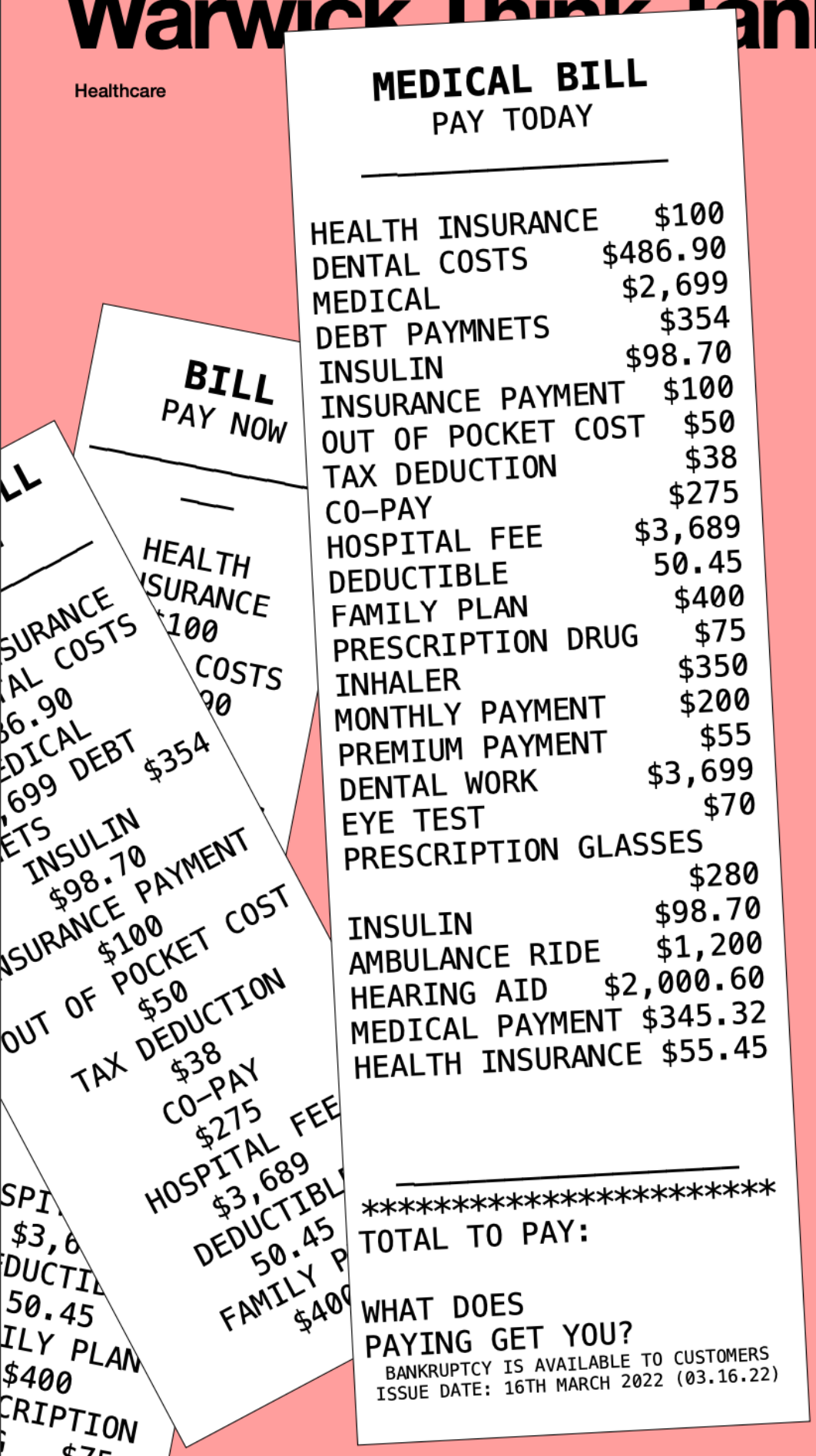
Warwick Think Tank Report

Healthcare

March 16, 2022



A COMPARATIVE ANALYSIS OF PATIENT-PHYSICIAN POWER DYNAMICS IN A PUBLIC V/S PRIVATE HEALTHCARE SYSTEM IN NORTH AMERICA

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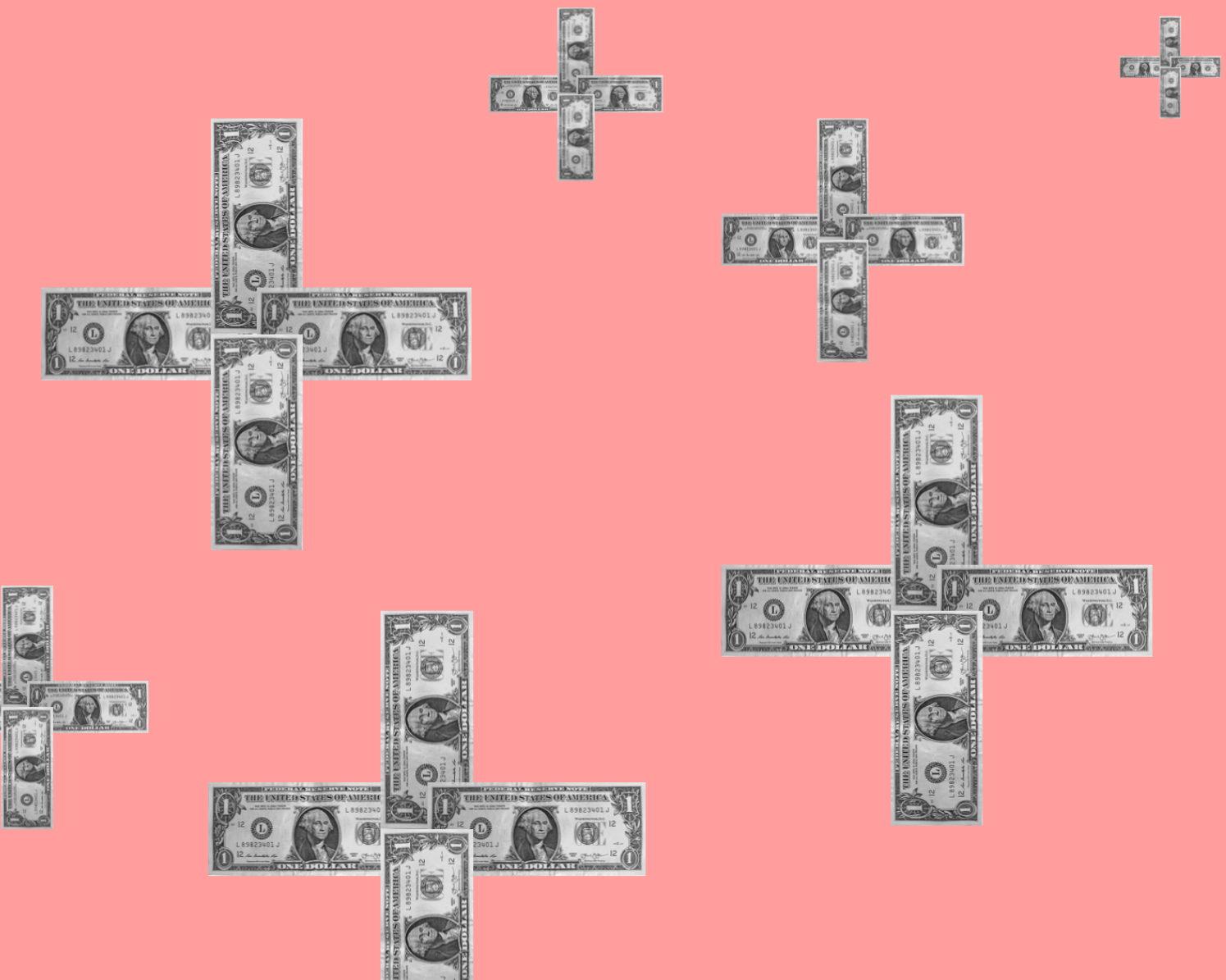
Briefing

Overview

The Physician-Patient dynamic is typically overlooked and not paid attention to, even though it affects the care individuals are provided. North America has a variety of systems, private in America and public in Canada. Therefore, there is some variation in the way that the system works, however, the outcome seems to be similar. Both of them leave the individual feeling less powerful and continue to uphold the hierarchy in care. Through the briefing, we will begin by giving an overview of both of the systems and the way that they work, and the way that they impact the patients as a whole. We will then delve into the role of international institutions to have a look at the way that they affect the role in protecting patients, moving from a focus on North America and looking at the wider image of the world and its role in the way that patients do/ do not get aid.

