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Women's Human Right to Healthcare Senior Project

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Abstract

Healthcare is denied to people around the world and women experience this human rights violation more often than men (Ewerling et al., 2018). This study was designed to investigate whether this is more evident in certain systems of healthcare by conducting a cross-sectional survey of people in the United States, the Dominican Republic, and Canada. These countries were selected because each of them has a unique healthcare system. The responses from the survey were analyzed and coded for common themes and converted to quantitative data. From this data, it was concluded that Canada rated the worst in healthcare overall but the best in equality whereas the Dominican Republic and the United States rated slightly better, although still not well, overall and significantly worse in equality.

Introduction

Is access to regular healthcare and treatment (healthcare) a human right? According to article 25 of the Universal Declaration of Human Rights signed by the United States in 1948, it is, but this question has been continued to be debated for years in the United States as well as other countries around the world (United Nations, 2020). This question is important because women are marginalized in healthcare in both developing and developed nations around the world and therefore deserve better in regards to their human right to healthcare. Investigating the cause of these violations of their human rights is essential in order to create a society in which they are seen as equal. Women are marginalized in a number of different areas of society and this is then reflected in their health and the healthcare they recieve (or do not receive). For example, problems such as inadequate income, poverty, and inadequate education are more prevalent among women than men and these are some of the strongest predictors of health (Moss, 2002). This is not the only problem though, women also have additional health problems associated with pregnancy that men do not have and these needs are not always properly addressed. In the *Moment of lift* by Melinda Gates (2019), she states that a million teenage girls die or are injured in childbirth each year. Therefore, women have a disproportionate number of health problems compared to men, so how is this disparity addressed in different healthcare systems? The focus of this project is to investigate how healthcare systems can systematically promote inequality by violating women's human rights or prevent inequality by promoting those rights. This study will also address whether some healthcare systems foster more human rights violations against women than others. There are four different basic forms of healthcare that exist around the world. The first system is the Beveridge model or the National Health Service where the government controls all healthcare facilities and costs. Next, the Bismarck model is where health

insurance is determined by employers. Then, there is the National Health Insurance model which is universal health care through private facilities and the out-of-pocket model where individuals each pay for their own services and medications out-of-pocket. The study includes survey responses from both patients and providers in three countries with different healthcare systems. One of these countries is the United States which uses primarily employer-insured medical care in conjunction with a variety of other programs for the unemployed, seniors, and military personnel. The Dominican Republic is also included and uses the out-of-pocket model for healthcare and finally Canada which uses universal healthcare. This investigation may result in findings that could function as a basis for further investigation of healthcare as well as a guide for investigation of whether certain healthcare systems need to be reformed.

Methods

Data was collected from participants using a survey to evaluate the care they gave or received in a specific country. Participants included women who have experienced the healthcare system in the designated countries (men were excluded from this part of the study) as well as providers that have provided care in those countries (some men were included in this part of the study). A snowball technique was used to gather participants for the survey that included the following questions.

- How would you describe the type of healthcare you receive/provide?
- What do you like about your healthcare system?
- Where do you think your healthcare system falls short?
- Do you think men and women receive equal care?
- Do you have a personal example of when your healthcare system met your (or your patient's) needs especially well or failed you when you (or your patient) needed it most?

- How long do you (or your patient) typically have to wait to get an appointment with your PCP or another doctor who could help you (or your patient) with a health issue if you don't have a PCP? How long is the wait to see a specialist?
- Are you able to find the types of doctors you (or your patient) need within 30 minutes of where you live? If not, how long do you have to travel to get to the types of doctors you need?
- Which country or countries have you experienced these healthcare services?
- Will you be answering these questions as a patient who has received healthcare in this country or a provider?

