Addressing the State of International Healthcare:

An Analysis of Health Inequities in Developed States

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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 inequities[1]. 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 systemic social differences in health outcomes and have in recent years become a prevalent aspect of the discussion on health inequities. Considering these developments, this report 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? This paper focuses on particular interconnected social determinants of health, namely race, socioeconomic status, and government structures and policies. These factors both contribute to high inequalities in health outcomes, namely in diverse countries such as Canada and Denmark. It then evaluates the importance of market structure and national and international economic values to understand the prevalence of these determinants in developed countries. The report uses the case studies of Denmark, Canada, and the United States of America, each of which have their own economic and governance structures, in order to compare and contrast these SDHs and arrive upon potential policy solutions to bridge the existing gaps in health outcomes.

[1] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

Background Information

With the rise of neoliberalism and a market-oriented outlook on healthcare, developed states continue to see prevalent disparities in health outcomes between various groups. In recent years, experts have been analyzing these disparities through social lenses, attempting to identify social determinants of health (SDHs) that contribute to inequities. The Commission on Social Determinants of Health, established by the World Health Organization, determined that these SDHs are interconnected and create a "toxic combination of poor social policies, unfair economic arrangements and bad politics" that result in significant disparities between groups (Marmot & Friel 1095). Prominent among these SDHs are race and socioeconomic status, both of which tie into a vicious cycle of inequality with one another. In most cases, those with lower income levels, at least in the Western context, belong to racial or ethnic minority groups. For them to move up the supposed 'social ladder,' these groups must attain higher-paying jobs, the greater part of which are dominated primarily by White individuas. Their lower socioeconomic status, along with their racial categorization, makes them more susceptible to inequitable health outcomes, as they are hindered from receiving the treatment that would otherwise be offered to their wealthier, non-minority counterparts. This arises due to both their inability to pay for healthcare and their inability to access adequate healthcare. These inequities are further emphasized due to governance structures in several countries. In countries where healthcare is primarily privatized, lower-status groups face further disadvantages in receiving treatments, as they have disproportionate access to private insurance plans. Due to the gradual marketization of healthcare, equal treatment is being progressively denied to lower-income individuals and minority groups, and the government structure in several developed countries further aggravates this inequity.

Approach to Case Studies

My chosen countries for case studies are Denmark, Canada, and the United States of America. I chose these three states due to the fact that they each possess similar governance structures to one another, but still have differences that are significant enough to contribute to varying health outcomes among groups. While Canada and Denmark both have public healthcare, Denmark has adopted the welfarist Nordic healthcare model, whereas Canada is more influenced by neoliberalism in its structure. Meanwhile, while Canada and the United States have similar governance structures, the latter has a much more significant emphasis on private healthcare, allowing for a contrast between their respective health outcomes. These three case studies will allow for a greater understanding of the role of the social determinants of health in influencing health outcomes and will further provide guidance for future policy implementations to ameliorate the disparities.

Findings: Denmark

Healthcare Structure

Denmark has a universal healthcare system that is decentralized. Following the Nordic healthcare model, Denmark pursues a system of tax-based funding, publicly owned and operated hospitals, universal access based on residency, and comprehensive coverage (Magnussen ix). The federal government provides tax revenue funds to regions and municipalities, which administer healthcare services. All residents receive publicly funded healthcare, which consists of mostly free primary, specialist, hospital, mental health, preventive, and long-term care services. In 2007, Denmark changed its administrative and political structure, creating a more efficient healthcare system to provide for its citizens. Prior to that, there were three administrative levels (state, country,

and municipal) that each had the jurisdiction to levy taxes (Christiansen & Vrangbæk 321). This structure created too many small units at the lower two levels that weren't properly resourced to provide good quality of service (Christiansen & Vrangbæk 321). As a response to this issue, the government created larger administrative units at the second level to allow for larger hospitals with better quality of treatment, allowing municipalities to focus on other health-related responsibilities (321). This provided better government administration of healthcare (Christiansen & Vrangbæk 321). The country went from having 40 public hospitals in 82 locations in 2007 to 21 hospitals in 68 locations in 2016 (Christiansen & Vrangbæk 323). The purpose of this change was to create fewer hospitals with "joint acute facilities" that have a wide range of specialties and resources for those specialties (Christiansen & Vrangbæk 323). As a result of this process, the number of bed days is expected to be reduced by 20%, while outpatient treatment may be expanded by 50% from 2007 to 2020.

