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HEALTHCARE SYSTEM TYPOLOGY

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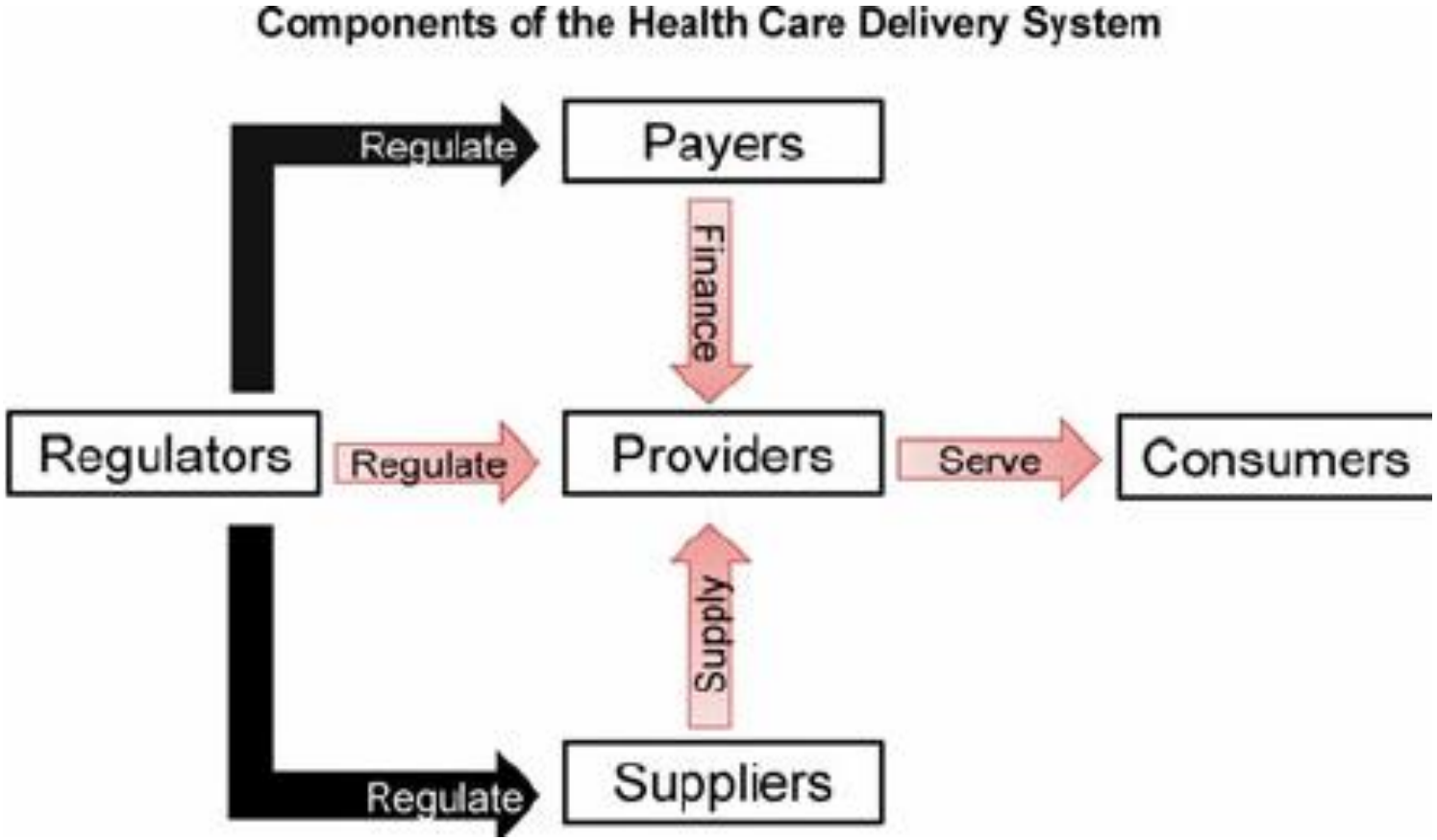
Health service or health care system

- Institutions of society that deliver health services
- the channels used to deliver health care services to the human population.
  - Micro level- hospitals, clinics, private practitioners
  - Macro level- medical, dental, nursing services etc

Healthcare systems

- “organizations that both deliver care and medical services (hospitals, physicians’ practices, clinics) and that arrange for the financing of care (governments, agencies, states, local communities, and private insurance companies).