Qualtrics was used to conduct the survey so that data was secure and personal information like names and email addresses were not attached to responses. A consent information document was included as the first question of the study and participants gave informed and voluntary consent to complete the survey by answering yes to the question. If the participant answered no branching questions were used to take the participant to the end of the survey. This study was reviewed for approval by the Institutional Review Board at Grand Valley State University. The survey responses were compiled in one location and analyzed for common themes and words throughout the response and among responses from the same countries. Then they were coded and the frequency of these words and themes among countries and health systems were compared. The responses were coded by both members of the research team separately and then compared to ensure reduced bias in both the qualitative and quantitative analysis.

Results

The responses analysis was divided into those that related to personal experiences of the participant and those that related to the participants opinion about the system as a whole. The entire response of participants are included below so that each experience and story can be heard.

Table 1: Personal Experience Based Responses

ID	Likes	Dislikes	Story
US provider	Our medical system seems to get people seen regularly and often **do not have a long wait** such as in other countries. I also like the **various number of doctors** that are available if needed.	I think the US healthcare system falls short in many ways. If a person loses their job they have a **small chance of receiving the same benefits** in the meantime of finding a new job. The rates of healthcare are ridiculous. As well as the benefits of healthcare depending on the company your employer offers.	I have had a personal example where my client (who needed services) **was unable to for a month** due to a parent's loss of a job. My client regressed in performance to the system not letting them continue until the parent found a job, although they applied for temporary health insurance and **were denied**.
US provider	Not much. It is way **too complicated** and always unclear as to coverage and payment scales. It does **discriminate based on economics**. The wealthy have access to a more personalized health care model that is not available to others.	First of all is tort reform. So many of us practice defensive medicine and **drive up costs** with unnecessary tests and procedures to protect us from the threat of litigation. Good tort reform would significantly decrease heath care costs and reduce the threat to clinicians over the fear of frivolous law suits. Other areas **failing in medicine is about access**. I accepted medicaid and medicare patients into my practice for more than 20 year. With reimbursement rates going down and the cost of operating a practice goes up, it became a business decision to stop seeing these patients. For a small private practice, we could no longer generate a profit. Making medicaid and medicare reimbursements for care more in line with commercial insurance would allow so many to have access to health care that is currently restricted.	So many failures due to the above **limited access**.
US provider	We provide healthcare to those in need **regardless of their ability to pay**. We provide high-quality care to all individuals from all walks of life	We continue to navigate barriers of patients in regards to healthcare. We have **overcome transportation barriers**, but continue to face language barriers. It would be helpful to have **more educational materials or handouts in different languages** (e.g. Kinyarwanda, Swahili). Many of our resources are in English/Spanish only.	
US/ Dominican patient	When the company I work for offers a plan where **I don't need to pay** monthly	It's **expensive** even with insurance	
Dominican provider	One of the identifiable strengths of the healthcare system in the Dominican Republic is the fact that there are **well defined rules**. Every entity that is part of the system has a very well defined set of functions,	Even though there are very well defined rules, entities overlap in the process of **putting these rules into practice.** In the last years, the Ministry of Health has become a more passive participant, leaving the process	There are many examples where **patients´ needs are met**, however, in many of these cases these **services come after cases are uploaded in social**

	and there is separation of functions. For example, the Ministry of Public Health is responsible of guaranteeing the quality of healthcare services, by the elaboration of guidelines and protocols, whereas the National Healthcare Service, is responsible of providing said services. In addition, other institutions are responsible of the overall financial functions, ensuring the economic sustainability of the system	of monitoring and evaluation, and guarantee of quality, to other entities.	**media, or money** is donated from NGO´s.
Canadian patient	I think our system is broken and **under funded** at best.	We **do not have enough doctors and nurses in the hospitals.** We are able to see a family doctor fairly easily, but if you require an MRI or cat scan you may have to wait for **a year or more**. If you need to see a specialist, like an orthopedic surgeon, dermatologist, cardiologist you have to wait months if it's considered urgent, and longer if it's not. Because our health care is considered to be free many people take advantage and clog up the system. The health is **free** for use, but 40% of our tax dollars go toward its funding.	I was VERY fortunate last year when i was diagnosed with breast cancer. From the time i found the lump to the time i had surgery was 6 weeks. I had to have multiple tests to determine what the lump was and they were what we (Canadians) would call **timely**. From the time of diagnosis to surgery was 20 days. Which is very quick. 12 years ago when my husband had chronic back issues it took months for a diagnosis. He had a tumor on his right kidney. From the time the tumor was found he had to wait almost **3 months** for surgery.

