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Nationalized Healthcare vs. Privatized Healthcare

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Abstract

For decades, countries around the world have been battling in the debate on what type of healthcare is most beneficial - privatized or nationalized. Though it doesn't look like it will be resolved anytime soon, Nationalized health care seems ideal, considering patients don't pay for their medical treatment. However, to account for all medical expenses and ensure that care is free of charge, countries must find other mediums to cover production and employment costs such as taxation. Privatized health care has been notorious for its lack of affordability to the average citizen and better care. As it is a for-profit business, there is no need for other financial support methods other than cost-sharing and out-of-pocket payment. Both Nationalized and Privatized healthcare come with their benefits and disadvantages. The debate continues, as countries with different healthcare systems prove to be well functioned and organized.

Healthcare in the US

The US fosters a healthcare system that is a mix of public and private for-profit and non-profit insurers and healthcare providers. The federal government provides funding for the national Medicare program for adults age 65 plus, those with low income, disabilities, and veterans. In 2017, public spending accounted for 45 percent of total health care spending (8 percent of GDP). Federal spending represented 28 percent of the total cost of healthcare. Federal taxes fund public insurance programs, such as Medicare, Medicaid, CHIP, and military health insurance programs (Veteran's Health Administration, TRICARE). The Centers for Medicare and Medicaid Services is the largest governmental source of health coverage funding. On the contrary, in 2018, spending on private health insurance accounted for one-third (34%) of total health expenditures. Private insurance is the primary health coverage for two-thirds of Americans (67%). The majority of private insurance (55%) is employer-sponsored, and a smaller share (11%) is purchased by individuals from for-profit and nonprofit carriers.

Many employers contract with private health plans to administer benefits. Most employer plans cover workers and their dependents, and the majority offer a choice of several plans. Both employers and employees typically contribute to premiums; much less frequently, the employer fully covers premiums.

In today's society, Tolbert '19 finds that almost 30 million Americans had no medical coverage in 2018, with Pifer '20 explaining that an additional 43 million Americans could lose their insurance in 2020 and 2021 due to the COVID-19 pandemic. Because of such extreme cuts to medical coverage in response to the pandemic, Americans are surely in danger. The issue becomes catastrophic when looking to Brody 17, who quantifies that 125,000 people die every year because of medical nonadherence. On the other hand, Yale researchers find that increased coverage and hospital access under Medicare for all would save over 68,000 lives a year.

Privatized Healthcare

Though privatized healthcare is typically viewed as a sole means of profit for large medical corporations, privatized healthcare comes in many forms. Universal healthcare is a form of healthcare where a country requires each individual to buy a healthcare insurance plan. When purchasing health insurance from a private insurance company, there are three types of cost-sharing charges. Cost-sharing is the amount that one has to pay for their medical item or service, including hospital stays, physician visits, and prescriptions. The first kind of cost-sharing charge is called a deductible, which is set on a yearly basis. If an individual pays for a $1,000 deductible plan, it means that until they spend $1,000 or more on medical services or items, they pay the total cost. Deductibles don't necessarily apply to all medical items and services. The second type of cost-sharing charge is copayment. Copayments are a fixed amount of money that an individual must pay for their service or item. For example, if someone buys a prescription drug from a pharmacy, they may have a copayment of $10, and the insurance company covers the rest. Finally, there is a coinsurance, which is a fixed percentage that an enrollee must pay for medical expenses. An example of such is in a hospital stay, where the enrollee is covered 70% and is required to pay the other 30% (Beyond the Basics, 2021).

Many countries such as Switzeralnd, Norway, Germany, Israel, and the Netherlands have universal privatized healthcare insurance systems. Switzerland, unlike the United States, has universal privatized coverage for healthcare. The federal health insurance act requires all citizens to buy statuary health insurance (SHI) from private insurance companies to cover essential health care services. These services include hospital inpatient services, general practitioner and specialist services, pharmaceuticals

and medical devices, home care services, some preventive measures, maternity care, outpatient care for mental illness, and hospice care in the case of an underlying disease (Tikkanen et al.,, 2020). It does not, however, provide insurance for dental work and eyeglasses or contact for adults. In Switzerland, competing insurance companies offer SHI, and upon arriving, each individual over the age of 19 is given three months to buy healthcare insurance from one of the private insurance companies.