INEQUALITIES BETWEEN
THE INSURED AND UNINSURED,
THE PANDEMIC,
PROVISION BASED ON CLASS,
AND EXPERIENCES OF
PEOPLE OF COLOUR



USA and its Private Healthcare System

There exist overall inequalities between the insured and uninsured under the US private healthcare system

- In 2019, approximately 30 million individuals were uninsured (9.2% of the population)- whilst it doesn't seem significant due to the nearing 10% of the population, there is a massive disparity in who is able to access healthcare and who isn't through implicit biases
- Majority of money spent on healthcare tends to be focused on hospital care, physicians and professional services, reducing the amount of focus on the actual patients and the time spent with them. A lot of the issues that we see is with the way that there is a push on 'efficiency' than actual focus on the patient care and listening to their struggles to better help them
- In addition, the different bands and companies that cover insurances change which then also continue to perpetuate these disadvantages due to the way that they continue to provide different services without having an upper limit on the charges in cost for the different types of benefits. Therefore, for many, there is a inner battles between the healthcare and wellbeing and the overall living standards.

The pandemic has revealed inequalities between the insured and uninsured under the US private healthcare system

- The high volume of COVID-19 cases in the US coupled with shortages in medical equipment and supplies, demonstrated the chilling consequences of neglecting public health and preparedness in fighting against pandemics such as COVID-19 and the disconnect between public health and healthcare delivery. This then meant that the distribution of resources continued to be unequally distributed.[1]
- The sudden surge in unemployment has caused many Americans to lose employer-sponsored insurance, again adding to the struggles that individuals in more disadvantaged backgrounds felt.[2] This continually caused more issues as loss of income and insurance meant that more individuals were worse off than ever before, especially when healthcare was much more needed.
- Research showed that even when inequities were exposed early in the pandemic, the government continued to reward hospitals that cater to the most

[1] Shadmi et al, 2020. Health equity and COVID-19: global perspective. Health equity and COVID-19: global perspectives | International Journal for Equity in Health | Full Text (biomedcentral.com)
[2] Covid-19 — Implications for the Health Care System | NEJM

privileged in the US, leaving hospitals that predominantly served low-income people of colour with less. [3]

The provision of insurance tends to be dependant on the social classes that individuals belong to which impact the quality of care that they are provided with

- Individuals coverage of insurance is also very divided. Within the 11.4 percent being uninsured in the US, only 7.5 percent are White Americans, leaving the rest of the 92.5 percent being ethnic minorities uninsured- overall showing the divide between those that are able to access care and those that do not have the same provisions [4]
- People of colour face disparities in access to health care, the quality of care received, and health outcomes.[5] Implicit attitudes are thoughts and feelings that are often institutionally there due to the outdated teaching resources, as Mukwende explains [6]
- Despite all of the advancements in healthcare in the past century, disparities based on race and ethnicity persist in access to health care, quality of care received, disease incidence and prevalence, life expectancy, and mortality
- White counterparts or providers may spend more time with White patients than with patients of colour

Experiences that people of colour face, impact the care that they are provided with and lead to longer term effects like iatrophobia

- There has been a decline in trust over the last 40 years in the healthcare system due to the growth of managed care and for-profit healthcare, disclosures of prior unethical medical research, growing public access to medical information, publicity surrounding medical errors, malpractice and fraud and abuse within the medical system. [7]
- The U.S. medical establishment has a long legacy of discriminating and exploiting black Americans, the indelible memory of which remains deeply embedded in the collective consciousness of the community.

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[3] Grogan et al, 2021. Unsanitized and Unfair: How COVID-19 Bailout Funds Refuel Inequity in the US Health Care System. Unsanitized and Unfair: How COVID-19 Bailout Funds Refuel Inequity in the US Health Care System | Journal of Health Politics, Policy and Law | Duke University Press (dukeupress.edu)

[4] Jenny Yang, Statista. 2021. Percentage of uninsured Americans by ethnicity. • Percentage of uninsured Americans by ethnicity | Statista

[5] Hall et al, NCBI. 2015. Implicit Racial/ Ethnic Bias Among Health Care Professionals and its influence on Health Care Outcomes. Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review (nih.gov)

[6] Mukwende, Mind the Gap, 2021. Available at: Mind the Gap — Black & brown skin (blackandbrownskin.co.uk)

[7] Armstrong et al, NCBI. 2007. Racial/Ethnic differences in Physician Distrust in the United States. Racial/Ethnic Differences in Physician Distrust in the United States (nih.gov)

- Historically, medicine has used black bodies, without consent, for its own advancement; while, medical theories, technologies, and institutions were used to reinforce systems of oppression.[8]
- This has continually grown on the issues of iatrophobia, which is becoming a known problem that ethnic minorities are facing due to more awareness and more attention being brought to the topic.[9] Overall, it has led to more mistrust in these areas.[10]
- Even in the modern day, there is a massive divide in the treatment of the different ethnic groups. Blacks are less likely to be prescribed modern, better tolerated medicine but given more older medications which have greater side effects.[11]
- After long wait times, when minority patients are finally able to even see a physician, several studies have shown that physicians spend less time with blacks patients when compared to whites, and are less likely to perceive the patient as being honest regarding their symptoms [12]

Lower socio-economic status tend to have worse experiences when it comes to the health care they are provided with in the US

- Lower socioeconomic status (defined as lower income, lower education, and no health insurance) was associated with higher levels of distrust, with men generally reporting more distrust than women.[13]
- People of colour that come from low and middle SES groups are viewed more negatively by physicians compared to whites and upper SES groups [14]
- This shows that many of the intersectional groups are more affected by healthcare systems, exacerbating the issues that we already know but also forming more anxieties around health for these marginalised groups.

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[8] J. Corey Williams, the hill. 2017. Black Americans don't trust our healthcare system. Black Americans don't trust our healthcare system — here's why | TheHill

[9] Ibid.

