Universal vs. Private: How Healthcare Delivery Models Shape Equity

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ABSTRACT

Delivering optimal healthcare involves navigating a complex interplay of factors, with healthcare delivery systems and equity standing out prominently. This editorial aims to contrast healthcare models in Canada, the United States of America (USA), and the United Kingdom (UK) to analyze their implications on equity. The universal healthcare model, exemplified by Canada's Medicare system, ensures access to essential services for all citizens, minimizing financial barriers and promoting social equity. Contrastingly, the USA primarily operates a private, for-profit healthcare system, where access and quality of care vary widely, often leading to disparities. The UK's National Health Service (NHS) offers universal coverage funded through taxation, supplemented by a less prevalent private sector. This article highlights the intricate relationship between healthcare delivery systems and equity, shedding light on the strengths and weaknesses of each approach.

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Implications of Health Equity in Healthcare Models

A multitude of confounding factors contribute to the most optimal deliverance of healthcare to a population. One of the major factors is the system in which healthcare is delivered; the two most prominent being universal and private. Equity is another prominent factor that contributes to an effective healthcare model. Equity is a concept that is seemingly transient, there is always room for various infrastructures within the health sector to improve access to sufficient healthcare services. In this article, we contrast three healthcare models in developed countries, Canada, the USA, and the UK to analyse the advantages and disadvantages of each system, in addition to their implications on equity.

Deliverance of Healthcare

The longstanding debate over the most effective healthcare delivery system has been a source of global contention among citizens (Reid, 2023). There are two major systems that can be contrasted, universal healthcare and private healthcare. Universal healthcare provides medical services to citizens of all financial standings, largely paid for by federal taxation (Amadeo, 2018). There are 3 main submodels: single payer, social health insurance, and national health insurance (Amadeo, 2018). Single payer models collect revenue from income taxes to ensure free access to healthcare. Services and providers are employed by the government, who influence purchasing power to secure the most optimal care at reasonable costs (Amadeo, 2018). Citizens are required to purchase their own coverage under the social health insurance model. Healthcare expenses are settled by employers deducting taxes from payrolls, to pool them into a government run health insurance fund to cover their employees (Amadeo, 2018). The government sets health insurance prices, which influences the privately run doctors and hospital prices. National health insurance is paid for citizens who are all covered by the same plan (Amadeo, 2018). Since there is only one insurance company, administrative costs are lower relative to the other models. Public insurance will pay for private care, the costs of which are influenced by the government (Amadeo, 2018). In contrast, providers and institutions in the private healthcare sector are neither owned or controlled by the government. They are also referred to as 'non-state actors' such as families, individuals and non-governmental corporations (World Health Organization, 2021). Recognition, scope, and definition are inconsistent, as is the quality of care as doctors may or may not be formally trained. Subcategories of privatized healthcare are: for profit or not for profit, formal or informal, and domestic or international (World Health Organization, 2021). Further including faith based organizations (FBOs), non-governmental organizations (NGOs), and civil society organizations (CSOs) (World Health Organization, 2021). Citizens pay for these services out of pocket, unless they have extended coverage (CBC News, 2006). About 27 million Canadians have private insurance to pay for prescription medicine, counselling, and dental care not covered under public healthcare (CMA, 2023a).

Universal Healthcare In Canada

The Canadian healthcare system is characterized by its universal public health program, known as Medicare, administered at the regional level and financed through federal and provincial tax revenues (Piamonte, 2023). While all residents are generally covered, additional insurance can be purchased for extra benefits, with two-thirds of Canadians opting for such coverage. Primary care is typically fee-for-service, with some alternative payment models (Lavis, 2016). As the healthcare needs of Ontarians

expand beyond traditional hospital-based and physician-provided services, there is a growing reliance on private financing, with 32% of total health spending in Ontario now coming from out-of-pocket payments, or premiums paid to private insurance plans. The largest government expenditures on the health system are directed towards the Local Health Integration Networks and the Ontario Health Insurance Plan. These allocations are periodically adjusted to align with health-system priorities, such as supporting interprofessional primary care. However, decisions regarding the coverage of products, services, populations, and costs publicly may inadvertently create disincentives for accessing care that falls outside of publicly covered services (Lavis, 2016). Canada's healthcare system provides universal access through the use of a health card, ensuring that all citizens receive necessary medical treatment regardless of financial status. This eliminates out-of-pocket expenses, benefiting low-income families, seniors, and those with chronic conditions. Moreover, it promotes social equity by offering vital services irrespective of income or health condition. The health card streamlines healthcare delivery, facilitates travel for treatment, encourages preventive care, and aids in public health management. However, challenges such as extended wait times for procedures and shortages of healthcare providers persist, particularly in rural areas, affecting the quality and timeliness of care and introducing healthcare disparities (CMA, 2023c). In 2020, Canadians had an average of 4.7 physician consultations according to Organization for Economic Cooperation and Development (OECD) data. In 2010, nearly half (45%) of Canadians could get a medical appointment the same or next day when sick. However, 65% found it challenging to access medical care after usual office hours. 41% waited two or more months to see a specialist, and 25% waited four or more months for elective surgery.

Additionally, 15% experienced access barriers due to cost, including failing to fill prescriptions or recieve recommended care (OECD, 2024).

