthiest nations in the world, most of which are the US, Canada, Europe, and then Japan and Australia and New Zealand, we always rank last both in health status and in quality.

[00:01:03] Amélie Quesnel-Vallée
I'm sorry to say, but there is actually this organization, the Commonwealth Fund, that does an annual report measuring the performance of health systems. Several health systems. And the title for 2024 was a portrait of the failing U.S. health system.

[00:01:19] Sue Tolleson-Rinehart
Alas, despite our wealth and our power and our American creativity and ingenuity, somehow we wind up having overall the poorest quality of care and the poorest individual health status, where we're sicker than our peers in the wealthier nations, and we achieve that last status at a higher price. I'm Sue Tollefson Reinhardt. I am professor emerita of pediatrics in the University of North Carolina School of Medicine.

[00:01:58] Amélie Quesnel-Vallée
Hi, my name is Amélie Quesnel-Vallée and I am chair and professor in the Department of Equity, Ethics and Policy at McGill University.

[00:02:05] Nick Capodice
So before we get into why we fare so poorly versus other countries, Professor Quesnel-Vallée will cover that later. I have to mention something that filled me with abject joy. So when we reached out to Doctor Tollis and Reinhart for this episode, she had an automatic reply for her email that said she had finally retired after 41 years of teaching.

[00:02:26] Hannah McCarthy
41 years. Wow.

[00:02:27] Nick Capodice
And the automatic reply ended with a trivia question.

[00:02:31] Hannah McCarthy
Really? What was the question?

[00:02:33] Nick Capodice
Do you know the difference between a Japanese and a Western chisel?

[00:02:38] Hannah McCarthy
I have no idea. What's the difference.

[00:02:41] Sue Tolleson-Rinehart
A western chisel is forged from a single piece of steel, and a Japanese chisel is laminated.

[00:02:48] Hannah McCarthy
Fascinating.

[00:02:49] Nick Capodice
Also, Hannah in a western chisel. The blade and the tang are one piece of steel, not two.

[00:02:54] Hannah McCarthy
Is the tang the full width of the blade, or are we just going to let that one lie?

[00:02:58] Orlando Bloom
The blade is folded steel. The tang is nearly the full width of the blade.

[00:03:01] Hannah McCarthy
Getting back on track, Nick Sue said that our health care system ranks pretty low as compares to other nations, but it costs a lot. Can we go over how much a lot is?

[00:03:14] Nick Capodice
Trillions of dollars. And this is one place we definitely come in first. The US spends more than any other country on health care.

[00:03:24] Hannah McCarthy
Why is it so much here?

[00:03:26] Amélie Quesnel-Vallée
The US does not have a universal health care system. It has several systems. And the more we know that, the more systems you have. And so here I'm referring to different insurers. I think the last time I looked, the US had something like 1500 insurers. And within that, however many plans that are being negotiated between the insurer and the care providers, um, HMOs and various organizations that are providing care. So that level of complexity of the system means that there are a lot of resources that are being spent dedicated to managing that.

[00:04:08] Nick Capodice
This is part of the reason why, if you look at a very common everyday hospitalization, like, say, delivering a baby, it's about $14,000 in the United States versus about 3000 in Canada. And we're not yet talking about who pays that money. That is just what it costs. And a lot of that cost comes from the myriad American systems and people who work within it.

[00:04:33] Amélie Quesnel-Vallée
You have thousands of health plans, each with their own cost sharing requirements and coverage limitations. So not only, you know, people must navigate that, but physicians and other healthcare professionals must navigate that in order to figure out how to get reimbursed and how much to get reimbursed. You know, physicians won't be doing that on their their own time. They subcontract to another organization. And when you have something like that, where there's a whole like industry, that's that's actually sprung up to help physicians. Bill, then you have to start thinking, okay, this is getting really complex when it can actually be. It has to be a budget line, you know, for physicians.

[00:05:17] Hannah McCarthy
Can we talk about how we got here, how our health care system turned into this, a system that ranks so poorly and is also the most expensive?

[00:05:28] Nick Capodice
Well, Sue took me all the way back. Back to when health care wasn't really a thing before.

