Health Systems

PUBLIC HEALTH. LECTURE 9.

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Evolution of HS

Ancient centuries: town doctors

Middle Age: church's aid

Renaissance: medieval associations of craftsmen and merchants (Guilds) bought medical services

1881, Germany, Chancellor Bismarck - first national medical insurance programme for workers and military

1888 - Austria, 1891 - Hungary, 1910 - Norway

1911, Great Britain, Prime Minister David Lloyd-George - national health insurance system

1918, USSR, Semashko N.A. - free health care for all

1942 – GB, national Emergency Medical Services, hospitals escaped from bankruptcy resulting from the Great Depression

W. Beveridge – programme post-war social reconstruction outlined future national health system (1948)

1946 – Canada, tax based national health insurance

1965 - USA, Medicaid, Medicare

Important Distinctions

Health vs. Health Care

- *Health* refers to a state of the human body and mind
- *Health Care* refers to chemicals, devices, and services used by people to improve their health

Health insurance

- A system of paying for unpredictable needs for health care

Definition of systems

Economic systems

- a collection of economic units, agents, and institutions that interact coherently; adapting and adjusting to the social and physical environment

Health systems

- economic systems that are concerned with human health

Basic Definitions

Economic Units

- groups of individuals brought together for a common purpose

Economic Agent

- an individual with a specific role in the system, e.g. a patient, a nurse, a manager

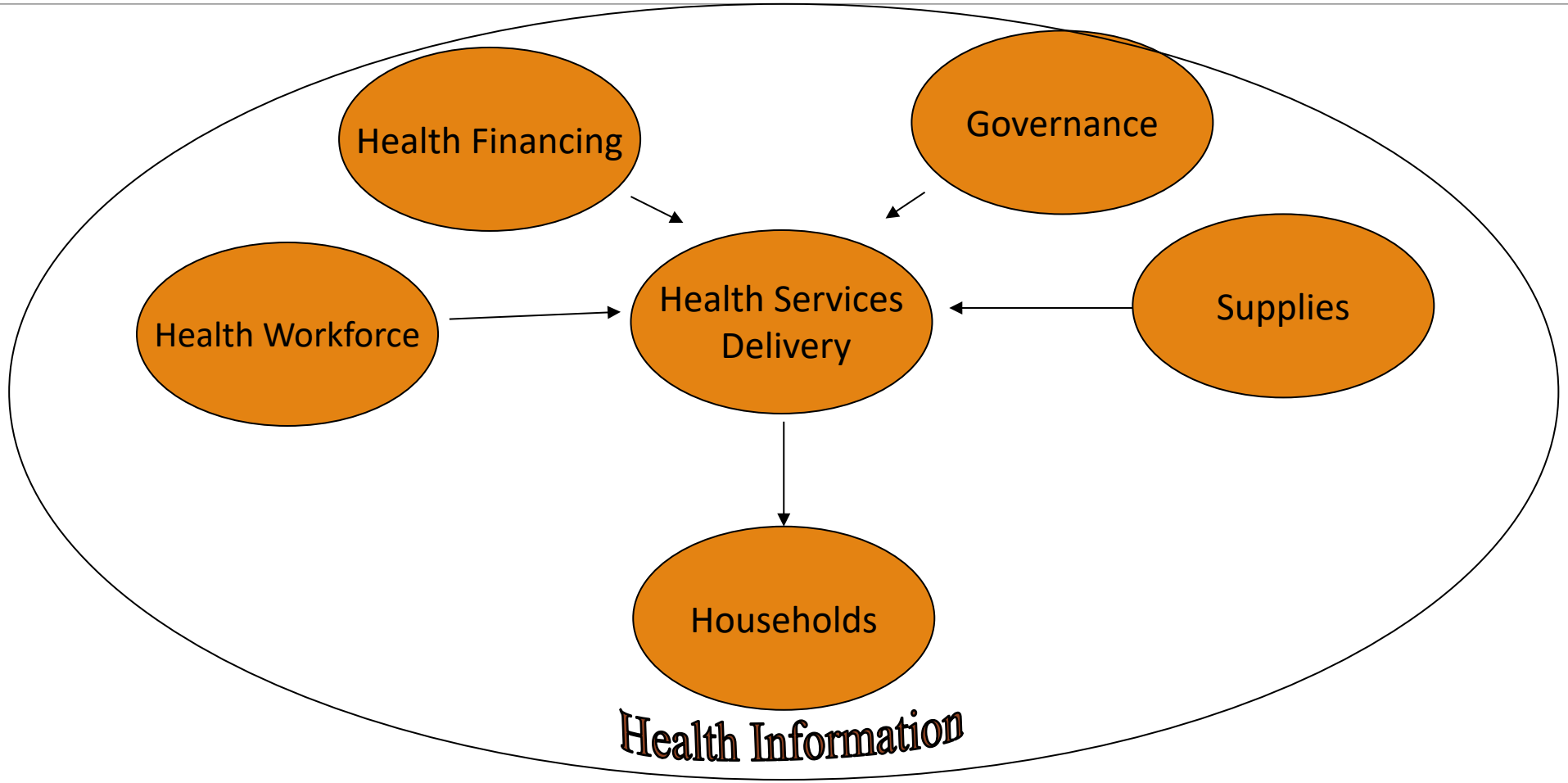
Institutions

- Norms, rules of conduct, established procedures e.g. property, corporations, paying fines, tipping waiters

