Free essay on the adverse effects of nationalized health insurance in britain and...

Countries, Canada

Loss of health decision choices as well as lack of privacy

The government has control over the individual’s records and decision choices. Basically, all the individual records that pertain to health are computerized for government access to increase accountability. The records are linked and accessed by doctors, hospitals, pharmacies, private insurers and other health care authorities. Such plethora of information and lack of privacy is open to misuse and is probable to be copied or transmitted electronically.

Equally, putting health records in a single database make individuals’ health records public. This increases the odds for break-ins by computer hackers and in effect, more doors to a number of untoward illegal or at the very least unpleasant events. As a result, government officials will claim forceful interest in areas considered private (Fleming, 2006).

Similarly, the government bureaucracy stands between a patient and their respective doctors and the autonomy of the patient is highly controlled. In essence, as opposed to basing decisions on the care, doctors base their decisions on cost because of government rulings. Such rulings may pose negative ramifications for patients. This results in loss of health decisions.

Decline in the quality of health care

It brings an apparent free health care to the masses. A health treatment that costs little or nothing attracts higher demand. As the demand for treatment increases, the accumulation of the burgeoning numbers of patients also increases. In Britain, for instance, people have to queue for hospital care

while in Canada they have to wait seventeen weeks to see a specialist after having obtained a referral from their doctor. This signifies poor hospital care delivery to the masses.

The skyrocketing demand for treatment burdens medical practitioners, healthcare workers and services. As a result, the quality of health care services and care deteriorates. Due to stiff demand and a larger ratio of patients to doctors, patients are allocated shorter time (Wollstein, 1992). Definitely, such a shorter time means poor judgment of treatment and quality of care. Doctors available thus have to work extra hours. Because of nurses and doctors shortage, hospitals are forced to farm out patients or put off certain health care services for some period.

The shortage of up-to-date medical equipment and the poor conditions of health care facilities result in low quality of healthcare. The government controls funding for upgrade of facilities and equipment and constantly strives to cut down costs. To completely minimize such costs, lowest bidders are awarded tenders for equipment and health facility cleaning as opposed to the most able bidders. In effect, a decline in service is realized.

Creation of new inequalities which take different bias forms

Wollstein (1992) noted that rural populace is less likely to receive specialized medical treatment than those living in major cities. Those living in cities, for instance in Vancouver, have higher chances of receiving referral to a specialist than one who lives in rural place like East Kootenay. Rural patients

have to wait for longer before they receive specialized treatment like heart surgery.

The government cut in both Britain and Canada have make elderly patients without money go without healthcare until they reach a crisis status that force them to be be admitted to the hospital. On the contrary, those with money have access to long term home health services. Also, elderly patients are likely to be denied full treatment in case the process is deemed cost effective (Tanner, 2008). Basically, there is bias in long term home health services and care (Fleming, 2006).

Those who have money or have governmental contacts are able to receive faster and better healthcare. The rich and doctor’s family friends receive faster treatments. Politicians and prominent people also have an upper hand in access to treatment. They easily jump the queues ahead of the elderly and the poor. In Britain, there is favoritism of Members of Parliament. They are granted exclusive primary care. On the contrary, those in the public domain are not granted such benefits (Fleming, 2006).

In conclusion, a health insurance deemed free escalates demand and the government devises ways of controlling costs either by overt or implied rationing. To the masses, such costs include loss of patient autonomy and privacy, decline in healthcare quality in terms of terms of equipment, facilities and access to health care. Besides, there is creation of inequalities such as bias to the poor, elderly and the minor groups, as well higher favoritism towards well connected individuals.

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