This table shows the responses that were given through Qualtrics broken down by the country where the person experienced the healthcare system. Specifically, this table looks at the responses related to personal experiences of the participant in the healthcare system. This information was gathered using the questions "What do you like about your healthcare system?" "Where do you think your healthcare system falls short?" and "Do you have a personal example of when your healthcare system met your (or your patient's) needs especially well or failed you when you (or your patient) needed it most?" respectively.

Table 2: Responses on System as a Whole

ID	Equal care	Wait time	Reasonable distance
US provider	**Probably not**	For my PCP it is usually **within 2** weeks until I am seen. For a specialist, it can be anywhere between a **few weeks and several months**, and I have had personal experience with that (gynecologist, gastro doctor, psychologist, etc.)	In Grand Rapids I am able to find the specialist doctors and PCP physicians within **30 minute**s, but this is not the case where I grew up in the East side of Michigan.
US provider	**Probably yes**	appointments in **1-2 weeks** usually.	**yes**
US provider	**Definitely yes**	In OBGYN, we can typically schedule appointments either **same day or next day** for patients. We have dedicated same-day slots on the schedule that we keep open for urgent/acute needs.	**yes**

US/ Dominican patient	**Probably not**	**A week or two.**	**yes**
Dominican provider	**Probably not**	Traditionally, primary care level appointments are easily available in a short period of time (usually **walk ins**). The real situation is the fact that these primary care facilities usually lack the most basic instruments and equipment for the provision of healthcare services, therefore obligating patients to visit second or third level hospitals where the wait can be up to **months**, for specialists.	There is an **adequate distribution of healthcare facilities** throughout the country, however some regions experience **shortage of providers**, as they tend to concentrate around and in bigger cities.
Canadian patient	**Definitely yes**	I can usually get into see my family doctor within **a week or 2**. We have walk in clinics and urgent care clinics if i require immediate attention. If i require a specialist it can take **month**s if it's urgent and longer **(year or more**) if it's not. There is an exception to the specialist wait when you are diagnosed with cancer.	For the most part yes, but you could be sent **2 to 4 hours away** for treatment.

This table includes responses gathered through Qualtrics also broken down by the country where the participant experienced the healthcare system. These responses were related to the participant's opinion about their healthcare system as a whole. This information was gathered through the questions "Do you think men and women receive equal care?" "How long do you (or your patient) typically have to wait to get an appointment with your PCP physician or another doctor who could help you (or your patient) with a health issue if you don't have a PCP? How long is the wait to see a specialist?" And "Are you able to find the types of doctors you (or your patient) need within 30 minutes of where you live? If not, how long do you have to travel to get to the types of doctors you need?" respectively.

Figure 1: Quantitative Analysis of Responses

Country	Access	Equality	Cost	Wait time	Variety	Complexity	Total
US Proportion of positive answers	5/9 .55	2/5 .4	0/1 0	2/6 .33	1/1 1	0/1 0	10/23 .43
Dominican Republic Proportion of Positive answers	3/5 .6	0/2 0	1/4 .25	2/3 .67	0	1/2 .5	7/16 .43
Canada Proportion of Positive answers	0/2 0	1/1 1	1/3 .33	2/6 .33	0	0	4/12 .25

	Less than .4
	Between .4 and .5
	Equal to .5

	Between .5 and .6
	Greater than .6
	No responses given in this area

Each response was coded for common themes between responses and then those references to a specific theme were broken down into positive references to that theme and negative references. Then the positive number of references to a theme (numerator of the fraction in each box) was divided by the total number of references to that theme (denominator of each fraction) to get the proportion of references to that theme that were positive. Then the total number of positive references to any theme were added together and divided by the total number of references to any theme for each country to determine the overall rating of a particular healthcare system.