Health Systems

	Units	Agents	Institutions
Basic Health Subsystem	***Organ Systems***	***Organs***	***Physiology***
Health Service Delivery	Clinics Hospitals Laboratories	Doctors Nurses Administrators	Professional autonomy Peer review
Health Information Systems	Sentinel laboratories Reporting from districts Health surveys	Registration clerks Survey data collectors	Data quality check systems Dissemination procedures Evidence to policy

Centrality of Health Services



Participants In National Health Systems

Government - national, state and local health authorities;

Employers - through negotiated heath benefits for employees;

Insurers - public, not-for-profit and private for-profit;

Patients, clients or consumers - as individuals or groups - population; Risk groups - persons with special risk factors for disease e.g. age, poverty;

Not-for-profit and for-profit providers: hospitals, managed care plans, medical, dental, nursing, laboratories, others;

Teaching and research institutions;

Professional associations;

Social security systems;

Political parties;

Advocacy groups - age, disease, poverty or public interest groups;

The media;

Economies - national, regional and local;

International health organizations and movements;

Pharmaceutical and medical technology industries.

Governments, Markets, NGOs affect Reach

Governments (MOH)

- Government decides location of workers located in space
- "Command and control" incentives
  - Service obligations
  - Constructing, buying, new facilities
- Political factors and population needs enter these decisions

Markets

- Primary service agents seeking revenue
- Looking for patients with ability and willingness to pay
- Assessing competition

NGOs

- Organizations locate facilities and hire staff
- Population needs and organizational convenience enter decisions
- Impact capacity of governments and markets by hiring away their staff

Government Institutions

Hierarchical levels of decision making

- Center, province, district
- Decision-making can be centralized or decentralized

Budgets need to be allocated across primary, secondary, and tertiary services

- National hospitals, provincial hospitals, health stations
- Costs escalate at hospitals

Hospitals

Hospitals and politics

- Hospitals have economic gravity
  - Impact hundreds of health worker livelihoods
  - Supply chains and financing infrastructures are hard to change
- Hospitals have political gravity
  - Civic pride
  - Sense of security for middle/upper class

Hospitals have limited preventive impact, limited relevance to 98% of clinical problems

Population, GNI per Capita, Health Facilities and Utilization and Health Indicators, 2015-20

Countries	Population (millions) 2018	Health expenditure per capita US $ /% of GDP, 2017	% GNI for Health 2018	Hospital Beds/1000 2015	Average Length of Stay (days) 2017	Maternal mortality/ 100,000 live births, 2017	Infant Mortality/ 1,000 live births 2018	Life expectancy, 2018
USA	326.7	10,246/17.1	13.5	2.9	5.5	19	6	79
India	1352,6	69/3.5	9.2	0.7	4.3	145	30	69
Kyrgyz R.	6.5	79 /6.2	8.6	4.5	5.2	60	17	71
Pakistan	212.2	45/2.9	10.4	0.8	6	140	57	67
Finland	5.5	4,206/9.2	7.2	4.4	6.4	3	1	82
Denmark	5.8	5,800/ 10.1	7.4	2.5	6.1	4	4	81
Israel	8.9	3,145/7.4	8.0	2.4	5.1	3	3	83
UK	66.5	3,859/9.6	6.7	2.8	5.9	7	4	81

Basic functions of a state

- State policy in public health protection

Regulation, political assurance

Objectives/goals of national public health

Social policy

- Financing
- Resources provision
- Monitoring and scientific investigations
- Regulation and epidemiological control
- Health protection and health promotion