[10] Armstrong et al, NCBI. 2007. Racial/Ethnic Differences in Physician Distrust in the United States. Racial/Ethnic Differences in Physician Distrust in the United States (nih.gov)

[11] Copeland et al, NCBI. 2003. Racial disparity in the use of atypical antipsychotic medications among veterans. Racial disparity in the use of atypical antipsychotic medications among veterans - PubMed (nih.gov)

[12] Eack et al, NCBI. 2012. Interviewer-percieved honestly mediates racial disparities in the diagnosis of schizophrenia. Interviewer-Perceived Honesty Mediates Racial Disparities in the Diagnosis of Schizophrenia (nih.gov)

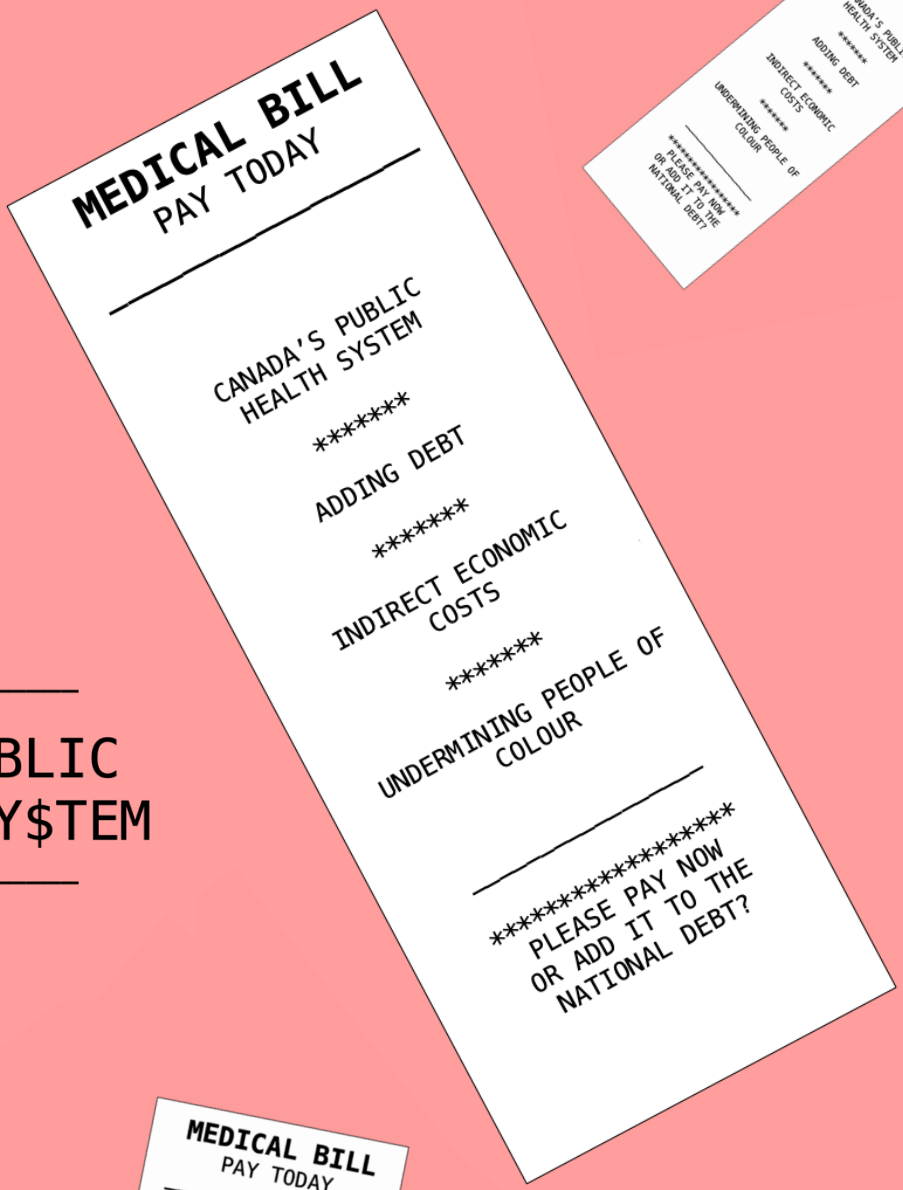
[13] Armstrong et al, NCBI. 2007. Racial/Ethnic Differences in Physician Distrust in the United States. Racial/Ethnic Differences in Physician Distrust in the United States (nih.gov)

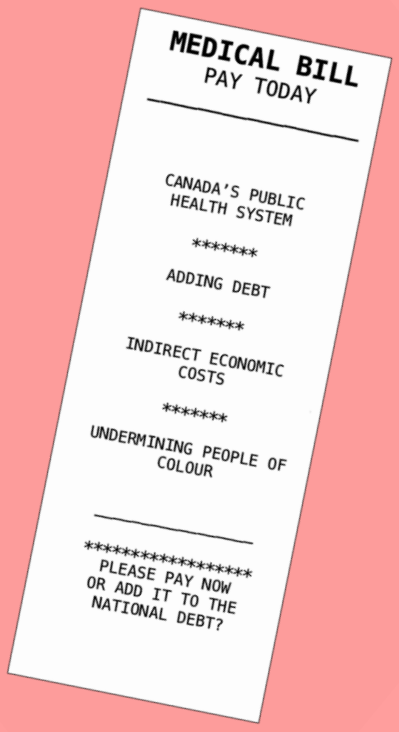
[14] Michelle Van Ryn, Jane Burke, Science Direct. 2000. The effect of patient race and socio-economic status on physicians' perceptions of patients. The effect of patient race and socio-economic status on physicians' perceptions of patients - ScienceDirect

- Research also suggests that there is a lot of assumptions that physicians make from the way that individuals present themselves and the race they belong to that they associate with the patient's intelligence.[15]
- This is quite harmful due to the way that it can further promote stereotyping and the images we have of individuals rather than trying to eliminate this type of behaviour.

[15] Ibid.

CANADA'$ PUBLIC HEALTHCARE YTEM





Canada and it's Public Healthcare System

Whilst healthcare is free in Canada, it still breeds inequalities in its providing of healthcare

- Whilst the healthcare system is free and the government spends a lot of money on healthcare, there is a lag in the results as there is no true reflection of this[16].
- Poor health and the conditions that cause it also creates huge direct costs for the healthcare system and indirect costs to the economy in general.[17]
- This continues to add to the debt that Canada has as a country, continuing to build on the pressures that they have.[18] Therefore, the continual conflict on bettering the economy or reducing inequalities and bettering the system is something that continues to be an issue that they have to battle.
- The most important consequence of health disparities is avoidable death, disease, disability, distress, and discomfort; but it is clear that disparities are also costly for the health system and Canadian society as a whole.
- Without a concerted effort to reduce disparities, the health and cost burden of disparities will likely accumulate and grow.[19]

Covid-19 has only exacerbated pre-existing inequalities within the healthcare system

- Research suggests that the poorest populations are more likely to have chronic conditions, putting them at higher risk of COVID-19 associated mortality. This then continues to add more pressure in disadvantaged districts due to the need for more healthcare provisions needed to help them.[20]
- Whilst there are beliefs that the pandemic is affecting everyone, there are more complexities that continue to affect individuals. Gender, class, and race are all intertwined, exacerbating the inequalities that they face generally.[21]

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[16] Livio Di Matteo, FON. 2021. Canada is a big spender on health care but we lag behind countries. Canada is a big spender on health care but we lag behind countries in results FON Commentaries. Vol. 2, No. 15 – Finances of the Nation

[17] Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004. Reducing Health Disparities- Roles of the Health Disparities. Reducing Health Disparities - Roles of the Health Sector : Discussion Paper (phac-aspc.gc.ca)

[18] Pinnacle Digest. 2021. One of the most indebted countries in the world: Canada. One of the Most Indebted Countries in the World: Canada (pinnacledigest.com)

[19] Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004. Reducing Health Disparities- Roles of the Health Disparities. Reducing Health Disparities - Roles of the Health Sector : Discussion Paper (phac-aspc.gc.ca)

[20] Ahmed et al, Lancet Public Health. 2020. Why inequality could spread COVID-19. Why inequality could spread COVID-19 - The Lancet Public Health