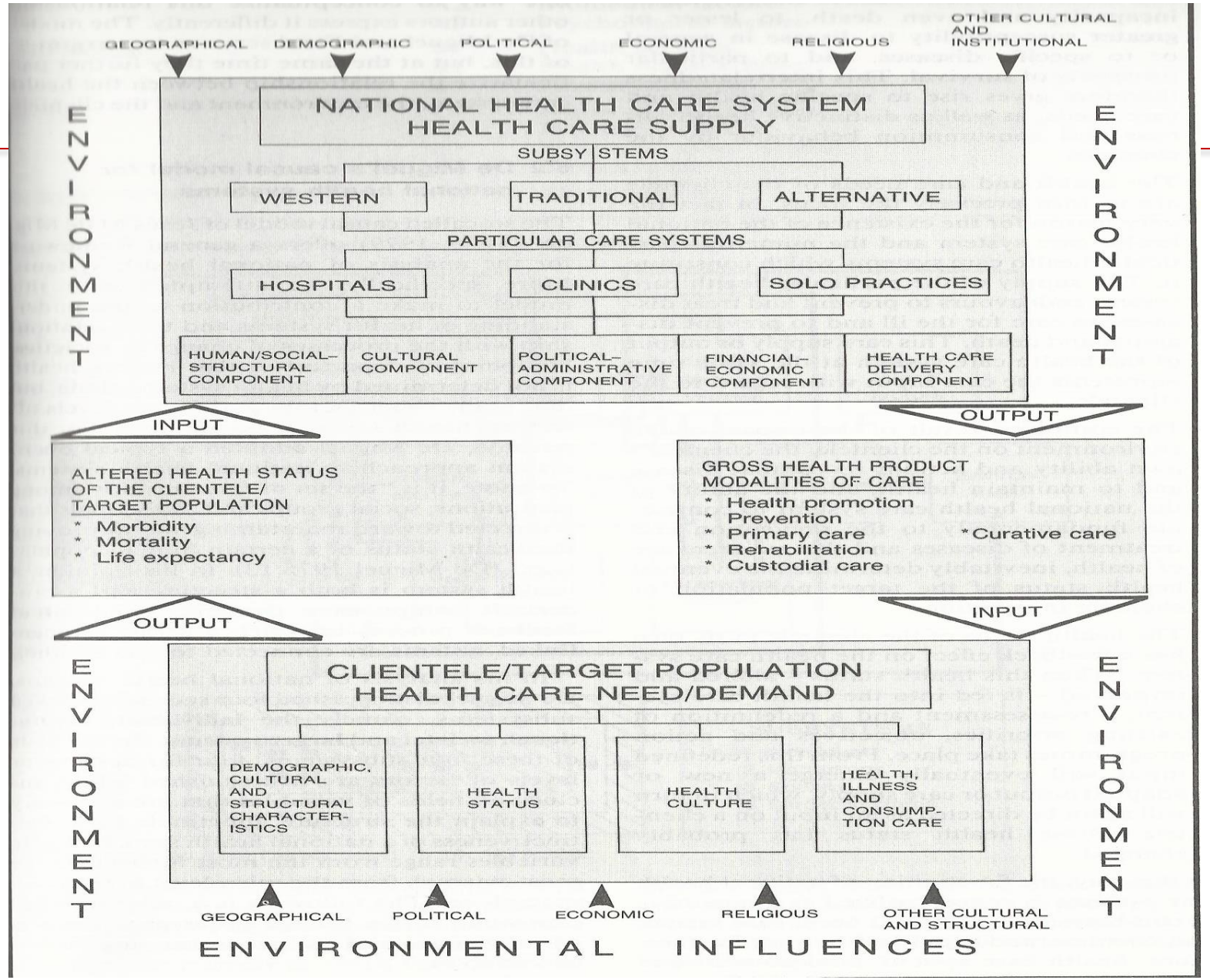

Components of the Health Care Delivery System
Regulate
Payers
Finance
Regulators
Regulate
Providers
Serve
Consumers
Supply
Regulate
Suppliers

OBJECTIVES OF HEALTH CARE SYSTEM:

- To improve health status of population and clinical outcomes of care
- To improve social justice equity in the health status of the population
- To reduce the total economic burden of health care
- To raise and pool the resources accessible to deliver health care services

National healthcare system

- Total network or system of services (Policies, programmes, institutions and actors) that provide health care in a specific country
  - Includes official delivery system
  - Traditional health services


GEOGRAPHICAL
DEMOGRAPHIC
POLITICAL
ECONOMIC
RELIGIOUS
OTHER CULTURAL AND INSTITUTIONAL
ENVIRONMENT
NATIONAL HEALTH CARE SYSTEM
HEALTH CARE SUPPLY
SUBSYSTEMS
WESTERN
TRADITIONAL
ALTERNATIVE
