



# Healthcare Systems and Economic Inequality: A Comparative Analysis of the United States, India, and Sweden

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**Abstract.** The healthcare system plays a crucial role in shaping economic inequality, profoundly affecting the level of access to healthcare services, the financial burden on households, and the overall economic mobility of society. This study selected three countries, the United States, India, and Sweden, to conduct in-depth comparative analysis of their healthcare systems, in order to explore their different impacts on economic disparities. The US healthcare system mainly relies on private insurance and market-oriented operation, while India adopts a public-private hybrid healthcare model, and Sweden implements a universal healthcare insurance system while allowing certain private choice space. By delving into these vastly different healthcare systems in detail, this article aims to reveal how healthcare delivery structures to some extent determine economic disparities among countries. The research results show that the structure of the healthcare system has a significant impact on economic inequality, and the universal healthcare model exhibits greater fairness in accessing services and financial protection.

**Keywords:** Healthcare Systems, Human Capital Theory, Economic Inequality.

## 1 Introduction

Healthcare reflects the health of a country's population and the stability of its economy. The structure of a healthcare system—whether privatized, public, or hybrid—directly influences economic inequality by determining access to medical services, the financial burden on households, and the distribution of social resources. A well-functioning healthcare system can serve as a tool to reduce economic disparities, promote social mobility, and boost long-term economic growth. Conversely, inequitable healthcare access can exacerbate socioeconomic disparities, limit opportunities for disadvantaged groups, and reinforce the cycle of poverty.

This paper aims to examine the impact of different healthcare systems on economic inequality by comparing three countries with distinct healthcare models: the United States, India, and Sweden. By analyzing these diverse systems, this study seeks to understand how healthcare delivery structures shape economic disparities. Ultimately,

this review seeks to provide insights into potential policy improvements that can lead to more equitable healthcare outcomes and, in turn, reduce economic inequality.

## 2 Literature Review

The Endogenous Growth Theory proposed by Paul Romer in 1990 emphasizes the role of human capital, innovation, and knowledge in driving long-term economic growth [1]. This theory provides a framework to explain how increasing health spending can enhance human capital because health is one of the determinants of human capital theory and an important determinant of economic development and people's well-being.

However, when people face high out-of-pocket costs for medical care, or when insurance coverage is inadequate, they may experience financial strain, which can limit their ability to invest in education, housing, or savings. In the context of the U.S., the private healthcare model presents significant barriers to achieving equitable economic outcomes. Many Americans rely on expensive private insurance that often come with high out-of-pocket costs. High healthcare costs and unequal access prevent low-income individuals from investing in their health, reducing their productivity and perpetuating income inequality. Health care spending, both per person and as a share of GDP, continues to be far higher in the United States than in other high-income countries.

In addition, the disparities in healthcare access lead to unequal opportunities for economic advancement. India's rural populations face significant barriers to healthcare access, this divide exacerbates economic inequality by limiting opportunities for rural residents. For instance, the National Family Health Survey reveals that only 21% of rural households have access to a hospital within a 5-kilometer radius, compared to 58% of urban households [2]. This disparity in healthcare access has created an inhumane cycle where poor health limits human capital formation, particularly among low-income and rural populations, thereby perpetuating economic inequality. Poor health directly reduces labor productivity by limiting physical and cognitive abilities. In India, widespread issues such as malnutrition, infectious diseases, and inadequate maternal and child healthcare disproportionately affect low-income populations. For example, India accounts for one-third of the global burden of malnutrition, with stunting affecting 35% of children under five [3]. Malnourished children are more likely to experience cognitive impairments and reduced educational attainment, which limits their future earning potential. As Romer's theory suggests, these health barriers limit the development of human capital and lead to stagnation of economic mobility, especially in the lower income segments of society.

Unlike the U.S. and India, Sweden's universal healthcare system is funded through taxation and provides comprehensive care to all residents. This accessibility directly contributes to higher labor force participation rates and economic productivity. Sweden's labor force participation rate approximately 84% in 2022 due to its effective healthcare system [4]. Sweden's emphasis on universal health care promotes better health outcomes for the population, thereby increasing levels of human capital accu-

mulation. Improved health supports long-term economic growth by reducing absenteeism, improving cognitive abilities, and fostering a healthier workforce. This system fits well with Romer's view that human capital is the core of long-term economic growth.

### **3 Healthcare and Economic Equity**

#### **3.1 Financial Burden of a Privatized System in the U.S.**

The healthcare system in the U.S. is characterized by high out-of-pocket costs, employer-sponsored insurance, and limited government programs such as Medicare and Medicaid. Unlike public systems that redistribute resources through taxation and social insurance, the U.S. model places the financial burden on individuals, widening economic disparities.