[21] Bryant et al, OJS. 2020. Unequal impact of COVID-19: Emergency Neoliberalism and Welfare Policy in Canada. Unequal Impact of COVID-19: Emergency Neoliberalism and Welfare Policy in Canada | Critical Studies: An International and Interdisciplinary Journal (scholarsportal.info)

- The inequities have impacted who has access to urban infrastructure which promotes health and quality of life. This is quite important in the fact that it continues to complicate who and where individuals have access to resources

The healthcare system in Canada continues to undermine people of colour

- Research completed by Mahabir et al. shows that there is a continual daily experience in discrimination and/ or a more precautious view before individuals access healthcare support
- The results they found were that patients felt disrespected or mistreated when receiving healthcare. Many times this was due to patients being viewed as 'inferior' when speaking to the physicians.
- Racialised healthcare users reported that 'race'/ethnic-based discrimination or everyday racism is a large contribution to the challenges experienced when receiving health care.
- Perceived racism in the health care setting is strongly related to worse mental health for racialized groups.[22] In many cases, we have seen a growth in individuals with iatrophobia due to this.[23]
- In Canada, structural racism manifests in ways that include severe gaps in health-care access among racialised migrants; these gaps are more closely linked to factors such as limited health insurance eligibility, concerns about negative immigration consequences (eg, medical repatriation, a requirement to present proof of status at the point of care), and scarce culturally and linguistically appropriate care.[24]

[22] Ben et al, PLOS one. 2017. Racism and health service utilisation. Racism and health service utilisation: A systematic review and meta-analysis (plos.org)
[23] Lisa Fritscher, 2020. Understanding Iatrophobia or Fear of Doctors. Understanding Iatrophobia or Fear of Doctors (verywellmind.com)
[24] Germaine Tuyisenge, Shira M. Goldenberg. The Lancet, 2021. COVID-19, structural racism and migrant health in Canada. COVID-19, structural racism, and migrant health in Canada - The Lancet

The Role of International Institutions and Organisations in Protecting Patients

As the preeminent institution for global health since 1948, the WHO sets the framework for public health policy globally

- The WHO advocates for universal health coverage for a billion more people as well as the promotion of health and wellbeing, coordination responses to health emergencies and monitoring public health risks. [25]
- Additionally, as the leading authority in global health, the WHO sets frameworks for public health that are consequently implemented across domestic health systems. For example, the highly successful Framework Convention on Tobacco Control (adopted in 2003) and the 2005 revision of the International Health Regulations (IHR) have been globally integrated into national healthcare systems.
- However, the Declaration of Alma-Ata on primary health care pledged in 1978 to ensure the goal of Health for All, suggesting that countries defund military endeavours to tackle the gross inequality in health status of people.[26] There was the aim to achieve this by 2000. However, we have seen these issues exacerbated, especially in the case of the US's private healthcare system. [27]

The issue of sovereignty is raised when the WHO intervenes in the healthcare policy

- The perceived failure of the WHO to manage the COVID-19 pandemic has raised issues of sovereignty and national health agencies.[28] In July 2020, the United States government, led by Donald Trump, notified the World Health Organisation of its withdrawal due to Trump's suspicions of the WHO withholding information and of being too close to China. [29]

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[25] The World Health Organisation. 2019. Thirteenth General programme of work 2019-2023, 2019 https://www.who.int/about/what-we-do

[26] The World Health Organisation. 1978. Declaration of Alma-Ata https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata

[27] Dickman SL, Himmelstein DU, Woolhandler S. 2017. Inequality and the health-care system in the USA. Lancet. Apr 8;389(10077):1431-1441.

[28] The Independent Panel. 2021. COVID_19: Make it the Last Pandemic https://theindependentpanel.org/wp-content/uploads/2021/05/COVID-19-Make-it-the-Last-Pandemic_final.pdf

[29] The Guardian. 2020. US officially notifies World Health Organisation of its withdrawal US officially notifies World Health Organization of its withdrawal

- Despite Biden overturning the decision to leave, these tensions have persisted across a change of administration as Biden's administration opposes the reforms to strengthen the WHO. [30]
- As the largest contributor to the WHO, giving 20% of the programme budget [31], the US's funding makes them highly influential in the organisation and enables them to set the global health agenda. This is demonstrated by the organisation following the priorities by the US closely, placing a high importance on tackling specific diseases, rather than the holistic approach preferred by the WHO scientists.

There is a broader issue of corporate interests interfering with the level of care patients receive and can access, due to their increasing dominance over global health governance

- In 2017, the Bill and Melinda Gates Foundation (BMGF) contributed over 10% of the World Health Organisation's (WHO) $3.15 billion annual budget, making them the organisation's 2nd largest contributors, after the United States [32].
- The WHO contributions from member states through 'assessed' and 'voluntary' contributions has decreased over years, with assessed contributions from nations making up less than 20% of the total budget [33].
- At $3 billion, the Foundation's annual spending budget for global health and global development in 2017 was nearly as large as the WHO's entire budget. [34] This highlights the increasing dominance of the Bill and Melinda Gates Foundation over global health as it eclipses the influence of formal institutions such as the WHO.
- The BMGF is also involved in many of the other "H8" groups for global health decision-making, such as The Global Fund and GAVI, the Vaccine Alliance as well as the general medical journal, the Lancet.
- This reflects into the policy agenda as the BMGF and other large donors' focus is infectious diseases and this has translated into 20% of the WHO's budget in 2016-17 going into tackling polio [35].
- In the particular case of COVID-19, the Gates Foundation has led the response through pledging up to $100 million for the global response, directing the funds

[30] New York Post. 2022. Biden vowed to reform WHO from within — instead, it's taking advantage of America Biden vowed to reform WHO from within — instead, it's taking advantage of America
[31] KFF. 2021. The U.S Government and the World Health Organization The US Government and the World Health Organization | KFF
[32] Gates Foundation. 2020. Foundation Fact Sheet https://www.gatesfoundation.org/Who-We-Are/General-Information/Foundation-Factsheet
[33] World Health Organisation. How the WHO is funded https://www.who.int/about/funding/
[34] Gates Foundation. 2020. Foundation Fact Sheet https://www.gatesfoundation.org/Who-We-Are/General-Information/Foundation-Factsheet
[35] Wilson, J. 2021. Philanthrocapitalism and Global Health. In S. Benatar & G. Brock (Eds.), Global Health: Ethical Challenges (pp. 416-428). Cambridge: Cambridge University Press.

through the WHO and the United States Center for Disease Control and Prevention, with $60 million allocated for the acceleration of a vaccine and $20 million directed towards helping 'at-risk populations in Africa and South Asia' [36].

- In addition to funding the WHO, The BMGF funds the Institute for Health Metrics and Evaluation, the pre-eminent organisation for global health statistics used by the WHO [37].

Supported by influential corporate interests, the implementation of the TRIPS agreement by the World Trade Organisation has led to unequal access to medicines, reflecting a larger issue in the US private healthcare system

- By implementing the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in 1995 and binding its members to it, the World Trade Organisation has affected the level of care patients can receive and access globally.
- The TRIPS agreement requires all WTO members to adapt their laws to the standardised patent laws that enable Pharmaceutical companies to implement patents on life-saving medicines. This allows them to charge high exclusive prices to medicines, making them inaccessible to poorer developing countries
- As a result, one-third of the world population lacks access to the most basic essential drugs and this figure rises to one half in the poorest parts of Africa and Asia [38].
- In the context of North America, the pharmaceutical industry profits off patients through high markups that are unaffordable, particularly in the US' private healthcare system. Even in Canada's publicly-funded healthcare system, more than CAN$6.5 billion in household funds was spent on pharmaceuticals alone in 2014 [39].