PARTICULAR CARE SYSTEMS
HOSPITALS
CLINICS
SOLO PRACTICES
HUMAN/SOCIAL–STRUCTURAL COMPONENT
CULTURAL COMPONENT
POLITICAL–ADMINISTRATIVE COMPONENT
FINANCIAL–ECONOMIC COMPONENT
HEALTH CARE DELIVERY COMPONENT
ENVIRONMENT
INPUT
OUTPUT
ALTERED HEALTH STATUS OF THE CLIENTELE/ TARGET POPULATION
* Morbidity
* Mortality
* Life expectancy
GROSS HEALTH PRODUCT
MODALITIES OF CARE
* Health promotion
* Prevention
* Primary care
* Rehabilitation
* Custodial care
*Curative care
INPUT
OUTPUT
ENVIRONMENT
CLIENTELE/TARGET POPULATION
HEALTH CARE NEED/DEMAND
DEMOGRAPHIC, CULTURAL AND STRUCTURAL CHARACTER-ISTICS
HEALTH STATUS
HEALTH CULTURE
HEALTH, ILLNESS AND CONSUMP-TION CARE
ENVIRONMENT
GEOGRAPHICAL
POLITICAL
ECONOMIC
RELIGIOUS
OTHER CULTURAL AND STRUCTURAL
ENVIRONMENTAL INFLUENCES

Components of the National Healthcare system

- Internal determinants
  - Human Resources
  - Cultural
  - Political-administrative
  - Financial-economic
  - Care