[00:05:37] Sue Tolleson-Rinehart
80 years ago or so, health care couldn't do very much, so I wouldn't demand health care as a right. When health care wasn't very meaningful. Health care was pretty self-limiting. There was a very narrow window of things that a physician could do for you, and then either you would get better or you wouldn't, and that would be about that.

[00:05:59] Nick Capodice
However, there was a big shift around World War One with some new surgical techniques like lung surgery, the first ever hip replacement, and with the invention of a drug I'm going to come back to later in the episode insulin, people started to think, wow, healthcare is something, and it's something that I should be entitled to.

[00:06:20] Sue Tolleson-Rinehart
And then World War two. And World War two, we made astonishing improvements in what health care could accomplish, both in terms of the development of penicillin and then other antibiotics to control infectious disease. And unfortunately, war produces great leaps forward in medical technology. It's really it's really sad. But in terms of surgery, emergency care, long term wound management, breakthroughs and treatments of infectious disease, world War two did some really dramatic things after World War Two. The allies, who had fought so hard to win the war, tried to come back to normal life and started saying to themselves, you know, I fought for a better life. And it seems to me that that better life also means having access to these new developments in health care. All right.

[00:07:25] Hannah McCarthy
So the war is over. Soldiers are coming home, having received top of the line care while they were serving. And they're asking for that same level of care for both themselves and their families.

[00:07:37] Nick Capodice
Yeah, and we're not just talking American soldiers. This was happening to everybody who was involved in the war.

[00:07:43] Sue Tolleson-Rinehart
So now this is where the United States and many of the European nations split Most of the European nations right after World War two opted for organized national health care systems. We did not because we thought we were one of the two world superpowers, and the other one was the Soviet Union. And we were afraid of socialism and communism. And so we opted for our own unique American solution, which was to create a hybrid public private system.

[00:08:22] Hannah McCarthy
Public private system. I understand that private means private insurance, like what we have, but what is the public piece of the equation?

[00:08:32] Nick Capodice
So this was decades before Medicaid and Medicare. And don't worry, I'm going to explain those soon. So initially the public part was care for veterans, for orphans and for widows. And it was also giving tax incentives to employers to have them offer private health insurance to employees. But again, these were very early days. Health care was so small at this point.

[00:08:56] Sue Tolleson-Rinehart
So what I always liked to tell my medical students, I would say, imagine a kayak. How hard is it to turn the kayak? Not hard. One shift of the paddle and the kayak turns. That was the state of health care in the Western world at the end of World War II. It was a kayak. So I can create a national health care system because it's small, it's going to be easy to manipulate, easy to change. The difficulty is today we're talking about a right to health care and whether people should have access to health care. And the health care system is no longer a kayak. It's an aircraft carrier. How easy is it to turn an aircraft carrier? It's not easy. One of my former physician students, who was in the Navy, told me that it takes a mile of open water to turn an aircraft carrier.

[00:09:59] Hannah McCarthy
Basically, we picked a system and now we're stuck with it.

[00:10:02] Nick Capodice
Yeah. And once we picked that system, the procedures we started to require under that system grew. They grew at an exponential rate. Chemotherapy. Kidney transplants. Radiation. Things that most people can't remotely afford but need to survive are on that carrier.

[00:10:22] Sue Tolleson-Rinehart
Because now what we have is some more than $3 trillion system that is still a public private hybrid. But it's it's enormous. Some parts of it are purely for profit. Other parts are not for profit. It's hideously complicated.

[00:10:42] Hannah McCarthy
How much is paid for by the government versus private insurance companies.

[00:10:46] Nick Capodice
It's about a 50/50 split, and this is in large part due to Medicaid and Medicare, which were created in 1965, in the Lyndon Johnson administration.

[00:10:56] Archival
The new bill expands the 30 year old Social Security program to provide hospital care, nursing home care, home nursing service, and outpatient treatment for those over 65.

[00:11:08] Hannah McCarthy
All right, Medicare and Medicaid. We got to go over the difference between the two.

[00:11:11] Nick Capodice
Absolutely.