Total expenditure on healthcare, inclusive of private investments, increased from 9.3 to 10.6% of GDP during 2007-2015 (Christiansen & Vrangbæk 325). As of 2015, 84% of healthcare is publicly financed, while the remaining 16% comes from patient copayments ("Healthcare in Denmark" 5). If Danish residents receive treatment in other EU or EEA member states, they have the right to reimbursement for all costs of care.

Socioeconomic Status

All citizens in Denmark have the choice between health insurance Groups 1 or 2. Those who choose Group 1 are registered with a specific general practitioner (GP), who provides them with free medical assistance. They are also guaranteed the right to free medical assistance from medical specialists in private practice if they have a referral from their GP ("Healthcare in Denmark" 13).

This comprises more than 99% of all Danish patients ("Healthcare in Denmark" 13). The remaining part of the population belongs to Group 2 coverage, which allows access to specialists without a referral, although copayments apply. Under both insurance options, access to hospitals requires a referral (Tikkanen et. al. 47). Pharmaceutical companies are allowed to set the official prices of medicine but are subjected to a price cap agreement with the Ministry of Health and the Danish Regions (Tikkanen et. al. 43).

Denmark has the lowest level of income inequality among the Eur-A countries ("Highlights on Health in Denmark 2004" 5). About 9% of Denmark's population lived below the 50% median income level ("Highlights on Health in Denmark 2004" 5). Economic inequality in Denmark is amongst the lowest in the OECD, while child poverty and household poverty rates in Denmark are consistently amongst the lowest within the same group of countries (OECD 145). Out-of- pocket expenditure for Danes is at about 3.1% of final household consumption, which is just below the OECD average of 3.2% (OECD 170). As such, health disparities because of socioeconomic inequities are considerably lower than for multiple developed countries.

Race

All registered Danish residents are automatically enrolled in publicly financed health care, which is mostly free. This includes registered immigrants and asylum-seekers, while undocumented immigrants have access to acute-care services through a voluntary, privately funded initiative by the Danish Medical Association, the Danish Red Cross, and the Danish Refugee Council (Tikkanen et. al. 47). Moreover, the country seeks to bridge racial gaps by providing interpreters for immigrants that are not fluent in Danish (OECD 172). Beginning from 2011, this is guaranteed to these individual for 4 years, after which they will have to pay for such assistance themselves

(OECD 172). This eliminates barriers to access, as it ensures equitable treatment guarantees for individuals regardless of ethnic background.

Findings: Canada

Healthcare Structure

Canada has a decentralized, universal, publicly funded healthcare system. Healthcare is funded and administered mainly by the 13 provinces and territories. Each has its own insurance plan and receives cash assistance from the federal government. All citizens and permanent residents, however, receive free hospital and physician services. Total spending on was about 11.5% of GDP in 2017 (Tikkanen et. al. 27). The main funding for healthcare comes from provincial government revenue, which in turn is obtained primarily through taxation (Tikkanen et. al. 28).

The Public Health Agency of Canada reports on health disparities, while the Canadian Institute for Health Information does the same, with a focus on lower-income Canadians. Several provincial governments have departments and agencies focused on addressing health inequities. In particular, both the federal and provincial governments are concerned with health disparities between Indigenous and non-Indigenous citizens. The 2018 federal budget set aside CAD 5 billion for the Indigenous peoples, and in combination with previous investments, this sums up to CAD 11.8 billion for the purpose of reducing inequities between Indigenous and non-Indigenous Canadians (Tikkanen et. al. 33).