As a consequence of TRIPS, pharmaceuticals has become a highly lucrative industry, profiting off patients through high markups

- The pharmaceutical industry exaggerates its expenditures on research and development (R&D)[40], as incentivized by the patent system of TRIPS.

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[36] Gates Foundation. 2020. Bill & Melinda Gates Foundation Dedicates Additional Funding to the Novel Coronavirus Response Bill and Melinda Gates Foundation Dedicates Additional Funding to the Novel Coronavirus Response

[37] Mahajan. 2019. The IHME in the Shifting Landscape of Global Health Metrics The IHME in the Shifting Landscape of Global Health Metrics

[38] t Hoen. 2002.TRIPS, Pharmaceutical Patents and Access to Essential Medicines: Seattle, Doha and Beyond https://www.who.int/intellectualproperty/topics/ip/tHoen.pdf

[39] Martin, Danielle, et al. 2018. "Canada's universal health-care system: achieving its potential." *The Lancet* 391.10131: 1718-1735. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138369/

[40] Love. 2005. Pharmaceutical Research and Development and the Patent System https://journals.sagepub.com/doi/pdf/10.2190/PXBW-TRDR-XAC0-2THW

- For example, the company Novartis spent under $100 million developing their cancer drug Gleevec yet in comparison, this only amounts to 13 days worth of profits from worldwide Gleevec sales [41].
- In another study they found that nine out of ten “Big Pharma” companies spent more on marketing their prescription drugs than on researching them. In particular, Johnson & Johnson spent $17.5 billion on sales and marketing in 2013, compared to $8.2 billion on R&D [42].
- These ‘profiteering’ strategies have led to the Pharmaceuticals industry having the highest, on average, profit margins than any other industry, surpassing oil and gas as well as Banks [43].
- This unregulated market of pharmaceuticals in the United States has led to Americans spending $858 per person on prescription drugs, which is 2 and a half times as much as Canadian prices [44] [45].
- Medicines are also seen to be rising in price with the average list price of insulin nearly tripling between 2002 and 2013, having disastrous consequences for the millions living with diabetes. [46]
- The incentives created by the huge profits of the Pharmaceutical industry, in which Pfizer has a 42% profit margin[47], has led to a disparity in the priorities of medicine innovation, favouring that of developed countries and their needs.

Health insurance is another demonstration of corporate interests dominating over patient care

- Health insurance is another lucrative business within the healthcare industry, completing the many elements of the current ‘medical-industrial complex’. This

[41] The Wire. 2016. The Gates Foundation and the Anatomy of Philanthrocapitalism https://thewire.in/business/the-gates-foundation-and-the-anatomy-of-philanthrocapitalism
[42] The Washington Post. 2015. Big pharmaceutical companies are spending far more on marketing than research https://www.washingtonpost.com/news/wonk/wp/2015/02/11/big-pharmaceutical-companies-are-spending-far-more-on-marketing-than-research/?noredirect=on
[43] BBC News. 2014. Pharmaceutical industry gets high on fat profits Pharmaceutical industry gets high on fat profits - BBC News
[44] Vox. 2018.The true story of America’s sky-high prescription drug prices The true story of America's sky-high prescription drug prices
[45] Government of Canada. 2017. Protecting Canadians from Excessive Drug Prices: Consulting on Proposed Amendments to the Patented Medicines Regulations https://www.canada.ca/en/health-canada/programs/consultation-regulations-patented-medicine/document.html#a6
[46] Hua et. Al. 2016. Expenditures and prices of antihyperglycemic medications in the United States: 2002-2013. *JAMA* 315:1400–1402
[47] BBC News. 2014. Pharmaceutical industry gets high on fat profits Pharmaceutical industry gets high on fat profits - BBC News

is demonstrated by the United States spending around 20 percent of its gross domestic product on healthcare [48].

- Even in the midst of a pandemic, The UnitedHealth Group, America's largest health insurer, was able to make a profit of $6.7 billion dollars in the second quarter of 2020. This is aligned with many other companies who were able to double their profits, such as Anthem and Humana [49].
- On average, Americans spend about $5,000 a year on out-of-pocket health care costs, which includes insurance, prescriptions and medical supplies.[50] As a consequence, medical debt has become rife throughout the population, becoming the 'no.1 source of debt collections' in the United States [51].
- Four in ten adults with employer coverage say that in the past year they had problems paying medical bills or difficulty affording their premium, deductible, co-pays, or an unexpected medical bill for themselves or a family member [52].
- Medical debt is the largest source of debt and bankruptcies in the U.S despite three-quarters of people having health insurance when they fall ill. This results in patients going without their life-saving medicines with half of adults (with employer health coverage) reported that they or someone in their household have skipped medical care or prescription drugs due to the cost [53].

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[48] Stanford Medicine. 2017. Insurance policy: How an industry shifted from protecting patients to seeking profit https://stanmed.stanford.edu/2017spring/how-health-insurance-changed-from-protecting-patients-to-seeking-profit.html

[49] Wion. 2020. How insurance companies are profiting off the coronavirus pandemic https://www.wionews.com/world/how-insurance-companies-are-profiting-off-the-coronavirus-pandemic-336715

[50] CNBC. 2020. 32% of American workers have medical debt—and over half have defaulted on it 'https://www.cnbc.com/2020/02/13/one-third-of-american-workers-have-medical-debt-and-most-default.html

[51] Stanford Institute for Economic Policy Research (SIEPR). 2021. America's medical debt is much worse than we think https://siepr.stanford.edu/news/americas-medical-debt-much-worse-we-think

[52] Vanity Fair. 2009. THE SICK BUSINESS OF HEALTH-CARE PROFITEERING https://www.vanityfair.com/news/2009/09/health-care200909

[53] KFF. 2019. Kaiser Family Foundation / LA Times Survey Of Adults With Employer-Sponsored Health Insurance https://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance

Insight

Overview

This section of the report will focus on trying to understand the way that the different parts of the healthcare system work and the way that the dynamics between healthcare systems and the patient works. The three points we want to focus on are the differences in private and public healthcare and the way that they both continue to perpetuate these inequalities and the way that they need to try and reduce the inequalities. In addition to that, we highlight the issue with the way that there is a massive gap between the individuals and the health care systems and the hierarchy between the systems and the individuals. Finally, we want to focus on the emergence and rising importance of philanthrocapitalism through the example of the Bill and Melinda Gates Foundation and its correlation with the respective healthcare system.

Inequalities Continue to Exacerbate Irrespective of the Type of Healthcare System

Within North America, there is a complete difference in the two systems of Canada, and The USA. Whilst this division continues to proliferate, there is a massive disparity in the care provided to the citizens within these systems. These include social class, gender, race, and ethnicity. With this, there is a massive argument that comes to play - how does the system continue to build on these relations between the system and the individuals, and how does it impact patients for that matter?

The healthcare system in Canada, arguably, is fairer as they are provided with a similar process no matter the position of the individual socially which means, theoretically, everyone has a fair chance of getting needed care due to their free healthcare system. This, therefore, should mean that everyone has a fair and equal chance of being provided with care. However, practically, it is near to impossible to have such a meritocratic system as many external factors implicitly add more layers to the issues- intersectionality and the way that it disproportionally affects individuals. However, ideas that are typically theoretical, do not always turn out the way we want them to. This is due to the systemic issues that come to play here. Factors such as socio-economic issues like class, gender and race continue to build a gap between the system of care available and the individuals.

