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The Financial Ethics of Healthcare Privatization: United States vs. the United Kingdom

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Abstract: The provision of healthcare is a service often caught at the crossroads of ethical and financial considerations. In this paper I outline the relative benefits to the healthcare systems in the US and the UK from both a financial and ethical perspective. The quality of care provided in the US appears to be high, but not high enough to warrant the cost suffered by citizens. Equally, the service provided in the UK is universal, but lacking in efficacy and efficiency. The NHS could benefit from greater privatisation of key non-medical services and the introduction of minor fees for common procedures and treatments. Not only would this improve efficiency, but would likely result in a higher quality of care than currently provided.

Introduction

The provision of healthcare by private companies has long been a source of controversy, especially in countries where healthcare is generally handled by the state. Since 1948, the provision of healthcare in the United Kingdom (UK) has indeed remained a nationalised service. When government provided healthcare, arguments arose when there was suggestion of private involvement. The common ground of opponents to privatisation was their rejection of the sentiment and precedent set by privatising elements of a nationally owned service. The National Health Service (NHS) was founded upon one principle – it is unethical for the sick to pay for treatment out of their own pocket. However, the financing of free healthcare for all is unsurprisingly a costly program and as such privatisation remains an effective solution to combat cost. The NHS of England and Wales absorbs 19% of all spending in the UK. Comparatively, expenditure on important areas like education,

defence and transport range from £87m to £37m respectively – a range of 11% to 4.7%.

In the US, the quality of healthcare for certain socio-economic groups is superior to that of the UK. Instead, the problem here is clearly opposite – the *limitation* in healthcare spending is not an issue. Broadly speaking, the market decides who and who does not get treatment through the provision of insurance for those who can afford it. The ethical failure here is obvious – the duty of the government is to protect the citizen and treatment for the sick is perhaps the most obvious embodiment of this deontological principle. But, if private healthcare can deliver a better quality of treatment, then perhaps the utility of privatisation has been undervalued. That is to say, could private healthcare provide the greatest good for the greatest number when compared to nationalised healthcare? Once more, the cost of socialised healthcare has already been proven to be monstrous in both its size and ability to draw on funding that could be spent elsewhere. The purpose of this paper, therefore, is to find the optimal point between privatised and nationalised - between financially minded and ethically minded.

Definitions, Data and Fact

Measuring and understanding the relative quality of both US and UK healthcare is central to their comparison, as the quality of healthcare serves as an endorsement of the means through which it exists. For instance, if British healthcare treated a greater percentage of the population, and did so more successfully, than American healthcare, then our question would be easily answered. Alas, the comparison is not that one-sided; there is more to consider than the success of medical treatment and the reach of this treatment. The healthcare *system* is titled as such due to its wide-ranging and intricate infrastructure. Evaluating one system to be better than the other requires multivariate analysis. For instance, as a percentage of population, the American system lags far behind in hospital admissions. A rate of 10.7% when compared to the British rate of 25%, suggests more people are generally going untreated for illnesses. This is perhaps linked to an associated fear of the cost which comes along with treatment and is certainly not because Americans are in less need of medical treatment – on average, life expectancy, obesity and access to exercise facilities are worse in the US than in Britain (Brown, 2013). In this singular regard, the American system can be viewed as worse, but this alone is not worthy of total condemnation. This single example serves as a good indicator of the importance of multivariate analysis in the proceeding comparative study, especially as the US system starts on a somewhat poorer position due to its reputation. Common measures of healthcare quality used by organisations such as the OECD and health.org include qualities such as efficacy, accessibility and safety (Sutherland & Coyle, 2009).

The United States: Benefits of The Private System

The provision of healthcare in the US has long been a source of controversy and demonization. To most, the idea that one is punished via payment for illness is as foreign as it is unsettling. However, it is important to provide a full account of this system rather than the one experienced by individuals without health insurance – these instances are where the popular horror stories propagated by particularly partisan news sources detail over '$5000 in bills after an E.R. trip despite the lack of treatment', and similar stories. The legitimacy of these stories, amongst a plethora of others, is covered next. For the meantime, serving as rare example, we will be extolling the virtues of the private healthcare system offered in the US.

