

ADDRESSING THE STATE OF INTERNATIONAL HEALTHCARE

AN ANALYSIS OF HEALTH INEQUITIES IN DEVELOPED NATIONS

CREDITS:

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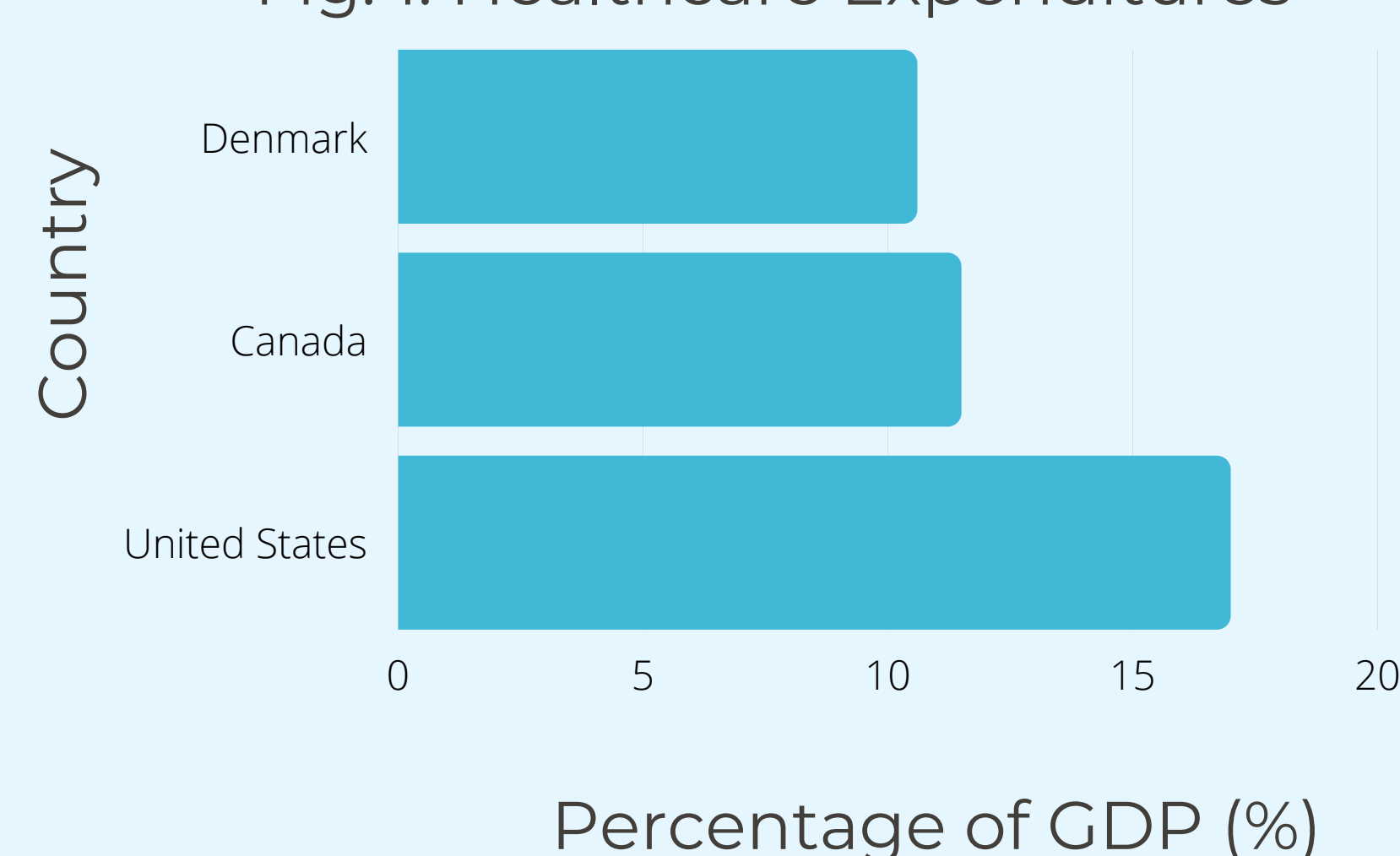
INTRODUCTION

In May 2005, the former Director General of the World Health Organization, J.W. Lee, set up the Commission on Social Determinants of Health to begin research on health inequities¹. The Commission described the social determinants of health (SDHs) as being “the circumstances in which people are born, grow, live, work and age; and the inequitable distribution of power, money and resources that are drivers of those circumstances of daily life” (Marmot & Friel 1096). These determinants result in systematic social differences in health outcomes and have in recent years become a prevalent aspect of the discussion on health inequities.

RESULTS

Regardless of the nation being studied, it is evident that race plays a key role in determining one's health outcomes. The existence of greater health inequalities within multiracial nations indicates that greater racial diversity correlates with health disparities, as certain groups are discriminated against and provided with lower quality of and access to healthcare. Moreover, those of lower socioeconomic status, whether it be due to income level, job status, or educational attainment, report significantly lower health outcomes than their counterparts. Nations that emphasize the privatization of healthcare produce greater gaps in health distribution.

Fig. 1: Healthcare Expenditures



RESEARCH QUESTIONS

This research seeks to answer two pertinent questions: (1) What are the socioeconomic factors that contribute to inequality in health outcomes? (2) How can government structure and political ideology shape a country's response to healthcare? Denmark, Canada, and the United States of America are used as case studies in order to compare and contrast these SDHs and arrive upon potential policy solutions to bridge the existing gaps in health outcomes.