Socioeconomic Status

Although Canada has a universal public healthcare system, severe disparities in relation to socioeconomic status continue to prevail. Many forms of healthcare are not covered by public health insurance. To pay for these excluded services, such as vision and dental care, outpatient prescription drugs, rehabilitation services, and private hospital rooms, provinces and territories provide some coverage only for certain targeted groups. The remaining portion of the population must pay for these expenses through private insurance. However, only about two-thirds of Canadians have private insurance (Tikkanen et. al. 27). This excludes one-third of the population, who are left with limited options to attain such healthcare. As of 2015, about 90% of private insurance came from employers, which disadvantages those who are unemployed, laid off, or work part-time jobs or jobs that do not come with health benefits (Tikkanen et. al. 28). Life expectancy is consistently lower among those individuals who live in lower-income neighbourhoods and have lower levels of education (PHAC 8). These disadvantages are multiplied when compounded with racial identity, especially for those who are of First Nations, Inuit, and Métis backgrounds (PHAC 8).

However, Canada does have some initiatives to eliminate barriers to access due to socioeconomic status. If an individual pays more than 3% of their net income, or $2288, whichever is less, for eligible medical expenses per year, they can receive a 15% tax credit for any remaining expenses (Tikkanen et. al. 29). While not covering all expenditures, this ensures that those in lower income brackets are not too significantly hindered from receiving healthcare, regardless of their income. Moreover, at the federal level, there has been increasing discussion on the topic of a federal drug policy. In 2018, the Advisory Council on the Implementation of National Pharmacare was established (Tikkanen et. al. 34)

Race

Unlike Denmark, which provides a certain level of healthcare to refugees and asylum-seekers, temporary legal visitors, undocumented immigrants, visitors who stay in Canada beyond the duration of a legal permit, and those who enter the country illegally are not covered by any program. Provinces and territories provide some emergency services to these groups, but do not guarantee any other forms of healthcare to them. Black adults in Canada were 2.8 times more likely to face household food insecurity than White adults (PHAC 384). Recent immigrants who have lived in Canada for 10 years or less are also 1.5 times more likely to face household food insecurity than their non-immigrant counterparts (PHAC 384).

A large part of the racial divide in healthcare in Canada occurs in the health disparities between Indigenous and non-Indigenous Canadians. The Canadian government accepted responsibility for the health Status Indigenous peoples in the Indian Act (Douglas 91). However, this responsibility, as with many after-effects of colonialism, did not benefit the Indigenous population to the extent that its intentions were. With the greater part of the population confined to reserves, the Indigenous peoples were limited in their access to land, food, and water, which are pertinent aspects of Indigenous health and sustenance (Greenwood et. al. 6). An even greater harm came with the implementation of residential schools, the majority of which were "underfunded and understaffed, which meant that children were often poorly fed, ill-clothed, and overworked" (Greenwood et. al. 8). This contributed to the long-lasting ill health of Indigenous children. It is important to note that the last residential school in Canada was closed in 1996, meaning that many of today's Indigenous adults were subject to these same circumstances, affecting the health of the current Indigenous population. Beyond directly affecting their health, colonialism can also be considered a "determinant of the social determinants of health" (Hankivsky 57). The societal structure

established by colonization affects Indigenous access to education and their job opportunities and income, thereby indirectly influencing heir health (Hankivsky 57).

The bureaucratic back-and-forth between the federal and provincial governments in providing healthcare to Indigenous peoples has ultimately resulted in the system failing to provide adequate care to them. In recent decades, Health Canada has begun transferring administration of health services to local authorities, including band councils and village administrations (Douglas 93). This primarily affects Status First Nations and Inuit peoples, as their healthcare was initially a federal responsibility, while the provincial governments were responsible for Indigenous peoples, including Métis peoples, non-Status First Nations peoples, and Status First Nations peoples living away from their reserves (Douglas 94). This web of responsibility between federal, provincial, and local authorities makes it unclear whose jurisdiction Indigenous health falls under, leaving many Indigenous patients to "'fall through the cracks'" (Douglas 94).