External determinants

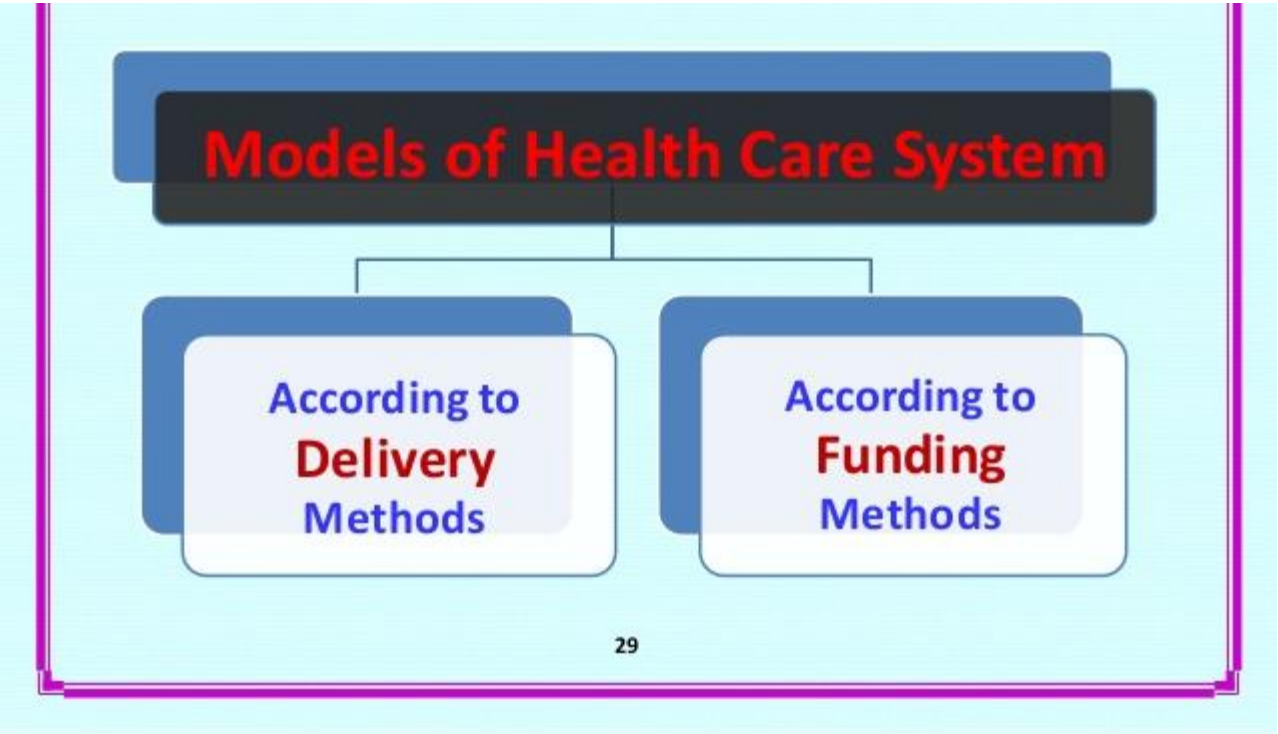
- Socio-cultural
  - Historical context of countries development
  - Economic climate
  - Political
  - Religion
  - Cultural beliefs

Natural environment- Demography and climate

- Climate
- Rainfall
- Temperature
- Topography
- Vegetation
- Structure of the population

National healthcare systems- Types and typologies

- Healthcare systems of countries display enormous variation
- No single uniform scheme of classification
- No pure types exist in practice
- Healthcare systems not static


Models of Health Care System
According to Delivery Methods
According to Funding Methods
29

Types of healthcare systems

- Milton Terris (1978)
  - Public assistance
  - National health insurance
  - National Health Service

Public Assistance

- Pre-capitalistic countries
- Economy is predominantly agricultural
- Land ownership is tribal
- Health services financed by taxes
- Few personnel, overworked and involved in private practice
- Population served in state hospitals or health centres
- Developing countries in Africa, Asia and Latin America

National Health Insurance system

- Industrialised countries
- Capitalistic economies
- Healthcare is managed by state and private insurance schemes
- Based on fee-for service private providers
- Doctors and other practitioners are entrepreneurs
- Contract with state or authorised medical schemes

National Health service system

- Provide services in form of salaried health personnel at state hospitals and clinics
- Financed out of state budgets- income tax
- Services provided free of charge
- National, Regional and local levels are responsible for all health services
- Community participation, primary healthcare and sectorization of services enjoy high priority
- Russia, Cuba and South European countries

Five Field typology

- Field- 1980
  - Anomic (Emergent system)
  - Pluralistic
  - Health insurance system
  - National health service system
  - Socialised health system