While Medicare and Medicaid provide public healthcare assistance, their coverage is restricted by age, income level, and specific eligibility requirements. Medicare is primarily available to individuals 65 and older, and along with those with certain disabilities; Medicaid serves low-income individuals but often excludes those who do not meet strict income criteria. Despite these programs, millions of Americans remain uninsured or underinsured, facing significant financial barriers to medical care. According to the Kaiser Family Foundation, nearly 45% of uninsured adults report delaying medical treatment due to cost, leading to worse health outcomes and greater financial instability [5]. Furthermore, the U.S. healthcare system's reliance on employer-sponsored insurance further deepens disparities. Workers with stable, high-paying jobs are far more likely to receive employer-sponsored health insurance, while those in low-wage, part-time, or gig economy positions often lack affordable options. According to the Economic Policy Institute, only 49% of workers in the bottom 10% of wage earners have employer-sponsored health insurance, compared to 94% of workers in the top 10% [6]. This disparity leaves low-wage workers, part-time employees, and gig economy workers vulnerable to financial shocks from medical expenses. These statistics highlight that low-income groups not only struggle more to obtain insurance but are also more likely to forgo treatment due to cost, reinforcing a vicious cycle of poor health and poverty.

The reliance on private insurance makes medical debt a leading cause of financial distress in the United States. "Unless you're Bill Gates, you're just one serious illness away from bankruptcy", stated David Himmelstein, a professor from the City University of New York's Hunter College. He also found that 66.5% of all bankruptcies in the U.S. were tied to medical issues, with many families facing insurmountable bills even after insurance [7]. This financial burden disproportionately affects low-income households, exacerbating existing income inequalities. While the Affordable Care Act (ACA) has enabled more Americans to gain health insurance, a large portion of our population still struggles to pay for care because insurance does little to alleviate their financial burden. The percentage of Americans filing for bankruptcy, citing medical issues, increased from 65.5% before the ACA to 67.5% in the first three years after

the ACA. Rising health care costs and stagnant incomes have had the opposite effect on the reforms of the ACA [8].

Ultimately, the U.S. healthcare model—characterized by high costs, reliance on private insurance, and limited public support—exacerbates economic inequality by placing the financial burden of healthcare primarily on individuals.

### **3.2 India: a Mixed Healthcare System and the Paradox of Inequality**

India's rapid economic growth is paradoxically undermined by its fragmented healthcare system, which fails to provide equitable access to medical services. While public healthcare is theoretically free or low-cost, chronic underfunding and resource shortages make it unreliable for much of the population. Consequently, private healthcare dominates both urban and rural areas, which exacerbates economic disparities and limits productivity. This divide between an inadequate public sector and an expensive private sector reinforces structural inequality, leaving millions of Indians unable to afford or access quality healthcare.

India's public healthcare sector is severely underfunded, resulting in overcrowded hospitals, limited medical supplies, and a shortage of healthcare professionals. The country spends only 2.1% of its GDP on healthcare, one of the lowest among major economies, compared to 9.7% in the UK and 11.9% in Germany [9]. This underinvestment has resulted in inadequate infrastructure and a shortage of doctors. There is a severe imbalance in the number of doctors between rural and urban areas, with urban areas having almost 6 times more doctors than rural areas. The lack of accessible public healthcare services forces patients to turn to the private sector, which dominates India's healthcare landscape, accounting for approximately 70% of outpatient care and 60% of inpatient care [10]. However, private healthcare remains prohibitively expensive for a large segment of the population. Low per capita health expenditure and insufficient government funding have resulted in one of the highest rates of private out-of-pocket health care spending in the world. Financial coverage of health care costs is far from universal. India lacks a universal health insurance system, leaving millions financially vulnerable when faced with medical emergencies. Low-income and rural populations are disproportionately affected. Out-of-pocket payments make financing difficult, forcing patients to sell assets or borrow money to pay for medical expenses, which account for more than 50% of total medical expenditure. This lack of financial protection leaves 55 million people fall into poverty every year due to huge medical expenses—equivalent to five times the population of Sweden [11]. This heavy financial burden not only exacerbates poverty, it also limits long-term economic mobility and reduces investment in education, entrepreneurship, and labor force participation. The World Bank's September 2023 update on global poverty shows that 24.1% of the world's population lives below the \$3.65 poverty line, with India contributing 40% of that total [12].