These problems faced are compounded by the socioeconomic and geographical barriers they face. Most Indigenous reserves are remote and far from education, employment, and adequate healthcare (Douglas 97). This further contributes to socioeconomic inequalities based on race, reiterating the notion of the SDHs being interconnected. More Indigenous Canadians have trades certifications than the general population and are only slightly behind in terms of college diplomas (Douglas 111). However, about 24% of the non-Indigenous population have university degrees, while only 6.4% of the Indigenous population have the same (Douglas 111). As such, low-paying jobs are oversaturated with Indigenous workers in comparison to non-Indigenous workers. These jobs, as mentioned before, are less likely to provide health insurance, and also do not provide enough income for the workers to afford adequate treatment. This causes Indigenous workers to become dependent on government assistance, and to be faced with the bureaucracy of jurisdiction

between different levels of government, thereby continuing the same cycle of barriers to healthcare (Douglas 97).

Findings: The United States of America

Healthcare Structure

The healthcare system of the United States is primarily privatized resulting in "a major industry with the same goal as other industries: to turn a profit" (Farmer 163). There is some level of public funding of healthcare for certain groups. For example, the national Medicare program applies to adults aged 65 and up and some people with disabilities (Tikkanen et. al. 211). There are also various programs for veterans and low-income people, including Medicaid and the Children's Health Insurance Program (Tikkanen et. al. 211).

Although about 92% of Americans had private insurance in 2018, this still left 27.5 million people, or 8.5 percent of the population, uninsured (Tikkanen et. al. 211). The government provides some additional insurance, but this still does not provide the level of care that accompanies universal healthcare. The Medicaid program initially gave states the option to receive federal funding to provide health services to low-income families, the blind, and individuals with disabilities, which was later extended to low-income pregnant women and infants, and later for children up to age 18 (Tikkanen et. al. 211). Currently, Medicaid covers 17.9 percent of all American people (Tikkanen et. al. 211). Lastly, in 2010, Patient Protection and Affordable Care Act, or ACA, was passed. This required most Americans to obtain health insurance at the risk of a penalty (which was later removed) and also allowed youth to remain on their parent's insurance plans until the age of 26, enabling more young people to have a guarantee of health insurance (Tikkanen et. al. 211).

Socioeconomic Status

The privatization of healthcare makes it seem as if health is more of a market commodity rather than a basic right, "available to those who are willing (and able) to pay for it" (Barr 11). As such, lower-middle-class Americans are more "mortal, morbid, symptomatic, and disabled" than upper-middle-class Americans (Barr 39). As one's educational, occupational, and income level decreases, their access to healthcare is further barred (Barr 39). Moreover, in the period between 1980 and 2015, the gap between the classes has expanded (Barr 46). Both the income gap and health inequality gap have widened, pointing to a positive correlation that increasing income disparity leads to increasing health disparity (Barr 46).

To further provide evidence of the relation between socioeconomic status and health inequities in America, about 38% of the deaths in 2000 were caused due to the effects of social inequality, especially low levels of education and poverty (Barr 60). Those who live in poorer neighbourhoods also have their health decline more rapidly than those that live in less-poor neighbourhoods, further pushing a cycle of widening health gaps (Barr 83). There is also a greater risk of heart disease in these neighbourhoods (Barr 84). These socioeconomic inequities also have a direct relationship with race.

Race

Donald Barr begins the preface of his book *Health Disparities in the United States: Social Class, Race, Ethnicity, and the Social Determinants of Health* by talking about a student of his whose mother was an African American health professional diagnosed with multiple myeloma. Her first doctor was white and told her nothing could be done for her condition. When her mother went for a second opinion from a Black doctor, she was put on the transplant list, which was a

significantly different response than she received from her initial doctor. Barr points out that "despite the higher incidence of multiple myeloma in the black population, nearly all the patients receiving transplants at the center were white" (Barr xii). Stories such as this prevail in America, wherein patients are dismissed or provided inadequate care on the basis of racial prejudice. Moreover, race is also connected to inequities in socioeconomic status. The distribution of wealth is unfairly skewed to favour White Americans over other ethnic groups[2]. Black Americans are more likely than white Americans to never complete high school, or to do so but not attain postsecondary education, while White Americans are more likely to complete post-secondary education, obtain a master's degree, and obtain a post-graduate degree (Barr 49). Due to the fact that education is a principal determinant of socioeconomic status, this translates into the understanding that race determines one's health outcomes. As there is lower average educational attainment among Black Americans, there is therefore also higher death rates among the Black community (Barr 49).