[00:11:12] Sue Tolleson-Rinehart
Medicare provides care for people who are 65 and over, and that's a truly national program. States have some opportunity to try to tweak or make innovations working with the federal government, but it's essentially a fully federalized program. It's not a national health system would look like in the United States, except that it's mostly for people who are 65 and older. Medicaid, on the other hand, is a national State partnership, the states pay 30 to 50% of the cost of the Medicaid program, and the Medicaid program is devoted to people who are low income, with a particular emphasis on pregnant and lactating mothers and children.

[00:12:05] Nick Capodice
And there's a whole nest of complexities to both Medicaid and Medicare that I will not get into at all, because it would be just too much. But real quick, there are four subsets to Medicare parts A, B, C, and D. People are eligible for different coverage, and the premiums for those can come out of your Social Security check. And eligibility for Medicaid is dependent on your income and marital status. And it's a different amount with different coverage in every state.

[00:12:33] Hannah McCarthy
There's a lot of layers there, Nick.

[00:12:34] Nick Capodice
Yeah, a whole lot.

[00:12:35] Hannah McCarthy
But I do feel like I have a pretty decent grasp on the US part of the episode, the US part. Let's get into the verses. What is health care like in the rest of the world?

[00:12:46] Nick Capodice
All right, I'm gonna explain that with the tried and true medical hypothetical, you break your leg, what happens? But first we got to take a quick break. But before that break, Hannah and I crammed all the stuff we've learned over the last six years or so, making the show into a book. It is a great resource. Around election time or any time for that matter. It's called A User's Guide to Democracy How America works. It's fun. It's loaded with cartoons from the wonderful New Yorker cartoonist Tom Toro. Check it out. We got a link right there in the show notes.

[00:13:22] Hannah McCarthy
We're back. We're talking about health care in the United States compared to health care in the rest of the world. And Nick, you were going to talk about broken legs.

[00:13:33] Nick Capodice
I was it is a classic hypothetical. So let's start with here in the US, I break my leg, I go to the emergency room. What happens again here is Sue Tolleson Rinehart.

[00:13:45] Sue Tolleson-Rinehart
That's a wonderful question. First of all, a federal law known as Emtala would require that the emergency room treat the person, but it does not require that the emergency room treats the person for free. So what then happens is I go to the emergency room to have my broken leg treated, and then I start. If I'm uninsured, I start receiving bills. The difficulty is if you don't have health insurance, you might be on the hook for some tremendously high payments. Actually, if you have insurance, you might be on the hook for some pretty high payments when you have to meet your coinsurance and deductibles.

[00:14:27] Hannah McCarthy
So if I don't have insurance and I'm not on Medicaid or Medicare, what is my bill going to look like?

[00:14:35] Nick Capodice
Well, for a broken leg, you're looking at around $2,500 for the treatment at the hospital up to another grand for the x ray, some other cost for a cast or for crutches, but that is for a simple fracture. If it's a more complicated break and it requires surgery, that's going to be anywhere from another 17,000 to $35,000.

[00:14:56] Hannah McCarthy
So in other words, if you don't have insurance, if you're not on Medicaid or Medicare, illness or injury can be unbelievably expensive, devastatingly expensive.

[00:15:07] Nick Capodice
And Sue added another layer, which is what would happen if you were not a citizen of the United States. Now, the first scenario is, you know, you're visiting. You're a tourist. Most insurance plans in other countries offer a medical travel insurance, specifically if you're going to visit the US, because if you don't have that, you're on the hook to pay all medical expenses, whatever the hospital charges. All right, second scenario, you live here. You're not a citizen. You're undocumented. You go to a hospital to have a baby. Say, what's that bill going to look like?

[00:15:44] Sue Tolleson-Rinehart
So undocumented immigrants are in, um, they're in a perilous position. Um, and they're probably going to have to pay out of pocket for any kind of care they can get unless they can enter, say, a federally qualified health clinic, a so-called fqhc, the federally qualified health clinics. Don't ask what your immigration status is. They just take you and deliver care. Now they have a sliding scale of payment, so if you can't afford to pay something, you probably will pay something. And if you can't, you don't. Then Amtala will allow you to deliver the baby in the emergency room and be covered. That doesn't mean you're not going to get a bill. However, if if I were an undocumented immigrant and I were pregnant and somebody could tell me. There's a federally qualified health center right over here. Go get yourself enrolled. I might have a shot at prenatal care and labor and delivery in that clinic.