The private healthcare system, however, is no better. In the US, many places do not provide you with care unless you have insurance. With that taken into consideration, 28 million individuals don't have healthcare insurance (8.6% of the population)[54] meaning that they wouldn't be given proper care. This could also mean that they are in a position of poverty and cannot afford the full cost themselves or with insurance, which leads to nearly 26 0000 deaths each year due to the lack of health care insurance[55]. In addition to the issue with health insurance coverage, the issues mentioned above in Canada are also included here too. With the issue of systemic racism, gender differences in the treatment of patients is also an issue. There are so many other socio-economic issues that rise too as well as insurance. However, it is arguable that health insurance is one of the largest issues that need to be tackled due to the severity of the issues it brings.

The main question that we want to ask is, how can we help the two thrive whilst they continue to reproduce inequalities through the different systems here? Whether it is

[54] Census.gov. 2021. Health Insurance coverage in the United States: 2020. https://www.census.gov/library/publications/2021/demo/p60-274.html#:~:text=In%202020%2C%208.6%20percent%20of,part%20of%202020%20was%2091.4.
[55] Janice Hopkins Tanne, NCBI. 2008. More than 26 000 Americans die each year because of lack of health insurance (nih.gov)

public or private healthcare, it is very similar in its way of working, except that the private healthcare system has many more barriers for patients to access necessities - like healthcare.

And this is similar around the globe too. Just over 70 countries have universal healthcare systems[56] out of the 195 countries in the world. There are 10 countries, including the United States, where there is no universal healthcare[57], many of which are still developing countries. It seems as though there is no one system, therefore, it becomes harder to see the faults in individual countries as the majority of them have major economic issues.

[56] Wikipedia.org, 2021. https://en.wikipedia.org/wiki/List_of_countries_with_universal_health_care
[57] 10 Countries Without Universal Healthcare - WorldAtlas

The lack of patient autonomy is undermined due to a lack of care for patients as a consequence of physician misunderstandings

Patient autonomy is the right of patients to make decisions about their medical care without their health care provider trying to influence the decision[58]. However, whilst this is the universal truth that is taught at many medical schools, there is somewhat of an unspoken truth, in which the medical professionals tend to undermine patients and use their power to go above the patients. Many social groups, like ethnic minorities and gender, tend to be affected by this.

Ethnic minorities have experiences of iatrophobia in which going to seek medical advice or support seems to be daunting due to the traumatic experience that they have received before. The case study that is perhaps somewhat recent is the one from the pandemic. In the first wave of the pandemic, we learned about the death of 36-year-old Kayla Williams who died of suspected COVID-19 [59] the day after, being told by ambulance staff that visited her home to administer self-care and that she did not need to go to the hospital. The undermining of patients doesn't stop there. This undermining of patients has led to fears that have deep impacts on these individuals' lives as much of the blame is placed on the patients for either being too cautious or not enough. There is always the upper hand for the institutions that run the healthcare system. It was massively seen in the UK and the USA, perhaps due to the massive coverage on the news on the disparities in care for both patients and caregivers by the institutions (like the NHS in the UK).

Similarly, the undermining of female patients is something that is clear to see within any healthcare system. Examples that have been on the news in the last few months have been of women not being heard clearly by first line carers and further too. The tragic death of the 27 year old woman is just one example of the way that many doctors tend to blame women for being 'too hormonal'[60] or being psychological, typically known as the pain bias.[61]

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[58] Carolyn A. Bernstein, Harvard. 2018. https://www.health.harvard.edu/blog/take-control-of-your-health-care-exert-your-patient-autonomy-2018050713784#:~:text=Patient%20autonomy%3A%20The%20right%20of,trying%20to%20influence%20the%20decision.&text=They%20would%20plan%20the%20care,would%20either%20comply%20or%20not.

[59] Leah Cowan, Charlie Brinkhurst Cuff. Gal-dem, 2020. https://gal-dem.com/this-week-we-demand-prisoners-release-and-hear-more-about-the-covid-19-victim-who-died-after-she-was-deemed-not-priority/

[60] Laurence Sleator. The Times, 2022. Woman died of cervical cancer after gynaecologist said symptoms were 'hormonal' | News | The Times

[61] Jennifer Billock. BBC Future, 2018.Pain bias: The health inequality rarely discussed - BBC Future

With the two other social factors, class is also one of them which is normally a factor which should be taken into consideration when seeing the autonomy of the patient. Within private healthcare, being able to ‘pick and choose’ the care provider is somewhat helpful for the individuals as they are able to get examinations done due to the need to ‘optimise’ and build on ‘efficiency’ through doing as many expensive tests to bill patients with. Therefore, wealth and care correlate as well as gender and race.

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IT COULD BE ARGUED THAT THE DIRECTING OF CAPITALIST PROFITS DOES NOT NECESSARILY PRODUCE A CONFLICT OF INTEREST BUT WE CAN SEE THAT THE INTERESTS DO NOT ALIGN WITH THE PUBLIC’S.

The Philanthrocapitalists Bill and Melinda Gates dominate global health governance and its agenda for patients

Since its launch in 2000, The Bill and Melinda Gates Foundation (BMGF) has increasingly exerted influence over the global healthcare industry and its agenda. This, in turn, affects the priorities and the level of care that patients receive as the interests of investors and trustees often dominate that of patients.
However, it is also argued that this form of influence, stemming from their Philanthrocapitalism, has a 'heroic narrative'[62] surrounding it and therefore must be lauded. The tension between these two narratives is one that must be examined in the outcomes for patients in the global healthcare system and specifically can be analysed through the agenda these capitalists put forward within the context of international institutions such as the WHO.

The BMGF was established when Bill Gates donated $20 million to John Hopkins hospital in the United States and the Foundation has since expanded itself internationally to impoverished countries, especially in its endeavours to expand access to vaccinations. As a private foundation, it is funded by a co-joining trust, The Bill and Melinda Gates Trust, funded by Bill and Melinda Gates and until recently investor billionaire Warren Buffet.[63] The trust forms the second of a two-entity structure which invests in a multitude of corporations to form the endowment, including pharmaceuticals and oil industries. This is a clear conflict of interest that must be examined as the profits of these polluting and exploitative industries are put into shaping global health.

Through the current structure of the foundation, the trustees are able to influence the priorities of the foundation, therefore empowering these individuals, Bill and Melinda Gates as well as previous trustee, Warren Buffet. Despite the recent addition of the new (fellow philanthrocapitalist) trustees in January 2022 [64], this places a large amount of influence and power in the hands of a few wealthy individuals. These individuals often are not qualified in the area of global public health and do not have the incentive to work for the collective global good. There is no need to consider public priorities as

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[62] Wilson, J. 2021. Philanthrocapitalism and Global Health. In S. Benatar & G. Brock (Eds.), Global Health: Ethical Challenges (pp. 416-428). Cambridge: Cambridge University Press https://discovery.ucl.ac.uk/id/eprint/10079534/3/Wilson%20Philanthrocapitalism%20and%20global%20health%20clean%20final%20version.pdf
[63] The New York Times. 2021. Warren Buffett's Exit From the Gates Foundation Clouds Its Future https://www.nytimes.com/2021/06/23/business/warren-buffett-gates-foundation.html
[64] Gates Foundation. 2022. Bill & Melinda Gates Foundation Appoints Board of Trustees https://www.gatesfoundation.org/ideas/media-center/press-releases/2022/01/gates-foundation-appoints-board-of-trustees-to-shape-foundation-governance-increase-impact

there are no public forms of accountability or transparency, despite being subsidised by them by way of tax-deductibility.

The particular investments in pharmaceuticals is especially concerning when considering the significant power that the BMGF wields over global health institutions such as the WHO. As the second largest contributor of the WHO just behind that of the United States, the Foundation contributes over 10% of the WHO's budget. These funds are earmarked and therefore are directed to projects that Bill and Melinda Gates choose. This follows their individual public priorities which currently include tackling infectious diseases and maternal mortality rates. This is demonstrated by 20% of the WHO's 2016-17 budget being allocated towards tackling polio, following from the Foundations' priorities.