Given India's growing population and increasing healthcare demands, urgent government intervention is needed. Ayushman Arogya Mandirs was launched on April 18th, 2018, to provide convenient, affordable, and comprehensive medical and health services to the grassroots [13]. Despite their promise, Ayushman Arogya Mandirs

face significant limitations; many AAMs lack essential diagnostic equipment, limiting their ability to provide effective primary care. Ayushman Arogya Mandirs have the potential to play a transformative role in reducing economic inequality by providing affordable and accessible healthcare. However, their effectiveness remains limited if underfunding, staffing shortages, and awareness gaps are not addressed. By expanding public health funding and implementing large-scale insurance coverage, India can build a more equitable and efficient healthcare system that reduces poverty, increases productivity, and strengthens long-term economic growth.

### **3.3 Comparative Analysis: Universal Healthcare as a Tool for Economic Equity**

Sweden's universal healthcare system, funded through taxes and providing comprehensive coverage for all citizens, offers a sharp distinction to both the U.S. and India. Sweden's universal healthcare system is an example of how public financing can promote economic equity. Funded through progressive taxation, the system ensures that all residents have access to healthcare, regardless of income or employment status. According to the statistics, public funding accounts for 84% of the total health expenditure in Sweden. This public funding model ensures equitable access to healthcare, with the government's ability to invest in long-term care and preventive measures sustained by high taxes. Among older adults with three or more chronic conditions or difficulty performing activities of daily living, one-third of Americans skip medical care because of cost, compared with just 2% in Sweden [14].

One key component of Sweden's success is its low out-of-pocket expenses. The residents pay one of the lowest rates of out-of-pocket healthcare expenditures among developed countries, at just 15% of total health spending. In the U.S., out-of-pocket spending accounts for over 30% of total health expenditures, and in India, it exceeds 50% [15]. Additionally, the Swedish government imposes strict limits on patient expenses to ensure that individuals are not financially burdened by medical expenses. For example, out-of-pocket medical expenses are capped at approximately \$140 per year, and prescription drug expenses are capped at \$250 per year [16]. These policies ensure that low-income individuals and families can receive necessary treatment without fear of financial ruin. The model shows that government intervention in healthcare financing can create a fair, efficient, and economically sustainable system that ensures that people receive healthcare based on need rather than ability. This disparity illustrates how universal healthcare can reduce financial stress on individuals and prevent medical debt from becoming a driver of poverty, as seen in the United States and India. Another essential factor contributing to the success of Sweden's healthcare system is its purchasing monopoly. As the sole purchaser of healthcare services, the Swedish government wields substantial bargaining power when negotiating prices for drugs and medical equipment. This purchasing power allows Sweden to secure drug prices that are, on average, 58% lower than those in the United States [17]. By reducing the cost of pharmaceuticals and medical equipment, Sweden keeps overall healthcare costs lower while ensuring that necessary resources are available. This centralized purchasing system enables the government to streamline procurement

processes and direct resources more effectively, which enhances the long-term sustainability of the healthcare system. The combination of strategic purchasing and price negotiation further strengthens the efficiency and financial viability of Sweden's healthcare model.

Sweden's universal healthcare system not only promotes equity but also contributes to better health outcomes and greater economic productivity. The country consistently ranks among the top in global health indices, with high life expectancy and low infant mortality rates. Its health indicators compare well with most other European countries; life expectancy at birth in Sweden increased by 3.09 years from 79.6 years in 2000 to 82.7 years in 2021 [18]. From an economic perspective, Sweden's publicly funded healthcare system contributes to greater labor productivity and economic equity.

## 4 Conclusion

As this study demonstrates, well-structured healthcare systems contribute directly to economic stability, social mobility, and prosperity for a country as a whole. Privatized and fragmented systems, as seen in the U.S. and India, exacerbate financial burdens and limit access to care, perpetuating cycles of poverty. In contrast, Sweden's universal healthcare model demonstrates how equitable access to healthcare, supported by progressive taxation and low out-of-pocket costs, can enhance economic productivity and reduce disparities. Expanding public funding, implementing universal coverage, and capping out-of-pocket costs are critical steps toward reducing healthcare-related economic inequality. Governments must prioritize healthcare reforms that improve access, affordability, and efficiency of care to promote more just and economically resilient societies. Policymakers can draw valuable insights from Sweden's approach, particularly its emphasis on risk pooling and centralized drug price negotiations, which have helped reduce costs and improve healthcare efficiency. Countries facing rising healthcare costs and inequities could greatly benefit from adopting similar measures, such as investing more in preventive care and negotiating lower drug prices to alleviate financial strain. In addition, international cooperation through platforms such as the World Health Organization allows countries to learn from each other's successful experiences and foster sustainable economic growth and greater social cohesion.

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