[00:16:51] Nick Capodice
So to go back to the broken leg scenario. In contrast, Professor Carnevale lives in Quebec. So I asked her the same question. I break my leg in Quebec, I go to an ER. What does it cost? Um.

[00:17:08] Amélie Quesnel-Vallée
Um. Zero. You walk into an emergency room in a province where you are insured. You have your insurance card. I'm looking. I have mine here. Um, you go ahead and you just show this little thing, and here you go. You are, um. You're provided care.

[00:17:29] Nick Capodice
And this isn't an insurance card like you or I have. Hannah. This is her Quebec insurance card.

[00:17:35] Amélie Quesnel-Vallée
So whenever we talk about the Canadian health system, it's an averaging or a generalization statement, because really we are a federation a little bit like the US and indeed the the delivery of care of health care in the financing of health care is, is primarily managed by the the provinces and the territories. Each province and territory roughly establishes its own health care organization, and they all have in common. They offer universal free at the point of care access to physicians and and hospital services.

[00:18:12] Hannah McCarthy
How much does it cost to enroll in province or territory insurance?

[00:18:17] Amélie Quesnel-Vallée
The cost? I'm sorry. That's you. You pay your taxes. Um. Even then, like, even if you did like, it's not tied to my taxes. The cost is becoming a permanent resident or becoming or being a citizen.

[00:18:34] Hannah McCarthy
All right. Nationalized health care. I know that when debates about this come up in the United States, the concern is often higher taxes. So, Nick, do Canadians pay more in taxes?

[00:18:47] Nick Capodice
Well, it absolutely depends on which province or territory you're in. If you're in Canada and if we're comparing it to the US, it depends on what state or municipality you live in. But I do have a specific example here. And quick number alert. So many numbers are going to come your way. I got to find some fun number music here. Let's fire.

[00:19:06] Speaker7
This up.

[00:19:09] Nick Capodice
All right. Hannah, you're a single person who makes $60,000 a year. If you live in British Columbia, you will pay about $9,000 in federal taxes and about $3,500 in provincial taxes to your province. Now, by contrast, if you're just across the border, say, living in Montana, you will pay $5,200 in US federal taxes and 2100 in US state tax. But don't forget you're also going to pay Social Security and Medicare in America and the Canadian pension plan in British Columbia. Grand total. All in all, in British Columbia, you're going to take home $46,858. And in Montana, you're going to take home $48,056. That's a difference of about $1,200 a year. But I'm not done. I'm not done. Don't forget, coming out of that Montana paycheck is whatever you pay to your employer to get health care coverage, sometimes hundreds of dollars a month, and you're still paying your medical bills throughout the year, so that 1200 bucks is pretty likely to get eaten up by our medical system.

[00:20:17] Hannah McCarthy
All right, got it. Understood. Now, before we move on from the numbers, I do have one more money question. How much are doctors paid in Canada? What do they make there compared to here? All right, hold.

[00:20:31] Nick Capodice
On a second. I'm just going to start this back up. All right. Massive caveat. There is an enormous variety of salaries for doctors, depending on the kind of practice they run, whether they're in a hospital, what they do. There is such a disparity. That said, the average salary of a general practice doctor in the US is around 181,000 USD a year. Canadian general practice was 187 CAD. Quick currency exchange makes that about $135,000 American, which means Canadian doctors earn on average about 25% less. But do not forget those Canadian doctors do not have to pay health insurance premiums for their or their families health care. Whoa. Okay. Can I put the kibosh on the old money? Money? Music, Hannah? You can. Did you ever see Busby Berkeley's Gold Diggers of 1933, where Ginger Rogers sings we're in the Money and Pig Latin.

[00:21:32] Hannah McCarthy
Sure didn't.!

[00:21:46] Hannah McCarthy
All right, so that's the Canada lens. Our brothers to the north. Any other countries that we should highlight when it comes to comparing their care to our care?

