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| International Health Systems |
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# Learning Objectives

If healthcare systems were to choose a common mission statement, it would probably be the following: “We provide universal access to high quality healthcare based on need regardless of ability to pay.” Today, this statement is largely accepted around the world, but it raises fascinating questions on how this mission is achieved.

An essential starting point is the understanding of the aims and principles on which healthcare systems are built. What are the typical building blocks and how are systems governed to respond to changing needs? How are they held accountable if needs are not met? The second section of **International Health Systems** looks at healthcare systems from a delivery point of view: What are general principles regarding the organization of primary care, specialist care, inpatient care, and the pharmaceutical sector? Once this basis is established, general trends regarding the medical workforce are analyzed. This topic ranges from medical education to the distribution of the medical workforce across a territory. Next, efficiency considerations and equity are examined. When healthcare resources compete with other political priorities, such as housing, transportation, and defense, questions regarding the efficiency of healthcare expenditure become relevant. Are cross-country comparisons of healthcare system efficiency meaningful? If so, under what conditions?

Throughout the course book, cross-references to national healthcare system strategies are used to make topics such as equity, efficiency, and service organization tangible. However, a dedicated presentation of national healthcare systems is reserved for the final part of this course. Three models of healthcare organization in a national setting are presented: the German social health insurance model (“Bismarck” model) the British National Health Service or “Beveridge” model, and the more market-based healthcare system of the United States. A brief review of healthcare systems in emerging countries concludes the course book.

# Unit 1 – Healthcare Systems Internationally: Politics, Economics, and Policy?

**Study Goals**

On completion of this unit, you will be able to …

… understand aims and principles of healthcare systems.

… identify major building blocks of healthcare systems.

… analyze how healthcare systems are governed.

… describe contextual factors impacting healthcare systems.

# 1. Healthcare Systems Internationally: Politics, Economics, and Policy?

## Introduction

Caring for health needs is part of the human condition. Inevitably, humans had to develop organized or ritualized ways of maintaining good health since the dawn of humankind. Most modern-day healthcare systems are built on the principle of universal access to care based on need, not ability to pay. They provide state of the art medical services based on a scientific and mechanistic view of human health, resulting in the high specialization of medical services.

A comparative lens on healthcare systems benefits from a clear description of typical healthcare system building blocks. On an abstract level, health systems organize resources (workforce, capital, and technology) to provide services to the population. The World Health Organization (WHO) calls these components building blocks ([World Health Organization, 2010](#_ENREF_48" \o "World Health Organization, 2010 #53)).

Healthcare systems are also embedded in a wider cultural and social context, which determines the shape and priorities of healthcare systems. It also limits their ability to achieve a perfect state of health and well-being for every citizen due to socio-economic determinants of health. Acknowledging these determinants has led to a “health in all policies” approach that integrates housing, the labor market, the transportation policy, and many more.

To conclude this unit, issues of healthcare system governance are raised. How do political priorities translate into healthcare policy? The policy cycle is a useful analytical tool used to understand how strategy translates into policy that is implemented, evaluated, and eventually revised.

## 1.1 Aims and Principles of Healthcare Systems

Modern day healthcare systems need to balance competing requirements of cost, quality, and access, while staying true to their commitment to provide healthcare to the population. Understanding the historic roots of healthcare systems and the many aspects of health is important when considering current healthcare system challenges.

### Roots of Healthcare Systems

Healthcare systems have a long history. Ancient civilizations, such as Mesopotamia and Egypt, had rules about healthcare delivery. In Europe, the spread of Christianity and monasteries gave rise to early forms of institutionalized healthcare and, later, hospital-focused care ([Mills, 2018](#_ENREF_29)). Guilds were also an important social basis for solidarity in communities; they organized healthcare on their members’ behalf. The German public health insurer “*Knappschaft*” was founded by a medieval association of miners with the first traces of a hospital dating back to the late thirteenth century ([Knappschaft Bahn-See, 2022](#_ENREF_25)).

Definitions and models of health have also changed over time. Adinolfi (2014) describes pre-modern concepts of healthcare and healing as theurgical and magical models. He underlines that the connection of man with supernatural powers was at the center of medical reasoning, rather than a rational method. As a result “[healers] acted not by virtue of scientific knowledge, but thanks to a supernaturally endowed gift; therefore, they were not schooled in the art of medicine, but rather were consecrated by ancestral faith healers” ([Adinolfi, 2014, p. 226](#_ENREF_1)).

In the absence of actual “healing,” it becomes apparent that the aim of historical models of healthcare was not a reestablishment of perfect health in our current understanding. Rather, healthcare systems in the past were self-organized solidarity communities (in the case of the aforementioned *Knappschaft*) that sought to prevent an economic catastrophe for workers.