It could be argued that the directing of capitalist profits does not necessarily produce a conflict of interest but we can see that the interests do not align with the public's. The Foundation's priorities generally follow shorter term solutions and specific diseases rather than tackling the longer term social determinants the WHO would rather focus on. The WHO's Commission on Social Determinants of Health was set up to 'counter overly biomedical technologist approaches'[65], highlighting the diversion in priorities between the social scientific institutions and their wealthy donors. This corresponds with their close links to the pharmaceutical industry and the pricing they set. This is demonstrated by the $19 billion in revenues made by GlaxoSmithKline and Pfizer on the pneumococcal vaccine, of which they are the only producers.[66] This is a fact of a healthcare system in which it now costs 68 times more to vaccinate a child than a decade ago[67]; a system that these global health leaders refuse to change. [68]

Alongside these clear conflicts of interests, many lament the lack of diversity in budgetary direction as it means that a range of interests are not represented. WHO director-general, Dr Tedros Adhanom Ghebreyesus, argued this for the context of the WHO as 'No organisation can succeed when its budget and priorities are not aligned.' [69]

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[65] Birn. 2014. Philanthrocapitalism, past and present: The Rockefeller Foundation, the Gates Foundation, and the setting (s) of the international/global health agenda. *Hypothesis*, *12*(1), p.e8. Philanthrocapitalism Past and Present: The Rockefeller Foundation, the Gates Foundation and the Setting(s) of the International/Global Health Agenda (researchgate.net)

[66] Global Justice Now. 2016. Gated Development: Is the Gates Foundation always a force for good? Gated Development

[67] Ibid.

[68] Observer. 2021.Bill Gates' Comments On COVID-19 Vaccine Patent Draw Outrage]Bill Gates Opposes Opening COVID-19 Vaccine Patents To Poor Countries | Observer

[69] Wilson, J. 2021. Philanthrocapitalism and Global Health. In S. Benatar & G. Brock (Eds.), Global Health: Ethical Challenges (pp. 416-428). Cambridge: Cambridge University Press https://discovery.ucl.ac.uk/id/eprint/10079534/3/Wilson%20Philanthrocapitalism%20and%20global%20health%20clean%20final%20version.pdf

This corresponds to its contributions to other major organisations such as US$1.6 billion to GAVI, the Vaccine Alliance, in 2020, to deliver vaccines to the world's poorest countries.[70] This highlights a dominance over global health agenda through its involvance in over half of the H8, the 8 largest global health players. By analysing these priorities we can understand how these big business strategies of funding health programmes favour short term strategies of biomedical technologies such as vaccines rather than that of redistributive programmes recommended by WHO and its Commission on Social Determinants of Health. Their approaches are particularly ineffective as they claim that they simply cannot solve these pinpointed targets of child health and infectious diseases within 15 years, with Bill Gates himself aiming for a 30 year turnover. [71]

This long-term timeline is a dangerous prospect, especially in the context of the declining status of the WHO. The 'assessed' contributions for member states have decreased over the years and are close to equalling that of the BMGF. In parallel, public-private partnerships and private funds such as The Global Fund and GAVI are eclipsing the WHO in terms of funds and influence. With an endowment worth $49.9 billion,[72] The Bill and Melinda Gates Foundation has a much stronger influence than the WHO in current times and therefore can exert a greater influence over the level of care patients receive.

The overarching issue with Philanthrocapitalism is characterised by the extreme wealth inequality amassed by the likes of Bill Gates, Jeff Bezos, and Warren Buffet. The priorities of aid given by these individuals are acting in the interests that complement their capitalist pursuits. Additionally, we must also further question how the profits that are channelled into philanthrocapitalism are made by exploiting workers and the environment, the direct causes of poor health in the global poor. This highlights how we should be sceptical of philanthrocapitalism, embodied by the Bill and Melinda Gates Foundation, and its role in fulfilling the interests of patients in the global healthcare system.

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[70] Gates Foundation. 2020. Bill & Melinda Gates Foundation pledges $1.6 billion to Gavi, the Vaccine Alliance, to protect the next generation with lifesaving vaccines Bill and Melinda Gates Foundation pledges $1.6 billion to Gavi the Vaccine Alliance

[71] The Washington Post. 2015. Bill and Melinda Gates: More philanthropy can work against inequality Bill and Melinda Gates: More philanthropy can work against inequality - The Washington Post

[72] Gates Foundation. 2020. Foundation Fact Sheet Foundation Fact Sheet (At A Glance) | Bill & Melinda Gates Foundation

Policy Recommendations

Overview

After looking at the issues mentioned in the insight above, we wanted to find some solutions to the problems we highlighted. whilst we know that the system cannot be completely radicalised, we wanted to make recommendations that were manageable and that weren't going to create total seismic shifts. Some of them are mentioned as follows:

- Action Point 1: the need for a fairer system that can be universally recognised so that we can reduce inequalities as much as we can
- Action Point 2: have research more accessible for the public too for them to have more control over their bodies and the choices that they make
- Action point 3: Implement a shift in the global health agenda from short-term fixes towards long-term redistributive solutions

Action 1: The creation of a 'task force' with a special emphasis on demographic and social inequalities

In the previous report, we discussed pain and racial biases to do with female healthcare.[73] However, in terms of healthcare systems in general and the power dynamics between the patient and the physician, there is still a massive difference in the treatments of the individuals and how individuals are treated. This is through numerous ways of discriminating against individuals, especially through the race, gender, and class. Therefore, one of our main recommendations has been influenced by the recent information released on task forces being made in order to help tackle the inequalities within maternity outcomes.[74]

A diverse panel within task forces and proper research done will help reduce these issues. This will allow there to be an open dialogue between individuals and researchers, covering this field, to be able to get new perspectives into the individual experiences that people of different backgrounds have. This can be race, ethnicity, class, or gender. In addition, the task force will have regular meetings, once every two months with different representatives from different local areas, in order to get an understanding of the socio-geographical issues too and the need for support in terms of that. The frequency of the meetings will allow researchers, patients, and the institutions to keep a track of progress as well as gather feedback in order to further improve the systems. As a first-world country, like the USA, this should be something that is easily taken up as the shift in the spending from systems that do not work at the moment to a more 'taskforce' system will help place better solutions for the patients and the institutions that are involved.

The idea of the task forces would be very beneficial, in our opinion to help get a more understanding from patients and give them autonomy to then help them to get the help that they would like to be provided, of course within the limits of what the systems can workaround. By continuing to have an open dialogue between the patients and the physician, the systems will try to eliminate as many barriers as there are in healthcare and the services provided. Not only that, the task forces give the chance to be able to get more understanding of the needs of the individuals that seek health care help. This helps make sure that money is spent well on healthcare as there is more understanding of the things that work or don't within the systems, helping make decisions on whether they need to continue spending money on such areas that are not beneficial and spend more on areas where there is a direct impact being made on the patients. This is massively important, to a certain journey, as it gives them a more understanding of how to both help keep the spending on healthcare efficient- as there

[73] Patel,D. 2021. An Examination of the Socio-Economic Inequalities Impending Effective Female Cancer Care. Termly reports | Warwick Think Tank
[74] BBC. 2022. NHS to tackle 'unfair' maternity outcomes - BBC News

is more money being spent on areas which need the aid compared to areas where the money is being spilt without having any additional support or anything.