The most significant benefits to privatised healthcare, much like any other privatised business, are twofold. Firstly, spending is high as market forces determine who has and has not and therefore, prices are driven competitively by different providers, rather than controlled by a government. Secondly, the expenditure by consumers being high results in a larger sum of investment into the business of healthcare. Simply put, high prices lead to high expenditure per capita, which in turn promotes growth and improvement of healthcare, the same way that high investment into any program promotes development. As a result, the quality of health care is higher in the US than most countries. As of last year, total healthcare spending stood at 17.2% of GDP, a value, which has been steadily rising from 12.5% in 2000 (OECD, 2018). On average this sees each American spend, and therefore invest, over $10,000 into the medical field. However, the obvious issue is that few enjoy this high quality. Disparity in healthcare coverage across the United States is significant and, more troubling still, there exists over 28 million people without health insurance of any kind (United States Census Bureau, 2016). These concerns are explored in the following subsection – for now, we focus on the benefits of privatisation in healthcare.

As a result of higher spending and development, specific and important elements of treatment are far superior to other nations. Numerous measures of quality are higher in the United States than in the UK, according to a wide range of reports published between 2004 and 2018 (OECD, 2004:2017). Areas in which the US system is superior are plentiful – patient safety is 25% higher in the US and the quality of staff training and ability is higher by 10%. Once more, specific elements of treatment are far superior still. Between 2004 and 2016, US hospitals were not required to provide long term care as often as UK hospitals by a factor of seven times, suggesting a higher quality of preventative care and general health management in the US. This suggestion is

supported further by different metrics. For instance, 85% of American women aged 50 to 64 reported having received a pap smear in the last two years, with 84% of the same demographic reporting the same for a mammogram (Docteur & Berenson, 2009). Even in instances where long-term treatment is required, as is often the case with cancer, the U.S fares better. Between 2010 and 2014 cancer treatment in the US was 5% more effective than in the UK (OECD, 2018)

These developments are the result of higher spending on healthcare. Simple economics illustrates clearly that within private industry, an expansion of spending usually promotes an improvement in quality. The same principle explains why suspiciously cheap restaurants serve near-toxic food. Lower investment on their part rids them of excess cost and thus increases profits. The downside, of course, is microwaved, disgusting food. The U.S healthcare system on the contrary is supported in its development of treatment options by huge amounts of spending.

Despite the superior quality of some American treatment options, the ethical position of the USA is fairly indefensible. There has been some attempt by government, especially in recent years, to fulfil its duty of care and equalise the medical playing field for the consumer. Medicare serves as a clear manifestation of a sense of duty. More recently, the introduction of the Affordable Care Act (2010) attempts to widen the reach of Medicare, serving as an example of a continued commitment to the principle of accessible healthcare. Equally, President Trump's inclination to repeal the ACA and therefore, reverse not only the large number of individuals who have healthcare plans through the ACA, but re-indebt the government through nullifying the savings associated with ACA for the bottom 40% of taxpayers (CBO, 2018; CBO 2015).

Broadly speaking however, there appears to be little moral influence guiding the approach to medical care in the US. Indeed, it is one of the last industrialised countries to provide universal basic healthcare.

The USA: Drawbacks of The Private System

There are multiple drawbacks of the private medical system. Indeed, far more numerous are the drawbacks than positive elements. Aside from the quality of healthcare in the United States, almost every other comparative element fares worse. This remains true in relative terms, compared to the UK, and in absolute terms.

Despite the developmental benefits to treatment, expenditure is too high compared to the resultant quality. Although it is true the US system is superior to the UK and many others regarding specific elements of healthcare quality, it

is not *so* much superior to warrant the expenditure. In short, the trade-off between cost and improvement is poorly weighted toward cost. The same idea is expressed with greater clarity when it is punctuated by numeration. As previously noted, per capita, over $10,000 was spent on the medical field in 2017 (OEDC, 2018; WHO, 2018). In the UK that number was $3,851 (£2,999) per person (OECD, 2018). It is also true that the differences in numerous measures of healthcare quality were significant. However, the quality of US healthcare, by a number of measures, was not about 2.6x that of the UK's. As a function of currency spent, US healthcare quality is not in fact superior to the UK's as the allocation of resources is far more inefficient. Another way of stating this concept is to say that if the NHS had $10,000 to spend, they would likely far surpass the quality of healthcare available in the US today.