  - based on ownership and doctors' autonomy

Table 1.1 Field's five-part typology of national health care systems

Health system	Type 1 Emergent	Type 2 Pluralistic	Type 3 Insurance/ Social Security	Type 4 National Health Service	Type 5 Socialised
General definition	Health care as item of personal consumption	Health care as predominantly a consumer good or service	Health care as an insured/ guaranteed consumer good or service	Health care as a state-supported consumer good or service	Health care as a state-provided public service
Position of the physician	Solo entrepreneur	Solo entrepreneur and member of variety of groups/ organisations	Solo entrepreneur and member of medical organisations	Solo entrepreneur and member of medical organisations	Solo entrepreneur and member of medical organisations
Role of the professional associations	Powerful	Very strong	Fairly strong	Fairly strong	Weak or non-existent
Ownership of facilities	Private	Private and public	Private and public	Mostly public	Entirely public
Payments	Direct	Direct and indirect	Mostly indirect	Indirect	Entirely indirect
Role of polity	Minimal	Residual/indirect	Central/indirect	Central/direct	Total
Prototypes	Russia, US, western Europe in 19th century	South Africa, Switzerland, US in 20th century	Canada, France, Italy, Japan, Spain, Sweden,	Australia, UK in 20th century	Cuba, eastern Europe, USSR in 20th century

Roemer fivefold typology

- Under-developed systems
- Transitional systems
- Modern systems
  - Free market
  - Welfare state
  - Socialist system

Under-developed

- Resources are extremely deficient
- Majority of population outside the reach of health system- dependant on traditional healers
- Social insurance absent
- Hospitals found in large towns-operated by government with salaried personnel
- Population predominantly rural, impoverished and illiterate
- Predominantly infectious diseases

Transitional

- Majority of population live in poverty stricken condition
- Modest structure of organised service developed
- Beginning of social insurance

Free-enterprise system

- Predominantly free market
- Health services are bought and sold
- Distribution of service dependant on purchasing power
- Minimal state intervention
- Private sector play a huge role