[00:21:57] Nick Capodice
Absolutely. Amelia referred to a list from something called the Commonwealth Fund. That is an organization that does an annual report on health care internationally. They pick ten countries to contrast.

[00:22:09] Hannah McCarthy
Is this the one that you mentioned earlier where the US was way down there?

[00:22:14] Nick Capodice
Yeah, 10th out of ten.

[00:22:16] Amélie Quesnel-Vallée
Well, maybe, um, you know, the high performers that the Commonwealth Fund has given a shout out to are the UK, Australia and the Netherlands. What's been pointed out about the Netherlands is they actually have a high system performance relative to their spending. And this is also true of Australia and of the UK. So I think here we're not just looking at how they're doing, but also how much it's costing. And this is something that's hurting the US. You know, it's a very, very expensive system. So on any measure of cost efficiency it's going to look worse.

[00:22:52] Nick Capodice
And Amelia mentioned one extra prize for our friends across the pond in the UK.

[00:22:58] Amélie Quesnel-Vallée
Even though they've had challenges, they have managed, you know, since 1948, the National Health Service has provided free public health care, including hospitals, physicians and even mental health care. So I think that one is something that's a shout out to the UK. Many, many high income countries, actually all countries. I think lots of people are struggling with accessing healthcare and mental health care, and what they've done is that they have set up an institute that's called the National Institute for Clinical Excellence, and they evaluate ruthlessly their cost efficiency. And what they did with regards to mental healthcare is they went in and they looked at what worked, and they honed in on cognitive behavioral therapy. And they said, that works. That works. It's relatively cheaper than prescription drugs. It also provides more long term benefits and is more sustainable. And so they went all in on CBT on cognitive behavioral therapy. And they said we're going to make it available.

[00:24:00] Nick Capodice
So there's one other area of contrast I had to bring up. And that is reproductive rights. As of this moment in the US, October 2024, a person's right to obtain an abortion is dependent upon the state in which they live. So I asked Amelie, in those lists of other wealthy nations with their various health care systems, are there any that treat abortion access in a similar way? No.

[00:24:28] Amélie Quesnel-Vallée
The other ten countries I've named, you know, the Netherlands, the UK and Australia, Germany, Sweden, New Zealand, France, Canada and the US. To my knowledge, there are no countries in that group that would ban abortion access to abortion. It's a nonstarter issue in the sense that it's an acquired right and it's not up for discussion. So the I can speak about Canada perhaps more. There was actually a poll released in recent months, um, about, you know, the same kind of thing, political discussions and, and what would what would constitute a so-called third rail issue. So third rail issue. What what would be a third rail issue, something that would be a nonstarter if a campaign were run on this topic. And, um, among the topics that were proposed was Reproductive rights, and specifically in our case, we are very blunt about it. Access to abortion. Um, and that actually was, uh, in the poll very clearly stated as a don't go there.

[00:25:42] Hannah McCarthy
So, Nick, you pretty much started this episode out by telling us how poorly the United States fares compared to other countries when it comes to access to health care and the cost of our health care system. And, you know, Sue said, it's an aircraft carrier that's hard to turn right. But we have had changes. We've had massive changes every now and then over the years. I mean, Medicaid and Medicare were established in the 1960s. The Affordable Care Act was passed in 2010, which changed the face of healthcare for a lot of Americans.

[00:26:17] Nick Capodice
Yeah, it did some real quick notes on that. The Affordable Care Act let young people stay on their parents insurance until they were 26. It forbade insurance companies from denying coverage to somebody because of preexisting conditions. It expanded Medicaid access in many states. And finally, it lets people buy their own health insurance through a public marketplace.

[00:26:39] Hannah McCarthy
So if we do want to turn the carrier, even shift it one side or the other, how is that sort of thing done?

[00:26:49] Nick Capodice
Interestingly, Sue told me a story about something that happened very recently that demonstrated how these changes can happen, and it was the change in the price of insulin.

[00:27:02] Archival
Relief is coming to millions who rely on the life saving drug insulin. Drug maker Eli Lilly is cutting the price of insulin by 70%, capping patient costs for its insulin products at $35 a month.