The issue of spending does not end at inefficiency. Rather, a separate issue beyond the severity of the costs incurred by citizens is the situations in which one is still required to pay. This is especially true for a group of people who occupy a space where two demographics meet – the middle-aged and the moderately poor. Medicare and Medicaid are widely available for the elderly and the extremely poor respectively and the passing of the ACA has widened in their reach. Indeed, it is estimated the ACA expanded the provision of healthcare to between 20 and 24 million Americans (CBO, 2016; OASPE, 2016). However, the ACA fails to provide for a significant, although perhaps not as in-need, group of low earning, middle aged Americans. Insurance quotes for individuals earning $28,000 after tax equalled roughly $300 a month, an amount, which equates to 13% of monthly income (Tozzi & Ockerman, 2018). Once more, the jobs these people tend to hold are not so unrewarding, and therefore qualify them for Medicaid, but not essential enough for the employer to provide a healthcare plan for its employees. Bloomberg heard similar stories from over 3000 Americans after it ran a feature on the topic of health insurance (Tozzi and Ockerman, 2018). Evidently, the efficacy of government intervention into the private system remains limited and its reach curtailed under the pressure of market and private forces. Most significant of these forces are the interested parties involved in the business of healthcare. These include insurance providers, pharmaceutical companies and hospital owners. The common denominator of these interest groups being of course that they want to make money. As such, their policies and decisions are influenced far more by profit than by principle.

However, the cost of healthcare in the US is worse when considered in ethical terms. Although the average price of healthcare per capita is shocking, more shocking is that the state does not provide or aid in this cost, for most people. Instead, it expects its citizens to front the cost for their own welfare, illustrating a distinct ethical failing on the part of the state on multiple ethical levels:

Deontologically, even the opponents of duty-based practical ethics would admit the state has a duty to protect its citizens. Indeed, the relationship between the state and the citizen as one of protector and protected is perhaps the most central and ancient relationship in statehood. However, the inability of the US government to protect its citizens effectively from illness is dangerous and outdated. This failure to protect is more inexcusable considering the wealth and international supremacy of the United States. Beyond western ethical philosophy, a duty of the state to protect its citizens is present in eastern thought. The ancient Chinese school of Mohist philosophy suggests the state has a specific duty to care for its citizens not only militarily but with regards to personal health to ensure the state's survival.

Even a completely different ethical consideration yields a similar conclusion regarding the unethical practice of the US in healthcare. For instance, the teleological position focused less on principle and more on outcome similarly finds failure in the US system. Put plainly, the utility of the current system is low - 28 million Americans are not covered by health insurance. This equates with about 8% of the population not having access to regular healthcare or, in cases of emergency, risking possible bankruptcy. As proven by the prominence of universal healthcare around the world, at a far lower cost and of comparable quality, a few conclusions can be made:

1. The cost of the US healthcare per capita is too high to omit 8% of the population, this signals considerable inefficiency and therefore, suggests the healthcare provided, even to the 92%, could be greater for the cost, when compared to other systems/the British system. This idea has been covered in the previous paragraphs discussing expenditure in the drawbacks of the US system.

2. This expenditure, at such a high rate, should include the entire population, when compared to other/the British system.

3. The difference in quality between free systems and private is not so wide that the quality declines **at a greater proportion** than the **number of those who gain access –** therefore the utility is improved.

The British System: Benefits of the Nationalised System

Although an individual makes contributes through taxes, healthcare costs for the average person is far less than the United States and is of course, free at the point of use. This extends beyond an appointment or surgery to smaller elements of the NHS. Certain prescriptions are available for free, perhaps most notably contraception and all prescriptions for vulnerable groups. One might

be tempted to argue that all this does is reduce the funding available for medical developments, but as shown earlier the utilisation of funds toward research and development in the US is incredibly inefficient. Indeed, one might go as far as to say that tax is a more principled form of payment compared to that of the relationship between a consumer and a provider – tax is for the good of all and is applied, fairly, to all, whereas market forces are guided by no principle of fairness or for the good of all.

Perhaps as important an element of a free healthcare service is an egalitarian service – the NHS is based only on UK citizenship and individuals are not and cannot be discriminated against when they are ill. The phrase 'free at the point of use' encapsulates the concept that the NHS is available for all whenever they need it. The US system is subject to the rules of the market and therefore can and will only serve those who can pay. Worse still, those who do not pay monthly instalments for insurance are greeted with an often-insurmountable bill, should they fall ill. Unsurprisingly, the relatively high cost of health insurance excludes certain socio-economic groups from the possibility of obtaining it. In effect, a quasi-tax exists against perhaps the most squalid, destitute and diseased individuals in the US as a built-in feature of the healthcare system.

