



Health Systems

By
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WHO defines health systems as:

- A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.
- This includes efforts to influence determinants of health as well as more direct health-improving activities.

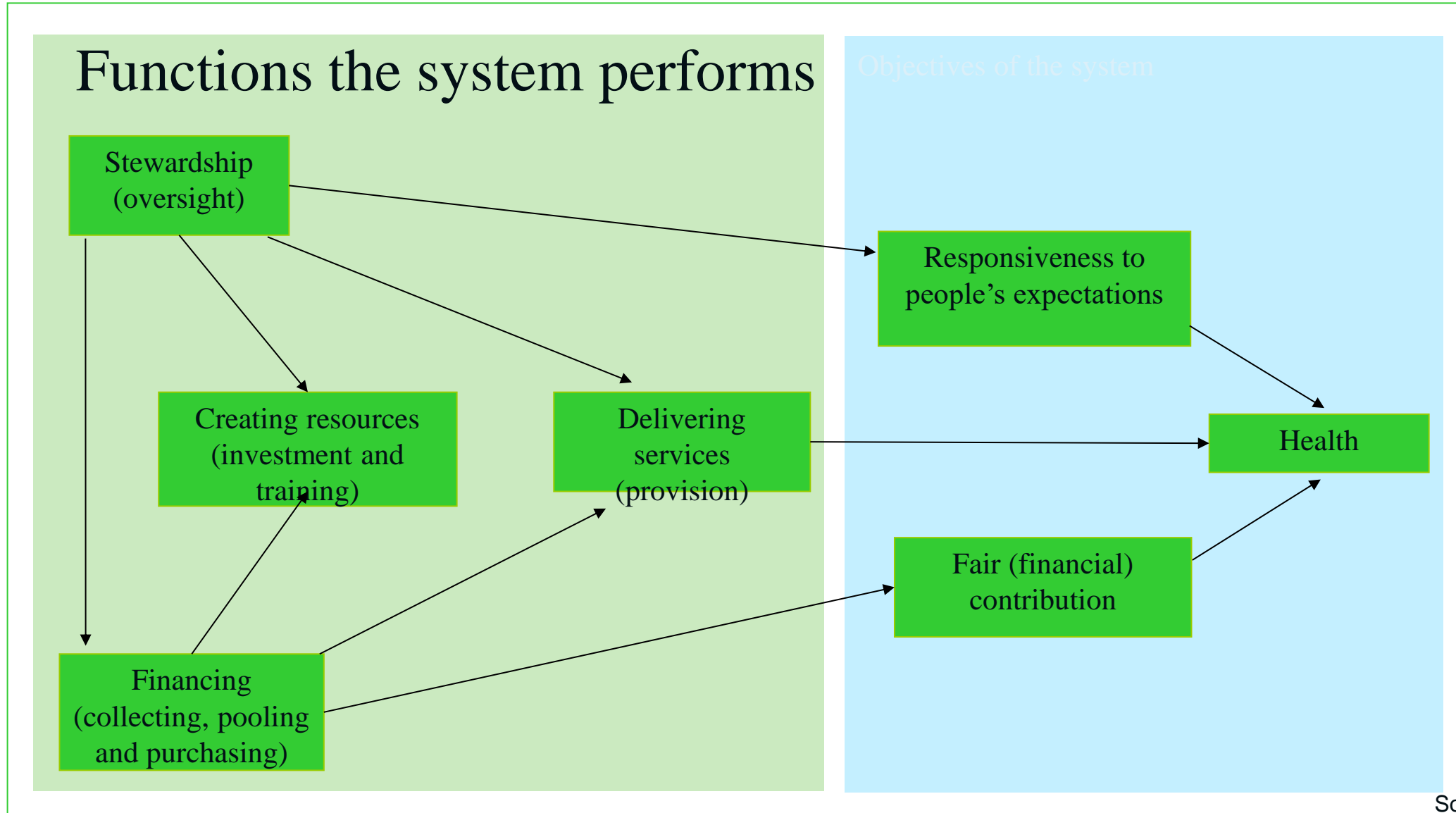


Health system

- Is more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example:
 - ✓ a mother caring for a sick child at home;
 - ✓ private providers;
 - ✓ behavior change programs;
 - ✓ vector-control campaigns;
 - ✓ health insurance organizations;
 - ✓ occupational health and safety legislation.
 - ✓ It includes inter-sectoral collaboration to improve health



Functions and objectives of a health system



What then makes a health system good?

Common elements of a good health system include: 'a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies' (WHO 2013).



The Performance of Health Systems

To assess performance of health systems, we must measure it against the objectives and intended results of a health system.