[00:27:15] Sue Tolleson-Rinehart
Insulin is 100 years old. Insulin is not a new drug. Nobody who's selling insulin now had to pay any of the upfront development costs of insulin. So when particular drug companies were purchasing the right to sell insulin and charging, oh, $400 a month, $800 a month, they were just simply profiting. They were it was just all, all profit. Right? So the way President Biden was able to lower the cost of insulin to $35 was to get Congress to agree to allow Medicare to negotiate the price. Medicare is hugely powerful in terms of the amount of insulin it finances. Right. And so if Medicare says we're going to pay this much and no more, then a company who's selling insulin, who had been making, oh, 3 or 4000% profit on it is not. Back to making only 350% profit on it. Right. Because insulin costs them about a dollar.

[00:28:34] Hannah McCarthy
But how did they do it? How did they get that through Congress?

[00:28:38] Nick Capodice
Yeah, it seemed tough. It seemed nigh impossible because back in 2003, when Congress was trying to pass a Medicare modernization Act, the only way they could get that through was to include a stipulation that prevented Medicare from negotiating prices, ever.

[00:28:55] Sue Tolleson-Rinehart
That situation arose because for profit pharmaceutical companies said, if you allow Medicare to negotiate prices, we're going to put our entire lobbying apparatus into stopping the bill. So Congress said, okay, okay. But in the Inflation Reduction Act, we clawed back the ability of Medicare to begin negotiating drug prices, and they started with ten. And that list will continue to grow each year. So insulin was an obvious target because it's an old, old, old drug. It's not a drug that required $1 billion of new research and development. It's and it's also a drug that people really need. And then what happens in our public private hybrid system is that if Medicare negotiates a $35 price, what is Blue Cross Blue Shield or Humana or Aetna going to say, are they going to say, oh, well, fine, we'll go on paying $800. No, they're going to say now you have to give me them the Medicare negotiated price too.

[00:30:12] Nick Capodice
And needless to say, when this happened, drug companies filed a lot of lawsuits challenging it, claiming it was unconstitutional. They lost those challenges. But I have to add that last month, September 2024, the fifth US Circuit Court of Appeals in New Orleans revived one of those challenges. And that brings me to my last point. So Sue talked about health and health care for over 40 years. And if you look at her UNC syllabus for introduction to the US health system, you're going to read this quote. The course takes a strong perspective that the health system is shaped by and dependent on the political system, end quote. And I wanted to know what she meant by that.

[00:30:56] Sue Tolleson-Rinehart
What my students always heard was, um, the only thing that matters is the economics of health care. So I wanted to get them to think of something different. I wanted them to say we're the largest economy on the planet. We could simply afford to do anything we wanted to do. The choices we make are political choices about how we're going to spend that money. So I don't mean to say that it's all Partizan politics or it's all. But what I do mean to say is that politics is the authoritative allocation of values. If we decide that one of those values is that health care is a right, then the choices we make about how to deliver that right are essentially political choices.

[00:31:46] Hannah McCarthy
You know, this is an interesting way to put it, Nick, essentially, that our health care system is the way that it is because politicians made the choice to ensure that it would be the way that it is.

[00:31:59] Nick Capodice
Yeah. And if you are someone who believes that health care is a right, then you have a right to hold the people who made those choices accountable.

[00:32:21] Nick Capodice
Well, that is us versus healthcare. And before I say a bunch of names, if you want to know how the US measures up against the rest of the world in one topic or another, let us know. Drop us a line. It's Civics 101 at nhpr.org. We will check it out for you. This episode is made by me Nick Capodice Nick Capodice. This episode was made by me Nick Capodice with you, Hannah McCarthy. Thank you. And with help from our producer, Marina Henke. Our staff includes senior producer Christina Phillips and executive producer Rebecca Lavoie. Music. In this episode from Epidemic Sound, Jesse Gallagher, HoliznaCCO, Blue Dot sessions, Azura and 50 cc's of Chris Zabriskie stat! Civics 101 is a production of NHPR New Hampshire Public Radio.

END OF TRANSCRIPT