POLICY RECOMMENDATIONS

For socioeconomic issues in countries such as Canada and America, one must begin by addressing educational disparities in correlation with race. While both these nations have incredibly high education rates, these numbers do not address the underlying disparities that exist within them. While most of the population may have high school education, the percentage that do not are disproportionately represented by minority peoples. This leads to a greater representation of ethnic minorities in lower-status occupations, which in turn leads to them earning lower levels of income and thereby being less likely to meet the costs of healthcare. Moreover, a large part of the reason why the Danish healthcare system is beneficial for its citizens is its emphasis on welfarism and providing guaranteed services to all its residents. A welfarist governance structure is contrary to the neoliberal market model of healthcare that has prevailed in most Western nations thus far. Denmark adopts the Nordic healthcare model, which is principally focused on welfarism and social redistribution. This ensure that all citizens have equal access to health, regardless of social determinants like race and socioeconomic status.

METHODOLOGY

This research was conducted using a combination of literature review relating to the chosen case studies of Denmark, Canada, and the United States of America. This was supplemented with an interview with an expert in the field. Overall, the research analyzed the importance of national healthcare structure, race, and socioeconomic status in causing healthcare disparities in a neoliberal age.

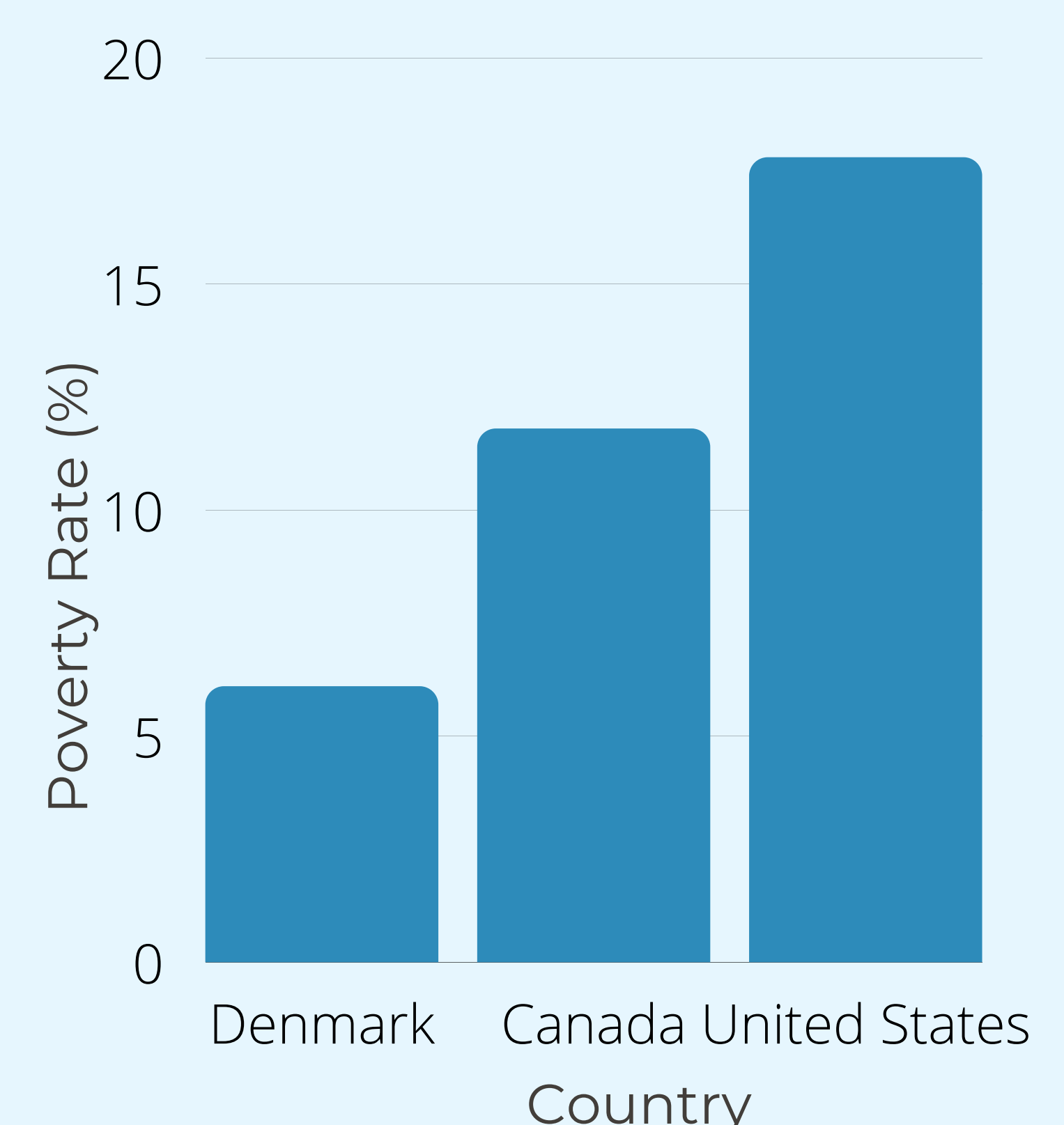


Fig. 2: Poverty rates in the 3 nations