Norway is another country with a universal private healthcare system. Like many countries with privatized healthcare, the government pays for medical facilities. However, every adult is required to pay an annual fee to private insurance companies to cover their medical expenses. Those under the age of sixteen receive free medical care. This differs from the standard medical procedures in most countries, with privatized healthcare. Norway's government provides basic healthcare coverage for all tax paying citizens. However, those who lost income due to illness receive a basic income to cover their medical needs. The public health expenditures represent 10.5% of GDP in 2016. The public insurance also accounts for most health coverage, at 85%. Though Norway is considered to have private healthcare, in 2016, only 10% of the population had additional private insurance and 90% of these were paid for by an employer. (Tikkanen et al., 2020)

Cost-Benefit Analysis

Privatized health care can come in many forms, two of the most common being employer-sponsored coverage and an independent plan purchase, the former being the *more* common of the two. The largest demographic of individuals taking advantage of these privately-funded plans are those under the age of 65.

Health care in the United States has been more or less taken over by the private industries, where we're seeing fewer people covered by government-funded healthcare. Over the years, and what is currently expected of future years, there has been an upwards trend for privatized health insurance spending; a trend almost twice as great in comparison to that of both Medicare and Medicaid. (Altman, 2015)
One of the main fights against the privatization of health care is the notion that everyone should be able to receive the same level of healthcare, despite financial differences. Although, Medicare offers a specific privatized insurance that offers more for less.(Altman, 2015) The reason behind why healthcare is so expensive is due to the original prices of the provided services and that these services can sometimes be viewed as luxuries, and not necessities. Specifically speaking, Medicare combats this fact by creating a more cost-efficient method than their publicly-enrolled counterparts.

Nationalized Healthcare

In the current society, there is little that comes without cost. In many countries, healthcare is extremely expensive, under a privatized system. Nationalized healthcare would lead to heavier taxes, lower wages for doctors, longer lines, but free health care for all. The big question is whether or not the benefits outweigh the costs.

Nationalized healthcare has been implemented in many countries around the world, primarily in the European region. Italy and Canada are known for their positive outcomes under nationalized healthcare. These governments try to provide most of their citizens in regards to medical care and to ensure that the benefit given is sufficient and does not provide a financial hardship to citizens.

Canada has a decentralized, universal, publicly funded health system called Canadian Medicare. Health care is funded and administered primarily by the country's 13 provinces and territories. Each has its own insurance plan and receives cash assistance from the federal government on a per-capita basis. All citizens and permanent residents receive medically necessary hospital and physician services free at the point of use. To pay for excluded services, including outpatient prescription drugs and dental care, provinces and territories provide coverage for targeted groups. In addition, around two-thirds of Canadians have private insurance. Total health spending is estimated to have reached 11.5 percent of GDP in 2017; the public and private sectors accounted for approximately 70 percent and 30 percent of total health expenditures, respectively. Italy's National Health Service covers all citizens and legal foreign residents. It is funded by corporate and value-added tax revenues collected by the central government and distributed to the regional governments, who are responsible for delivering medical care. Residents receive mostly free primary services, inpatient care, and health screenings. Private insurance plays a very limited role in the healthcare distribution of Italy. Evidently, medical schools in these countries are cheaper than in the US. Relatively, US doctors receive a significantly higher paycheck on average. Nationalized healthcare is implemented for the benefit of the people. It provides healthcare to all, but raises taxes by a significant amount.

Cost-Benefit Analysis

Nationalized healthcare is a governmental system in which the government itself funds the medical care of the country's/region's residents, fully and in a non-discriminatory manner. This concept creates a medical world where competition is nonexistent; the lack of profit incentive for doctors, nurses, and any other medical workers sets forth the idea driving the "universal healthcare system," which is medical

care for all. The government is the umbrella factor in this kind of healthcare; they both control and regulate the costs of this aid, which essentially reinforces the indistinguishable treatment that the residents would receive.

The government's funding of national healthcare within the United States tops any other. From 2018 to 2019, a 4.96% growth of this sector's expenditures had transpired, having an overall sum of upwards of $3.8 trillion. For the same year, this number represents 17.7% of the nation's GDP (Center for Medicare and Medicaid Services, 2020)

The question here is whether or not this large sum of governmental money (single-payer system) being spent on healthcare can be supported and justified by the quality of its output. This can be broken down into different categories, although the largest tie back into the level of healthcare that *every* resident receives, in a non discriminatory manner. While this concept is supposed to be what drives a universal healthcare system, there are notable instances of the opposite occurring in the US (Ryan Nunn, Jana Parsons, Jay Shambaugh, 2020).