Upon analysis of the data, it can be determined that Canada was rated the worst overall which in this study could translate to suggest that the most human rights violations to the right to healthcare occur in this healthcare system. However, it should be noted that Canada had the best equality rating out of the countries that were analyzed. This means that although human rights violations may occur, they are experienced by everyone in the country equally and therefore women are not more affected by these rights violations than men. In fact, in the story included by the Canadian participant, the woman actually received care more quickly than her husband and therefore her right to healthcare was more evident than her with husband, not less. Another important conclusion is that the Dominican Republic and the United States had the same overall rating. Also, in terms of equality, both of these countries had more negative responses than positive ones. In this study, this would translate to suggest that while in general the human right to healthcare is violated less frequently, some people (like women) experience this violation more than others. It is interesting that the United States scored similar to the Dominican Republic in terms of equality because one would think that the United States being a more developed country would score far better than a developing country like the Dominican Republic and more like other developed nations like Canada. It should also be noted that the United States and Canada had the same rating in terms of wait time. Wait times for these two countries were also

very similar in the qualitative portion of the study ranging from same day to about a week for primary care and up to several months for a specialist.

Discussion

The conclusion that people are dissatisfied with their healthcare systems around the world is not a new one. Many studies of healthcare systems have also come to this conclusion (Reid, 2010) (Recame-Osborne, 2016). In addition, the conclusion that the United States (Reid, 2010) and developing countries like the Dominican Republic (Bouilly et al., 2020) provide unequal healthcare and that Canada (Loufty et al., 2017) provides healthcare that is more equitable is also supported by other studies on the topic. Finally, in terms of the conclusion about wait times being similar in Canada and the United States, this conclusion was not as well supported by previous studies. In general, the main complaint about Canada's healthcare system is usually lengthy wait times and people generally speak highly of shorter wait times in the United States (Reid, 2010). However, the wait times for these two countries seem to be very similar according to the data collected in this study. This could reflect recent changes in Canada's healthcare system to ensure shorter wait times for its citizens (Reid, 2010).

One of the strengths of this study is the qualitative nature of the data collected which allows the stories of individuals to come to light. There is something about the personal experiences of both women and providers that cannot be captured with numbers alone. In addition, a quantitative analysis was also completed to support the qualitative data and provide data that was less biased. Another strength of the study was that participants from multiple different countries were used with different economic backgrounds and different healthcare systems. However, there are also several limitations to the study. The first limitation is that there is a very small sample size which makes the study less generalizable to the public. Secondly, only women were included as

participants for the patient end of the data which may have skewed the data towards recognizing inequalities that exist and also presents the possibility for confounding variables because the sample cannot be compared to control data using men.

This study was cross-sectional in nature and therefore can only determine association and not causation. Therefore, the results of this study should be taken lightly and used only to confirm conclusions from previous studies such as that people are generally displeased with their healthcare systems and that more inequality exists in countries like the United States and the Dominican Republic. In addition, the conclusion about inequality should promote further investigation of how that inequality might especially be affecting women since the data suggested that women may be receiving unequal care in the United States and the Dominican Republic. Since it would be unrealistic to conduct a randomized blinded trial with people experiencing different healthcare systems, more cohort studies should be completed about women's healthcare in different countries with larger sample populations including both men and women as subjects to confirm or reject the findings of this study.

Conclusion

The data collected from this cross-sectional survey suggested that as a whole Canada may foster the most violations against the right to healthcare, but that those violations are distributed evenly across its population. Also, the United States and the Dominican Republic scored similarly overall and in regard to equality of care which may suggest that these two countries foster more violations of the right to healthcare for women specifically.

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