Types of national health systems

Type	Financing Source	Administration
Bismarckian health insurance through social security e.g. Germany, Japan, France, Austria, Belgium, Switzerland, Israel	Compulsory employer-employee tax payment to Sick Funds or through Social Security	Germany - governments regulate Sick Funds which pay private services; strong Sick Fund and doctor's syndicates; Israel's Sick Funds compete as HMOs with per capita payments for mandatory basket of services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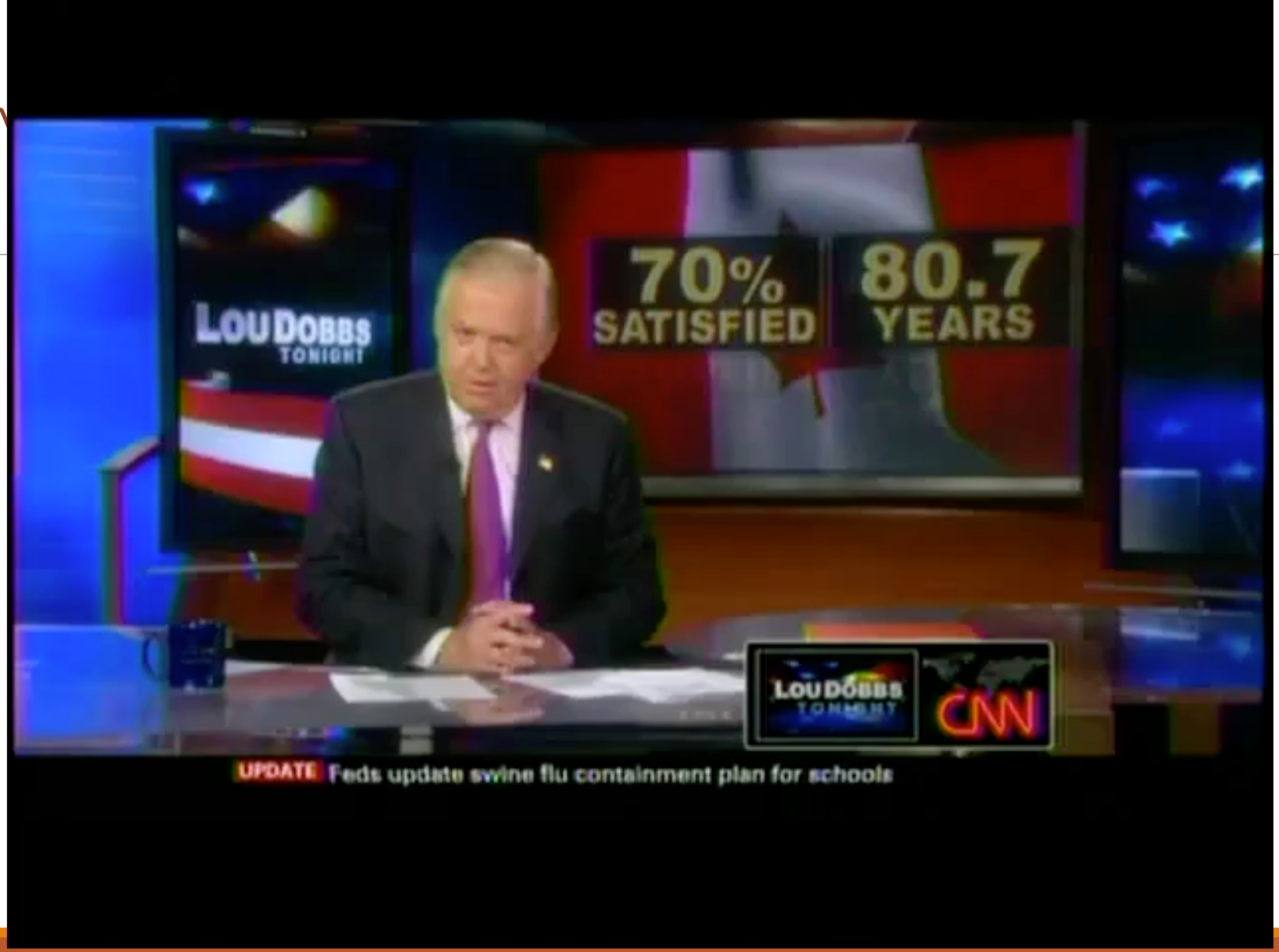
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Beveridge National Health Service e.g. United Kingdom, Norway, Sweden, Denmark, Italy, Spain, Portugal, Greece	Government - taxes and revenues; UK national financing Nordic countries combine national, regional and local taxation	Central planning, decentralized management of hospitals, GP service and public health; integrated district health systems with capitation financing in UK
Semashko national health systems e.g. former USSR	Government - taxes and revenues; post Soviet national health insurance	Central government planning and control; Financing by fixed norms per population; allocation of facilities and manpower promote increase in hospital beds and medical staff; Post 1990 reforms emphasize decentralization with capitation and compulsory health insurance i.e. payroll taxation

Douglas national health insurance through government e.g. Canada, Australia	Taxation - cost-sharing between provincial and federal governments	Provincial government administration; federal government regulation; medical services paid by fee-for-service; hospitals on block budgets; reforms to regionalize and integrate services
Mixed private/public system e.g. United States; Latin America (e.g Colombia), Asia (e.g Philippines) and African countries (e.g. Nigeria)	Private social insurance through employment and public insurance through Social Security for specific population groups	Strong government regulation (US); mixed private medical services, public and private hospitals, state/county preventive services; DRG payment to hospitals, rapid increase in managed care; extension of Medicaid coverage