This will also help to reduce the hierarchy within the healthcare system whilst also helping to build on the ideas of equality between the relationships between patients and physicians. We know that many individuals tend to feel scared to go to the doctor. For example, phobias like ‘Iatrophobia’ exist and show that perhaps with the input both doctors and patients place in a safe environment could place greater emphasis on the need to be more caring and more compassionate to each other. The use of the task force will give individuals to slowly break the barrier and be more considerate as well as help build on this relationship that there is an open discussion beginning to emerge for them to be able to understand the care that they can access.

MORE CONTROL THROUGH ACCESSIBLE RESEARCH

Action 2: Make research more accessible to the general public to promote patient autonomy

Another policy recommendation that we recommend is the need to make research and health information more accessible to reduce the gap in health education in individuals and reduce the chances of having 'fake' or 'rumoured' news spreading around. The majority of the time it is due to the number of information coming from group chats and other 'illegitimate' sources that then reduces the number of people getting pushed away from the institutions especially due to the increasing pressure that doctors are facing, leading to patients searching online for answers for their problems. Therefore, with more 'legitimate' sources being produced and being verified by experts, it might make sure that individuals get more evidence-based knowledge, therefore not ending up doing harmful things. It will also try to eliminate the gap between the patient and the physician and create a better relationship between the individuals.

The first way that we can reduce the gap in the education that individuals have on health is by utilising the resources we have already. Through the boom of social media, a lot of information is easily shared and spread to individuals in many different countries, areas and places. Through the utilisation of these platforms, messages and information can be spread easily. This can be done by the use of doctor influencers online. The growth in the viewership of US doctor 'Doctor Mike'[75] is very well respected online and can be seen to be an expert in family medicine. Similarly, the surgeon 'Dr. Karan Raj'[76] who shot in fame through the TikToks that he posts on the platform has helped individuals get a better understanding of many different areas of life. This can be from things such as weird things that surgeons find to the different signs that individuals miss when coming to health.

This approach allows patients, who would typically be scared to approach doctors due to the experiences that they might have had, to see that doctors essentially want to try and help individuals out as much as possible. This is through the doctors online normally making individuals feel comfortable. The Muslim female doctor Dr Nighat Arif, for example, has spread awareness of female health and helped build a more comfortable space for individuals that come from a more intersectional group to try and break away from the stigma that surrounds these issues.[77] With doctors like these, there can be more of open conversations between patients and the physicians making them more likely to access information from more 'legitimate' sources, leading to better and equal healthcare.

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[75]Doctor Mike, Youtube. 2022. Doctor Mike - YouTube
[76]Karan Raj, Mail Plus. 2022. https://www.mailplus.co.uk/authors/dr-karan-raj
[77] Dr Nighat Arif, Instagram. 2022. Dr Nighat Arif (@drnighatarif) • Instagram photos and videos

With these doctors using their online presence and the following they already have, we can utilise this to then create a more national, trusted website, where articles are written by these individuals to show us the latest research that is being conducted and myth bust and try out the different challenges that are becoming ‘crazes’ or ‘trends’ to make sure that different individuals understand that some of these challenges are misguiding and don't put the individuals at risk. This is more practical due to the doctors having much more knowledge on the limit to some of the challenges and the extent to go before it gets too much.

Thus, it will reduce the reliance we have on ‘Dr Google’ and individuals self-diagnosing themselves and give them more relied sites to go on. This will help make the sessions with the GP practices be more efficient and make sure that there are resources that the doctors can recommend to the patients to have a look at. Again, increasing the autonomy that the patient has as they will be able to decide and be more in charge of their bodies and be able to investigate for themselves whether they need medical attention or not in some instances as there is a more universal system that can be used by everyone rather than different forms of information being given to individuals.

Action 3: Implement a shift in the global health agenda from short-term fixes towards long term redistributive solutions

Under the dominance of philanthrocapitalists Bill and Melinda Gates, amongst others, global health has adopted narrow goals that merely reinforces increasing equalities within the health and wealth. These goals of tackling specific diseases and illnesses have proven to be ineffective in preventing widespread health crises, as demonstrated in the case of the COVID-19 pandemic. As a result, we should follow the recommendations of the WHO's Commission on Social Determinants of Health, delivered in 2008, previously ignored due to the dominance of corporate and short-term interests in the organisation's governance.

As outlined in the final report[78], the overarching recommendations are focused towards sustainable redistributive solutions throughout national healthcare systems as well the global system. By implementing an improvement in daily living conditions and tackling inequitable distribution of power, money and resources, we can tackle the root causes of poor health, rather than the superficial symptoms. This would address and improve the overall wellbeing of patients and would act as a suitable preventative measure. This contrasts the 'overly biomedical technologist' approach of global health organisations that is especially preferred by the BMGF, disrupting traditional thought in approaching public health.

The scale of implementation could start with a shift in approach by the Bill and Melinda Gates Foundation, arguably the most influential global health entity. This shift would be dramatic nevertheless as it would require its philanthrocapitalist trustees to reconsider their intentions in global health and their business practices also. The requirement to 'improve daily living conditions' includes that of working conditions, set by their business ventures and those they invest in.

More ambitiously, the equitability of power, money and resources, as suggested by the WHO's Commission, is not easily achieved by a single Foundation, but rather depends on our whole social and economic system. The reformation of capitalism and its wealth inequality is a longstanding issue but is essential to ensuring sustainable solutions in global public health. By changing the 'distribution of power'[79], the dominance of global funds must end but in the case of the BMGF, they can be used to shift distribution in money and resources, merely in shifting their aims.

Whilst the final report did not set out a target year for these changes, many later projects have tried to. Most prominently, the United Nations set up the Sustainable

[78] World Health Organisation. 2008. Commission on Social Determinants of Health, 2005-2008 Commission on Social Determinants of Health
[79] Ibid.

Development Goals (or Global Goals) in 2015, with the aim of 'ending poverty, fighting inequality and climate change by 2030'. This holistic approach is progressing well in the context of health [80], but its shortcomings lie in the inability to unify global health leaders and organisations under all its aims, including influential philanthrocapitalists. Whilst they publicly support the aims of the SDGs, the international institutions of IP frameworks and economic systems they uphold ensure that the current global health inequities stay entrenched.

From this, we can perceive the need for a dramatic shift in the structuring of the global healthcare industry to improve access and care for patients. This, however, can be achieved by incremental steps of improving access by reforming international frameworks such as TRIPS to increase flexibility in healthcare systems as well as increasing funding for sustainable, holistic approaches to healthcare, rather than the sole focus on short-term fixes such as vaccine and pharmaceutical development.

[80] World Health Organisation. 2016. World Health Statistics: Monitoring Health for the SDGs https://www.who.int/gho/publications/world_health_statistics/2016/EN_WHS2016_Chapter6.pdf

Conclusion

Overall, through the introduction of a fairer system, through the implementation of the task forces, there can be a more substantial way to reduce inequalities which can be regularly tackled rather than the huge surge in more mistakes being made or patient experiences being undervalued when trying to make the system better. Similarly, having more accessible research available to a wider community and for all to access, may allow more individuals to have better access to the resources and make more sound decisions when it comes to what sources to trust or rely on. This, therefore, gives the patients more freedom to have a look at the issues they feel they are experiencing and have expert advice on these issues before approaching physicians or even gaining further clarity about their own diagnosed illnesses. In addition, the shift in the global health agenda from short-term fixes to more long-term redistributive solutions seems to be a better solution as there can be a greater effect in the way that individuals are cared for in general, therefore, tackling issues much quicker and reducing the chances of a total system collapse. This will also allow the continual funding from philanthrocapitalists but in a more useful and efficient manner.