Private Healthcare In The USA

Private for-profit is the main form of coverage in the USA. It has a variety of insurers and providers that are a mix of public and private, for profit and nonprofit (CMA, 2021). The Medicare program covers people older than 65 years of age, some individuals with disabilities, programs for children, government workers, people of low- income, the unemployed, and veterans (CMA, 2021). Medicare is financed through federal and state tax revenues via payroll tax and premiums. Insurance may be acquired through employers, purchased privately, government issued, or via health care programs (Boslaugh, 2013). Services are also paid out-of-pocket. Most plans cover physician services, hospital care, prescription drugs, and preventative care, yet not to the extent where bankruptcy due to medical expenses are unheard of (Boslaugh, 2013). Majorly, primary care is paid for on a fee-for-service basis, sometimes used in conjunction with a capitation system. Hospital payments are settled with a mixture of per-diem and case-based payments, yet generally do not cover physician costs (Boslaugh, 2013). Reports on access to care are varied, while getting clinical care for illness within 24-48 hours is attainable, the majority of people find it difficult to receive care after office hours. For specialist care, wait times can vary from two months to two years (Boslaugh, 2013). Even when seeing a specialist, their visits are often inconclusive or redundant, and patients leave misguided or insufficiently prepared for their prognosis (Boslaugh, 2013). Cost of specialist care frequently prevents people from accessing care as well. Barriers of this system result in lower quality of life and life expectancies, and larger health disparities between demographics of

people (CDC, 2023). An advantage to this system is that it works towards addressing the growing chronic disease crisis, and mitigating associated healthcare expenditures (Boslaugh, 2013).

Dual Healthcare In The UK

Provided by the government, all countries of the UK are a part of the NHS which provides access to universal healthcare based on clinical need, not ability to pay (European Observatory on Health Systems and Policies, 2022). Services are separately managed by each country (Boslaugh, 2013). All individuals residing in the UK, regardless of their nationality or immigration status, are automatically entitled access to emergency and psychiatric care without charge. However, only “ordinarily residents” have coverage for secondary care services (European Observatory on Health Systems and Policies, 2022). The NHS is dominantly funded through general taxation of residents (Tikkanen et al., 2020). A dual system exists beside the NHS, as most hospitals are owned by the government, yet there are also private hospitals. Physicians may be employed by the government, while others are paid through government fees (Boslaugh, 2013). The NHS provides public health insurance under the aforementioned parameters, while ~10.5% of the UK (estimated in 2015) opted for private health insurance (Tikkanen et al., 2020). Private insurance is offered by employers, or is individually purchased. With private insurance, access to care is more expedited, has a wider choice of specialists, and better amenities. Despite these benefits, most policies ignore mental health, maternity services, emergency care, and general practice (Tikkanen et al., 2020). Under this dual system, from 2009-2010 the vast majority of people report access to clinical are within 24-48 hours, yet it is more difficult to access care after office hours. Around 20% of people report excessive wait times for specialized care or elective surgery (Boslaugh, 2013). Only 5% report a barrier due to costs. 14% of patients report inadequate specialist care, while half of people from the same cohort experienced insufficient information about their healthcare plan after discharge (Boslaugh, 2013). Despite the seemingly underperformance of the NHS, it standardizes healthcare costs in all UK regions, many services are free or highly subsidized, and private services are generally more affordable than those in the USA (Zieff et al., 2020).

The Universality Gap

In the current Canadian context, the universality guaranteed by the Canada Health Act is frequently praised by both the general population and politicians. In theory, every citizen carries the ability to access healthcare, yet lengthy wait lists for specialists and primary care limit true universality. Furthermore, geographical differences (i.e., rural versus urban), exclusions for specific covered services such as dental and vision care and differences in provincial health care plans, limit both the comprehensiveness and portability of the revered Canada Health Care (Boslaugh, 2013).

Regarding insurance payments, each provincial government in Canada acts as a single entity responsible for paying for healthcare services. This involves establishing fee schedules for healthcare providers and ensuring access to healthcare resources for residents of the province. Medical malpractice is also a fraction of the cost, primarily due to the absence of a personal injury/medicolegal culture in Canada driven by variations in tort laws (Arneja & W Buchel, 2014). Contrarily, healthcare in the USA is managed by multiple regional private or public insurers and the administration of these services differs from state to state. Individual practitioners often have to ‘carry the cost’ associated with insurance authorizations. Additionally, at each level of assessment and treatment, medicolegal ramifications influence diagnostic and treatment decision making (Arneja & W Buchel, 2014). For the great majority of patients, the system offers several advantages such as more hospitals, closer patient proximity to medical care, plentiful

resources with limited wait times for diagnostics and treatment. Obamacare, the Affordable Care Act, has been addressing the 'universality gap' between the United States and Canada (Arneja & W Buchel, 2014).

Optimization of Canadian Healthcare

To evolve our current system, Canadian healthcare can attempt to take lessons from various countries; however, such policies may not be translated due to variable political pressures. For instance, the idea of expanding a second tier that could offload the public system, improve access, develop efficiencies and deliver specialty care has been halted due to negative public perceptions of healthcare privatization.

Thus, evolution to the ideal healthcare system necessitates politically and fiscally acceptable changes to the broader population and congruence at the provincial and federal levels of government. Establishing provincial Crown health corporations could offer several benefits, including maintaining public oversight and garnering political acceptance. Specifically, such entities could prioritize enhancing quality and accessibility in healthcare. Crown corporations are wholly owned federal or provincial organizations that are structured like private or independent companies (Arneja & Buchel, 2014). For example, within the healthcare context, these corporations would be tasked with operating hospitals, clinics or other healthcare facilities on behalf of the government. Within the healthcare sector, they may serve to enhance transparency and accountability while ensuring prudent fiscal management (Arneja & Buchel, 2014). Despite government oversight, these corporations could reduce political interference that often hampers healthcare systems. Over time, they could explore privatizing certain aspects of care through public-private partnerships, fostering a competitive marketplace and benefiting both the system and its consumers.

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