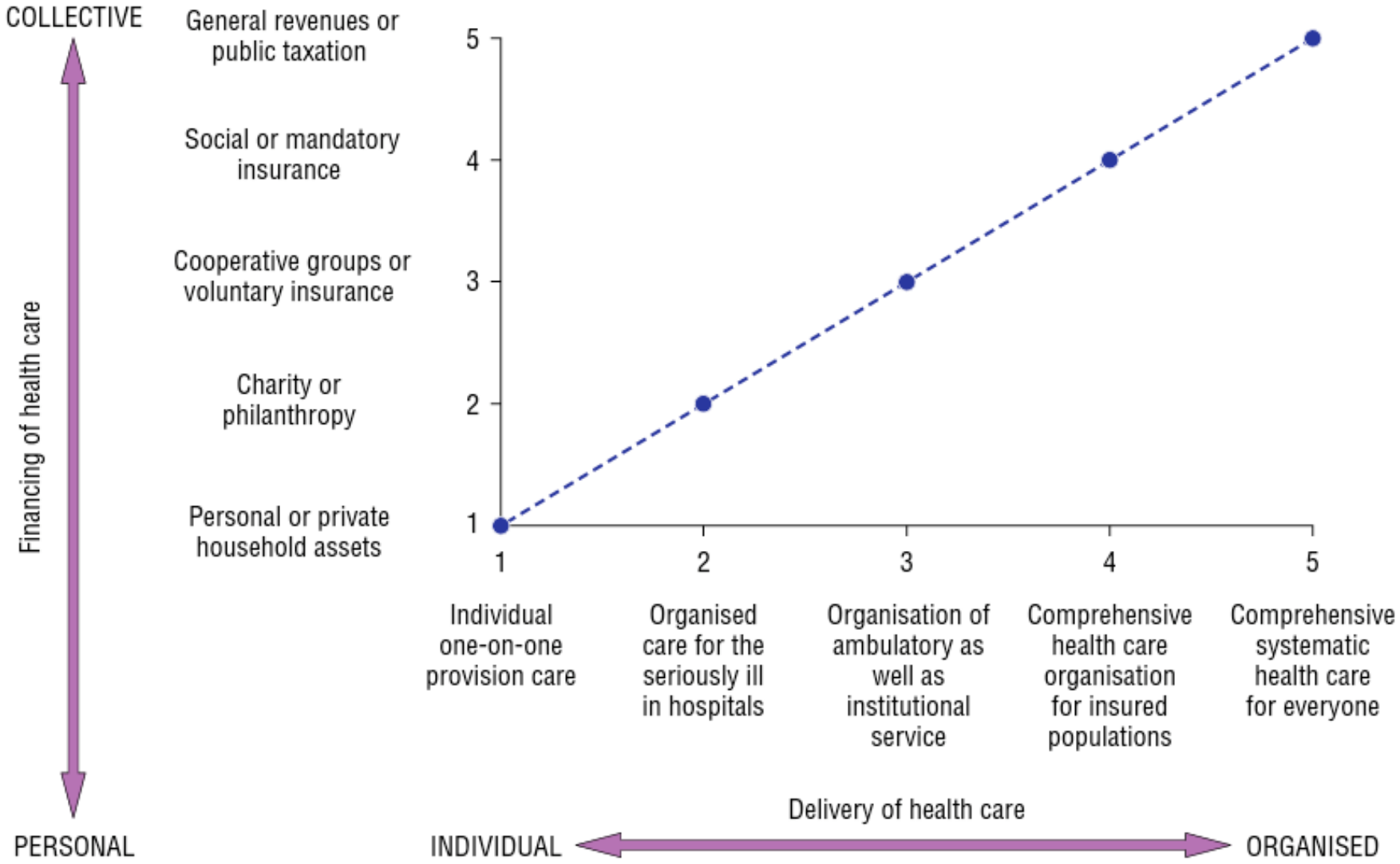
Welfare state system

- Government assumes responsibility for assuring health services for majority of population
- Collective financial responsibility- by social insurance
- Provision of services largely in private hands with variety of state measures to control cost
- Hospitals under state control with salaried personnel
- Majority of doctors are GPs
- Provision of preventive services separate from curative services

Socialist system

- Comprehensive health services free of charge to all citizens
- Healthcare is a right
- Health service is a public good
- All personnel employed as civil servants
- All facilities owned by government
- Preventive and curative services provided in one channel

Figure 1.1 Roemer's typology of national health care systems



Source: Adapted from Roemer 1980.

Different Healthcare Models

- Each nation's health care system is a reflection of its:
  - History
  - Politics
  - Economy
  - National values
- They all vary to some degree

Based on the source of their funding, three main models of national healthcare systems can be distinguished:

1. the Beveridge model,
2. the Bismarck model
3. the Private Insurance model

1. THE BISMARCK MODEL

- **Germany, Japan, France, Belgium, Switzerland, Japan, and Latin America**
- **Named for Prussian chancellor Otto von Bismarck, inventor of the welfare state**
- **Characteristics:**
  - Providers and payers are private
  - Private insurance plans – financed jointly by employers and employees through payroll deduction
  - The plans cover everyone and do not make a profit
  - Tight regulation of medical services and fees (cost control)

2. THE BEVERIDGE MODEL

- **Named after William Beveridge – inspired Britain's NHS**
- **Great Britain, Italy, Spain, Cuba, and the U.S. Department of Veteran Affairs**
- **Characteristics:**
  - Healthcare is provided and financed by the **government**, through tax payments
  - There are no medical bills
  - Medical treatment is a public service
  - Providers can be government employees
  - Lows costs b/c the government controls costs as the **sole payer**
- **This is probably what Americans have in mind when they think of "socialized medicine"**