Similar to the African American community, Hispanic Americans also have lower educational levels, meaning their household income is also lower. In 2017 the median income of Black households was $41,064, while that of Hispanic households was $37,377 (Barr 136). In the same year, the median income of White households was $55,250 (Barr 136). Moreover, African Americans and Hispanics are also more likely than Whites Americans to live in an area with fewer primary care physicians, and thereby limited access to healthcare (Barr 198). Even when these physicians are available to more racially divided residential areas, those physicians generally have lower incomes and limited resources, which significantly reduces the quality of cared provided to the residents (Barr 198).

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[2] Idea obtained from interview with academic scholar in field of health equity

Analysis and Policy Recommendations

Race

Regardless of the country being studied, it is evident that race plays a key role in determining one's health outcomes. Denmark's racial distribution is 90% ethnically Danish, meaning that there is a greater level of equality between patients in comparison with countries like Canada and the United States, which are far more racially diverse ("Denmark Population 2021"). The existence of greater health inequalities within these countries 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.

Socioeconomic Status

Another clear indicator of health disparities is socioeconomic status. In 2019, Denmark had a poverty rate of 6.1%, while Canada and the United States had poverty rates of 11.8% and 17.8% respectively ("Poverty Rates in OECD Countries 2019"). This drastic difference in poverty levels indicates that a part of the reason why health disparities are not as prevalent in Denmark is due to the fact that there are fewer social inequalities between the country's citizens. While they do not have to pay for the greater part of their healthcare, the costs that they must cover can be met by an overwhelming majority of the population, as only a small percentage are below the poverty line.

Policy Recommendations

In order to reduce the effect of race on health outcomes, it is vital that authority figures in diverse countries understand the prevalence of discrimination in health outcomes. This begins with providing thorough cultural sensitivity training to healthcare professionals. The case of Donald Barr's acquaintance is just one example of how racial minorities are disadvantaged even in initial stages of treatments due to their ethnicity. Moreover, many minorities are barred from access due to language obstacles, or because their citizenship status makes them ineligible for adequate healthcare. Solutions such as those provided by Denmark, including interpretation and guaranteed healthcare for legal residents, refugees, and asylum-seekers, will help improve the health of countless minorities in such countries[3].

For socioeconomic issues in countries such as Canada and America, one must begin by addressing educational disparities in correlation with race. While both these countries 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. Moreover, even in higher education, there are far more racial minorities attaining college degrees or trades certificates are racial minorities, while their White counterparts attain university education. 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. In a country such as America, wherein healthcare is almost completely privatized, this is a huge advantage. Even in Canada, these lower income levels are the reason why many minorities choose to forgo

[3] Idea obtained from interview with academic scholar in field of health equity

prescription medication, which prevents them from taking advantage of the universal healthcare system.

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. Welfare policies for families lead to lower poverty rates, as they have distributive effects, which can lead to better health outcomes (Marmot & Friel 1097). A welfarist governance structure is contrary to the neoliberal market model of healthcare that has prevailed in most developed countries 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. In a more capitalist society, it is unlikely that such a model can be adapted to its full extent, as it runs contrary to many of the principles of capitalism. However, in such countries, it is still necessary that governments and industries stop treating healthcare as a commodity. A first step towards this end is a federal prescription drug program. While Canada has been discussing a pharmacare program as a possibility, the United States has yet to make any moves towards this goal. A prescription drug policy that covers the larger portion of the costs of medication will be beneficial to all citizens but will also prevent the barriers to access that arise from the social determinants of health. In this manner, patients will be able to see their treatment completed, as the high costs of medication often mean that they receive a diagnosis but are unable to afford to undergo the full treatment. Developed countries have a long way to go to ensure that all citizens receive equitable healthcare, but a pharmacare program is a promising start. The United States must also make moves towards a basic health coverage for all residents, as this would serve as one's access point into the healthcare system[4]. Many people

[4] Idea obtained from interview with academic scholar in field of health equity

seeking treatment need an entry into the system that they otherwise have not received, and basic health coverage removes many obstacles that are imposed by both race and income levels.