### Health and Healthcare

It seems almost trivial to state that the aim of healthcare systems is to enable good health, but is this a good starting point for healthcare systems research? A look at the World Health Organization’s (n.d.-a) definition of health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” ([p. 1](#_ENREF_45)) raises more questions than it answers. What are the inputs into such an ideal state of health? Are they individual behavior, the environment, genetics, and social interactions? Is it realistic to expect healthcare systems to provide for or even influence all these inputs? International healthcare systems are not and cannot be organized for such a mission. Instead, a commonly accepted WHO definition of the purpose of a healthcare system is to improve health. Improvement of health depends on access to healthcare services. If and how these are used is determined by organizational and individual factors. A useful concept is the “**co-production of health**” continuum that places the individual on a range between their citizen role, where lifestyle and prevention activities dominate health, and a telemdicine assisted patient who is being cared for in the hospital ([Kalra et al., 2014, p. 185](#_ENREF_24)). It clearly shows that the health system role in the “production of health” is a small part of this continuum.

**Co-production of health**

An individual can co-produce their state of health by engaging in healthy lifestyles in addition to seeking care.

In line with the idea of improving health, healthcare systems tend to focus on a continuum of activities ranging from disease prevention to treatment and rehabilitation. The implied objective is to prevent the onset or worsening of disease, treat diseases that manifest themselves, and tackle the consequences of infirmity. To this day, the prevention dimension of healthcare systems is the most poorly developed because of the various factors that contribute to good health: a clean environment, personal hygiene, a balanced diet, physical activity, education, and wealth.

It is therefore unsurprising that the infrastructure of healthcare systems, doctor’s offices, hospitals, pharmacies, and rehabilitation clinics all focus on the treatment of diseases and rehabilitation. This can be explained by multiple historic factors. A key motivation for the introduction of the social health insurance model in Germany under chancellor Otto von Bismarck (1815-1898) in the 1880s was addressing the growing social plight of industrial workers ([Greve, 2006, p. 23](#_ENREF_20)). The devastating effects of accidents and infirmity in the German industrial revolution had created a workers’ movement with political clout that threatened the political status quo. It is not entirely unfair to argue that the aim of Bismarck’s health insurance model was the preservation of an individual’s ability to work and provide for a family. Hence, the financing principle of joint employer and employee contributions into a mandatory insurance scheme was introduced, which was soon complemented by an accident and retirement insurance scheme ([Blümel et al., 2021, pp. 14-15](#_ENREF_5)).

### Access Cost and Quality as Benchmarks

A healthcare system that is improving health through a collection of healthcare services can be analyzed across three dimensions from which the principles in the introduction are derived ([Johnson et al., 2017](#_ENREF_22)):

1. Access and coverage
2. Cost and affordability
3. Quality

The access and coverage dimension deals with the accessibility of healthcare services. This can have an organizational and a financial dimension. In health insurance systems, access and coverage relate to the groups of people that are covered by health insurance. Is access limited to the working population that pays insurance contributions? What about special population groups, such as the homeless, prisoners, military personnel, or civil servants? In many countries, separate access and coverage rules exist for different population groups. Tax-financed systems tend to work on the principle of universal coverage for all population groups with services provided for free at the point of care. Even if financial access to care is ensured, access to care may have a socio-economic and organizational dimension. On this level of analysis, healthcare systems research deals with the distribution of healthcare resources across a territory and barriers to access that are due to health literacy problems or socio-economic disadvantages. The table below summarizes typical indicators used to measure access and coverage from both supply and demand sides.

Access and Coverage Indicators

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|  | Access indicators | Coverage indicators |
| Supply side | Availability of healthcare resources (general practitioners [GPs], specialists, nurses, and medicines)Geographical distribution (hospitals within a 30-minute drive, GPs, or pharmacies within public transport reach) | Existence of a health insurance system (public or private)Share of co-payments or out-of-pocket payments, and role of deductiblesExistence of mandatory insurance coverage |
| Demand side | Citizens’ understanding of their own health problems and ability to seek access to care when needed | Share of people opting out of insurance (usually not relevant due to mandatory coverage laws in most countries) |

### Self-Check Questions

1. Please identify all statements that apply to the relationship between healthcare systems and health.

Healthcare systems guarantee the perfect health of individuals.

*Healthcare systems provide access to healthcare services.*

Healthcare systems are a modern invention.

1. The indicator “number of general practitioners per 100,000 population” is an example of which of the following?
* a coverage indicator
* *an access indicator*
* a demand side indicator
1. Please complete the following sentence.

Access, cost, and *quality* are benchmarks for healthcare system performance.