The NHS also grants the unalienable right to each individual to have a genuine voice and opinion on the healthcare system as it stands because technically, she owns a part of it. Although the majority of US hospitals are run not for profit, a significant number are. Once more, Americans enjoy no such ability to really influence the running of healthcare through their vote. If one votes in the US for a party based on its position on healthcare, it is to support or oppose the **introduction** of universal healthcare. Comparatively, the British vote on more specific issues. The direction and potential evolution of the NHS is handled very differently by the popular parties. For example, imagine a scenario in which two tribes each desire to traverse the oceans on board a boat. In one tribe, each member is involved in the construction of the boat and, as such, is privy to a vote and a say on where the boat goes. Meanwhile, the other tribe is still split over arguing whether to build the boat or not. This represents the ongoing political arguments over healthcare in the UK and US respectively. The British debate the direction universal healthcare should take, the Americans debate whether they should even introduce it or not.

A secondary benefit of public ownership is the lack of significant lobbying by businesses. Most of the interest groups involved in the running of the NHS are associations of medical professionals or unions of support staff. For instance, recent controversy over Jeremy Hunt's plans for the future of NHS riled the anger of the union for junior doctors. Resultant strikes served as one of the rare occasions in which medical workers organised and refused to work, a decision which had a 'significant impact' on NHS workings (Rimmer, 2018).

The English System: Drawbacks of the Nationalised System

First and foremost, compared to the US, specialised treatments and equipment are either unavailable or available in a diminished capacity in the UK. This not only serves to reduce the overall efficacy of treatment by the NHS but adds a form of taxation to those few individuals who are forced to either (a) buy private care in the UK or worse (b) travel abroad, often to America, at great personal expense, often under the stress of illness. Although not to the US, the number of individuals travelling abroad from the UK for medical treatment has increased significantly in recent years. It is posited that longer waiting times pushed over 100,000 extra Britons to seek medical attention outside of the UK between 2014 and 2017 (Donnelly & Morley, 2017). As noted previously, OECD statistics reveal the UK scores poorly compared to private systems regarding multiple variables of healthcare quality beyond efficacy of treatment – safety and patient satisfaction for example.

The spending problem of the NHS is opposite to that of the American system in that spending issues revolve around dearth rather than abundance. It is a source of constant turmoil for chancellors of either party to allocate certain amounts of the budget toward the NHS. Indeed, almost regardless of the amount given the NHS could always take more. The NHS serves as an effective black hole for public spending. For 2019 spending at the government level, both centrally and locally, is estimated to rise to £817 billion, amounting to 19% of total public spending (UKPS, 2018).

A secondary issue of excessive spending is inefficiency. Most notably, the process through which patients are seen, be it for a simple GP appointment or in an emergency, is too slow. The link between the nationalisation of services and sluggish performance is largely a managerial issue – the central government delegates certain responsibilities to local authorities that in turn give these to administrators of specific hospitals. The end result is usually an inconsistency in the utilisation of funds by administrators, as each of them has varying approaches to hospital management. Once more, this issue is naturally compounded by the fact that NHS hospitals, by virtue of being free, lose money. As such, the potential for waste is increased by a culture of complacency due to the public funding. In the US such complacency is not allowed to develop, as private interests involved in hospital management have profit margins to worry about.

Measured in a variety of ways, inefficiency in the NHS has been well evidenced. For instance, the past three years has seen an increase in the number of people waiting in excess of 26 weeks. Originally this totalled

60,402 in April 2014 and had risen to 136,030 in only three years (NHSE, 2017). Also worthy of note is the 3.783 million patients who were on the waiting list for treatment in April of 2017. Of these individuals, 382,618 (10.1 per cent) had been waiting for longer than 18 weeks, compared to 302,901 (8.4 per cent) at the same point in 2016 (NHSE, 2017). Equally, some inefficiency is misrepresented or misunderstood. For instance, claims have been made to suggest immigration in recent years has placed a marked strain on the NHS. Such claims are not supported by data and rather suggest an aging population and rising wage costs have a more significant impact on strain. Equally, perceptions about nurses on the other hand are also misinterpreted. Although the number of nurses in hospitals has decreased, this is only a 0.57% decrease over a three-year period from 2015. In all other regards (medical school intake, doctors, professionals etc.) the number of staff in the NHS is rising. Staffing issues are more likely related to the inefficiency (NHSE, 2017; NHSD, 2017).

Conclusion

The presentation of the benefits and drawbacks of these systems was in the pursuit of finding a solution. The middle ground between private and nationalised healthcare regarding ethical and financial considerations is a space in which the optimum quality of healthcare can be found. As demonstrated, there are clear issues with each system. At the more basic and obvious end of the spectrum are the ethical issues of accessibility to healthcare in the US and the financial issue of dearth and inefficiency in the UK. Within this exist further ethical issues of utility – unlike the nationalised system of the UK, the US fails to find the balance between access and expenditure as it excludes 8% of the population yet spends more per capita by a factor of 260%. In effect, a slightly lesser good could be provided to a far greater number of people.