Neoliberalism

As we discussed the role of governance structure in determining health outcomes, it must follow that we discuss neoliberalism and its effects on shaping governments in the developed world. The neoliberal age has disproportionately affected certain groups. As globalization has spread throughout the world, it has had an unequal distribution of benefits. The poor and racial minorities are overlooked in this wave, as multilateral organizations like the World Bank promote market-oriented healthcare that is centred around privatization. This makes medical treatment expensive for many patients, as “the laws of supply and demand will rarely serve the interests of [the] patients” (Farmer 5). Most patients who can’t afford healthcare are unable to do so not because they don’t want to pay, but because they can't. This market structure of healthcare also serves as a positive feedback loop, as patients will be using their minimal earnings to pay back their healthcare costs, and therefore cannot save money to eliminate poverty, creating ‘medical poverty traps.’ As Paul Farmer describes it, “The ‘neoliberal era’—if that is the term we want—has been a time of looking away, a time of averting our gaze from the causes and effects of structural violence” (Farmer 16). Governments are focused on providing the bare minimum floor to patients, while ignoring the increasing gaps between those at the top and those at the bottom. Rather than ensuring that all patients receive equal treatments, they feel it is satisfactory to simply provide them with a social minimum and leave them to their devices. This ignores the structural and societal barriers that stand in the way of them receiving healthcare and service that is on par to what a wealthy patient, or a White patient, may receive.

As healthcare is becoming increasingly commodified, there has also been a rise of private health plans, most of which focus on "selling 'product' to 'consumers' rather than providing care to patient." (Farmer 162). Due to this, healthcare has become like any other industry, wherein the goal has become to turn a profit, often at the expense of the patients (Farmer 163). This form of commodification allows not only for the existence, but the entrenchment of inequalities. In trying to make a profit, pharmaceutical companies and healthcare providers demand high expenses that leave behind the health of the economically and socially disadvantaged. Neoliberalism and modern emphasis on market structure has left behind the welfare state of the 1930s. While a complete return to this form of social redistribution may not be feasible given the structure of the modern economy and political structure, it is only with the reintroduction of welfarist ideals that those in a disadvantaged position may begin to close the gap in health outcomes that exist between them and the remaining population.

Conclusion

Health is a human right, and it is vital that it be continued to be treated as so. In countries such as Denmark, this is upheld, as all residents, regardless of race, socioeconomic status, citizenship status, or other social determinants, are guaranteed equal, unhindered, and unprejudiced access to healthcare. A partial cause behind this is the welfarist structure established as part of the Nordic healthcare model, which ensures that adequate healthcare reaches all residents of the country. However, it must be recognized that the reason for the lack of healthcare disparities bears a strong connection to the lack of diversity and low poverty rates in the country. In both Canada and the United States, the disparities brought about by racial divides and high poverty rates are compounded by the private market structure of the respective countries. Health must be guaranteed

to all regardless of their status in society or their income. Health must be guaranteed to all regardless of their race or ethnic background. Healthcare must be treated as a preliminary measure undertaken for all people, rather than a treatment method after the fact[5]. The system in many developed countries follows an approach that ameliorates the consequences of ill health, rather than establishing preventative policies and mechanisms to ensure that such consequences never take place[6]. These countries are intended to be the leaders of change in the world, but unless that change takes place internally, it is redundant for them to be bringing it about elsewhere. Health must be provided to all people regardless of their differences, and it must begin with the leaders of the new world.

[5] Idea obtained from interview with academic scholar in field of health equity
[6] Idea obtained from interview with academic scholar in field of health equity

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