3. THE NATIONAL HEALTH INSURANCE MODEL

- **Canada, Taiwan, South Korea**
- **Characteristics:**
  - Providers are private
  - Payer is a government-run insurance program that every citizen pays into; has considerable market power to negotiate lower prices
  - National insurance collects monthly premiums and pays medical bills
  - Plans tend to be cheaper and much simpler administratively than American-style insurance
  - Can control costs by: (1) limiting the medical services they will pay for or (2) making patients wait to be treated

4. THE OUT-OF-POCKET MODEL

- **Rural regions of Africa, India, China, and South America**
- **"non-system" countries**
- **Characteristics:**
  - Only the rich get medical care; the poor stay sick or die
  - Most medical care is paid for by the patient(out-of-pocket)
  - No insurance or government plan

5 MYTHS ABOUT HEALTH CARE AROUND THE WORLD

1. **It's all socialized medicine out there**
   - Many countries provide universal coverage using private providers, hospitals and insurance plans
2. **Overseas, care is rationed through limited choices or long lines – some truth.**
3. **Foreign health systems are inefficient, bloated bureaucracies**
4. **Cost control stifles innovation**
   - False. This pressure to control cost can generate innovation
5. **Health insurance companies have to be cruel**
   - Insurance plans in other countries accept all applicants
   - Cannot deny on the presence of a preexisting condition
   - Cannot cancel as long as you pay your premium

William Cockerham

Type	Definition	Characteristics	Country examples
Free-market medicine	Free-market medicine is primarily based on wider free-market principles, particularly private financing by fee-for-service, private initiative and ownership, and least state or third-party intervention. Such systems are characterised by a two-track system of financing and of health care delivery, i.e. a private track (based on individual purchasing power) and a public track (based on welfare provision).	Free-market medical systems • have both private and public systems of financing and organisation of health care services • have providers which are mainly private entrepreneurs • have facilities which are privately and state-owned • do not guarantee equal access to the general population and are mostly highly inequitable • encourage (even enforce) private care for patients who are able to pay for such services	US Switzerland South Africa
Socialised medicine (*Beveridge* model)	Socialised medicine refers to a system of health care delivery in which health care is provided in the form of a state-supported consumer service financed by taxation. That is, health care is purchased but the buyer is the government, which makes the services available at little or no additional cost to the consumer. There are several different forms of socialised medicine.	In socialised medical systems, the government • directly controls the financing and organisation of health care services in a capitalist economy • directly pays providers • owns most of the facilities (Canada is an exception) • guarantees equal access to the general population • allows some private care for patients willing to be responsible for their own expenses	UK Canada Scandinavian countries Italy Spain Saudi Arabia Kenya

Decentralised national health programmes (*Bismarck* model)	Decentralised national health programmes differ from systems of socialised medicine in that the government control and management of health care delivery is more indirect. The government acts primarily to regulate the system, not operate it. Often the government functions in the role of a third party, mediating and coordinating health care delivery between providers and organisations involved in the financing of services.	In decentralised national health programmes, the government • indirectly controls the financing and organisation of health services in a capitalist economy • regulates payments to providers • owns some of the facilities • guarantees equal access to the general population • allows some private care to patients willing to be responsible for their own expenses	Germany Japan France The Netherlands Mexico Belgium Austria Switzerland Luxembourg
Socialist medicine (*Semashko* model)	Socialist medicine is a system in which health care is a state-provided public service. The state controls, organises, finances and allocates health care directly to all citizens free of charge. No third-party organisations or insurance companies are interposed between health care providers and patients. The state owns all facilities and pays a salary to all health care workers.	In socialist medical systems, the government • directly controls the financing and organisation of health services in a socialist (communal) economy • pays providers directly • owns all facilities • guarantees equal access • bans/restricts private care	Former USSR and eastern Europe – Hungary, Poland, Russia People's Republic of China Cuba

Health Care Delivery System

There is no perfect healthcare delivery system for a country.

Some models seem to work better than others but each has its own advantages and drawbacks.

Broadly, healthcare delivery models could be classified under **tiered system** or **diffuse system**.

Tiered healthcare system