As has hopefully been made clear, there exist extensive drawbacks and benefits to each system. Indeed, they extend far beyond the ones I have covered and would be better suited to fill a book than a short paper such as this. Nevertheless, it is clear universal healthcare prevails over privatised healthcare on both financial and ethical grounds. The failure to fulfil the basic ethical duty of care to citizens of a state through the provision of even basic medical care is problematic. Once more, for this inaccessible healthcare to be so costly damages the utility of the entire system. My proposal and recommendation therefore, would be for the implementation of universal healthcare in the United States in a similar fashion to the United Kingdom. This proposal is not dissimilar to one made by progressive democrats – “Medicaid for All” is a slogan propagated with the idea of dissociating

universal healthcare from socialist policy. Most notably, this was a significant element of Bernie Sander's 2016 campaign pledge(s).

However, the nationalised system is not without its serious flaws. Once more, the effect of privatisation has proven to be beneficial to the quality of healthcare on a number of measures. I propose that further privatisation of certain elements of national healthcare systems would be beneficial to the utility of the overall system and, by extension, the good health of the population. More specifically these proposals are as follows:

1. Further private influence and involvement in administration, in direct conjunction with the central government. This could see the consultation of large management firms, by the government, in an attempt to cut down on the waste and inefficiency of the NHS. Earlier this year the NHS had already hired 107 different management consultancy firms around the UK to try and improve the staffing situation in a wide range of hospitals (Consultancy UK, 2018). The NHS hired the firms under a strict self-written guideline of how it wanted to see development and progress within the service. These included 'Health and the Community' placed among other purely administrative areas, such as 'IT'.

2. Further contracting of non-medical positions and services to private companies: waste disposal, cleaning and other similar tasks should be performed by outsourced companies outside of the NHS, rather than NHS funding being spent on hiring workers for these roles. Wages would likely be lower than those the NHS is required to pay, especially for commonplace tasks. Equally, private firms inevitably have equipment and systems already in place to handle all elements of one specific task, requiring very little additional input from the NHS. These long-term contracts should be organised by the government to ensure these jobs are done at a reduced cost – in fact, the Health and Social Care Act of 2012 began this process. More significant tasks could also be included in this area such as the construction of hospitals and other trust units. This, importantly, would not include the running of said constructions or hospitals. Indeed, hospitals sold to the private sector usually perform very poorly under entirely private management. Hinchingbrooke hospital was bought by Circle in 2009 but returned to the NHS in 2015 after it was placed into special measures (King's Fund, 2018).

3. Much like in the 1950s with ophthalmology and dentistry, small charges should be considered for introduction into other areas of the NHS, which are non-emergency and non-life threatening. I do not propose any charges to punish individuals for happening to be

> ill as the deontological argument still applies. For instance, GP appointments could have minimal charges introduced to subsidise more specialised areas of medical treatments. Once more, fines for missing these appointments could be introduced to a) deter the waste of NHS time and b) subsidise the availability and utility of other appointments. A dental student I posed the question of privatisation to suggested that core dental treatment (check-ups, cleaning and other commonplace treatments) be handled privately, with the NHS performing more serious surgeries and administering specific care requirements for serious conditions. This system could be widely applicable to areas of medicine in which check-ups and small procedures are common: minor physiotherapy, ophthalmology, general practitioner appointments, to name a few.

It is worth noting before that commissioner spending is where private sector spending would occur in the NHS. It is only commissioner spending we are interested in because of two factors. Not only are commissioners not the source of the deficit – commissioner's underspent in 2016 by £599 million whilst trusts/foundation trusts overspent by £2.45 billion – but they are also those who are primarily concerned with spending in the private sector. As such, my proposals rest on the idea of commissioners utilising the private sector in ways that would subsidise the large expenditures of foundation trusts and as such reduce waste, improve quality and efficiency.

However, these small suggestions are only a few in a sea of potential private ventures for the NHS. Once more, to suggest any of these fixes with any hard and true intentions of convincing a reader would require more research. Of course, providing a schematic for a perfect health service was never the intention. Rather, to describe what this optimum system would conceptually resemble – fair, free and directed by the people, but also efficient, utilitarian and of a high quality.

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