The first questionable aspect of the system present here in the United states is that the price tag hanging on the same services differ greatly within many parts of the country. This is a complete change in direction from the already-known definition of the foundation that a universal health care system is built off of. For example, the prices of things as simple as a blood test are completely different in certain metropolitan areas. The 2016 median for this test, "a comprehensive metabolic panel," in Portland, Oregon is less than 50 dollars. On the expensive side of the spectrum, places like Miami and Fort Lauderdale in Florida have the median price for this same test going for upwards of 350 dollars. These differences in prices are mainly due to the fact some of these stated metropolitan areas "have nicer facilities, or employ more experienced medical teams, allowing [them] to charge correspondingly higher prices."

Impacts of Nationalized v. Privatized Health Care on Insurance

The US system became increasingly costly, leaving now about 46 million of Americans uninsured. In 2005, expenditures were twice as high in the US as in Canada — US$6697 per person v. US$3326 in Canada (Schoen C, Osborn R, Doty MM, et al., 2007). And although Canada insures all its population for necessary doctor and hospital care, the US leaves 15% without any insurance whatsoever. (US Bureau of the Census, 2006). Those who are insured often need to pay a substantial fraction of the bill, and some necessary services may not be covered. In a recent survey, 37% of Americans reported that they went without needed care because of cost, compared with 12% of Canadians.

Whether privatization would shorten waiting lists by creating more facilities is arguable. What it would certainly do is change who would be waiting. In the US, for example, well-insured patients have a very short wait for a hip replacement, but the 46 million Americans without health insurance might wait for the rest of their lives. As in all such parallel systems, privatization would draw off resources from the public system (James Lorimer & Company Ltd, 2007). Waiting lists would be shorter in the private system, but they would almost certainly grow longer in the public system.

Money diverted to the private system would not buy the same health care as it would in the public system. There have been many studies comparing for-profit and not-for-profit health care in the US. For-profit care is nearly always more expensive and often of lower quality (Woolhandler S, Himmelstein DU BMJ, 2007).Indeed, logic and common sense would suggest the same conclusions even without the growing empirical evidence. Unless we believe, without any evidence whatsoever, that for-profit organizations have some secret of efficient operation not known to the not-for-profits, it makes no sense to suppose that, given the same payment system and the same patient population, the for-profit organizations can provide similar services while still extracting their profits and business costs from the system. Neither does it make sense to imagine that investor-owned businesses are charitable organizations that wish to contribute their resources to the community. It is obvious that their responsibilities to their investors require them to take profits from the community. To do this, as many US studies have shown, they skim off the profitable patients and the profitable services, leaving the leftovers to the not-for-profits.

Outweigh

Nationalized Health Care poses a benefit for those who are unable to receive by privatized healthcare institutions operating on the sole purpose of profit. This single payer system removes administrative costs and offers a large range of coverage compared to its counterpart. However, proponents of privatization of healthcare argue that the removal of these jobs in the administrative sector of healthcare industry would result in a loss of jobs and a larger influx of taxes that would immediately harm the working class through its extensive cost of implementation of (32 trillion USD for M4A) and high decreases in GDP of an utmost 8.5%.

30 million Americans have no medical coverage in 2018. With the raging pandemic, 43 million additional Americans can lose their insurance. Nationalized healthcare under a single medicare system would save 68 thousand lives a year. In fact nationalized healthcare would impact the working class in two ways: small businesses

and job opportunities. The average American family would see positive annual savings of about 2400 dollars which means that they are now pocketing dollars that would have previously gone to their treatment. Anderson ‘14 Every extra dollar going into the pockets of low-wage workers adds about 1.2 dollars to the national economy. This becomes largely significant when looking to the 53 million low-wage workers in America who would, therefore, add trillions of dollars to the national economy annually.

Currently, employer-provided health insurance locks workers into their jobs, acting as a perceptual incentive for employees to stay because they do not want to risk losing this insurance. Due to this phenomenon, Chute ‘15 864,000 people are discouraged from changing jobs which causes 1.8 billion dollars in lost income within the job market annually. Bivens ‘20 National Health Care would remove the job lock by guaranteeing healthcare for every individual, allowing them to switch to higher paying jobs without worrying about employer insurance. Therefore, Saez ‘19 the elimination of insurance contributions would allow an average employee to see their wages go up by 30%. Finally, Brownell ‘16 Every 1% increase in wages increases consumer spending by 2,800 dollars, looping right back into our economy while a 1% increase in per capita income reduces income poverty by as much as 4% which is critical when looking to the fact that, in the most recent evaluation, Galea ‘11 Approximately 291,000 deaths were caused by insufficient income in the US. The only way you can prevent these deaths within this debate is by allowing citizens to spend exponentially less on their medicine and more on their well-being.

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