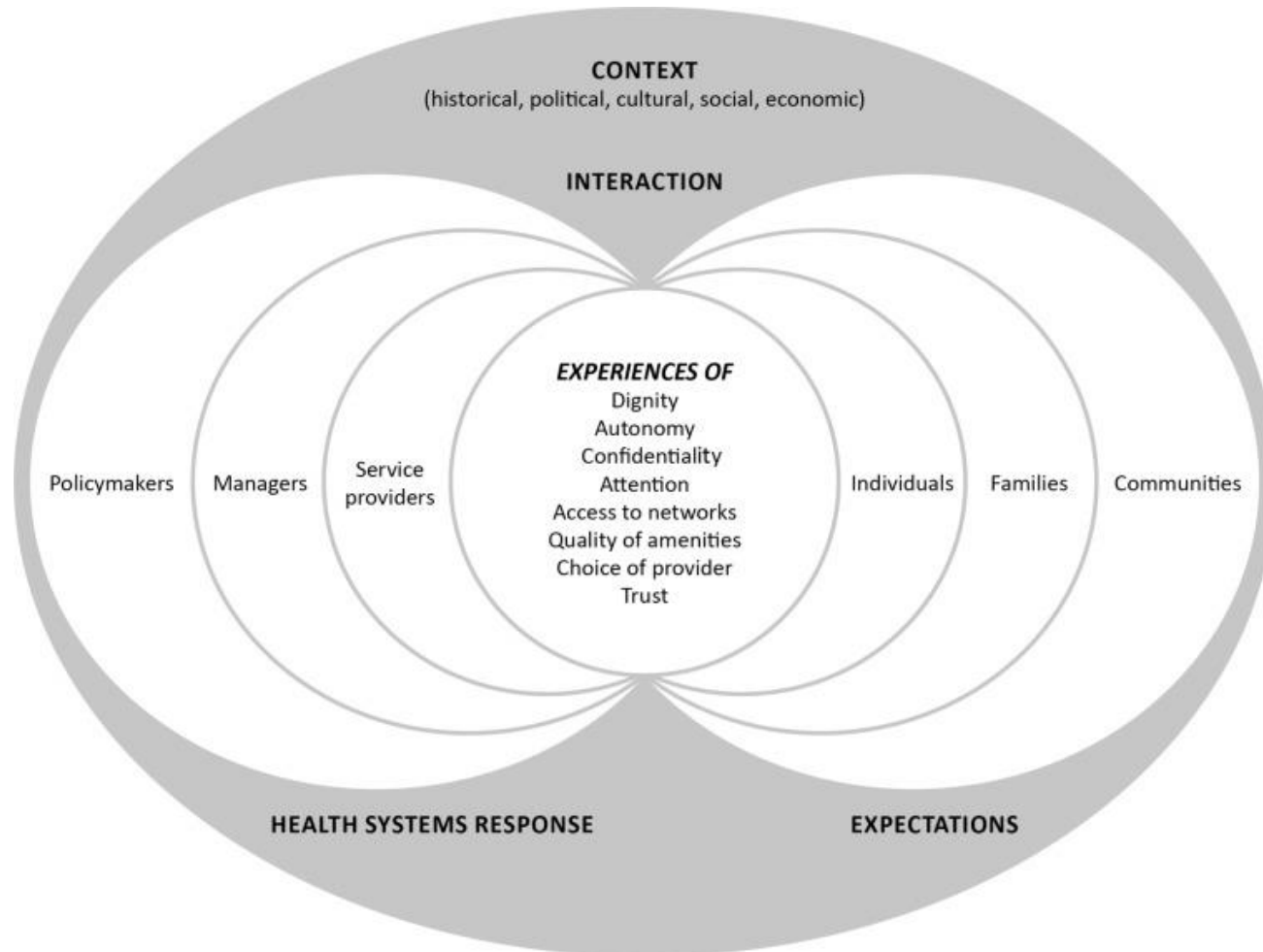
The Objectives for health systems are:

1. Improving the health of the populations they serve: measured by life expectancy, maternal mortality, and infant mortality in addition to its distribution across the population.



The Performance of Health Systems

2. Responding to peoples' expectations:



The Performance of Health Systems

3. Providing financial protection against the costs of ill health: - Health care costs are unpredictable and may be catastrophic thus Universal coverage protects from the financial burden of healthcare costs. However, many barriers of health insurance plans such as co-payment and ceiling may prevent patients from using them. **Payment should be progressive (related to ability to pay).**

4. Equity and fairness in the distribution of the above three objectives (across population subgroups).

- **horizontal equity** means similar treatment of people with similar needs;
- **vertical equity** means different treatment of people with different needs.



Financing of healthcare

Financing is one of the central functions of a health system and it encompasses:

- **Revenue collection** Revenue collection refers to the process of raising money from different sources. The '**primary sources**' of funding can include taxpayers, businesses and external funders such as donors.
- **Pooling:** Refers to accumulating the revenue to spread risks across population.
- **Resource allocation and purchasing** Resource allocation and purchasing refers to how those pooled funds are then channeled to pay for service provision.



STEWARDSHIP

Financing

Revenue collection

Fund pooling

Purchasing

Provision

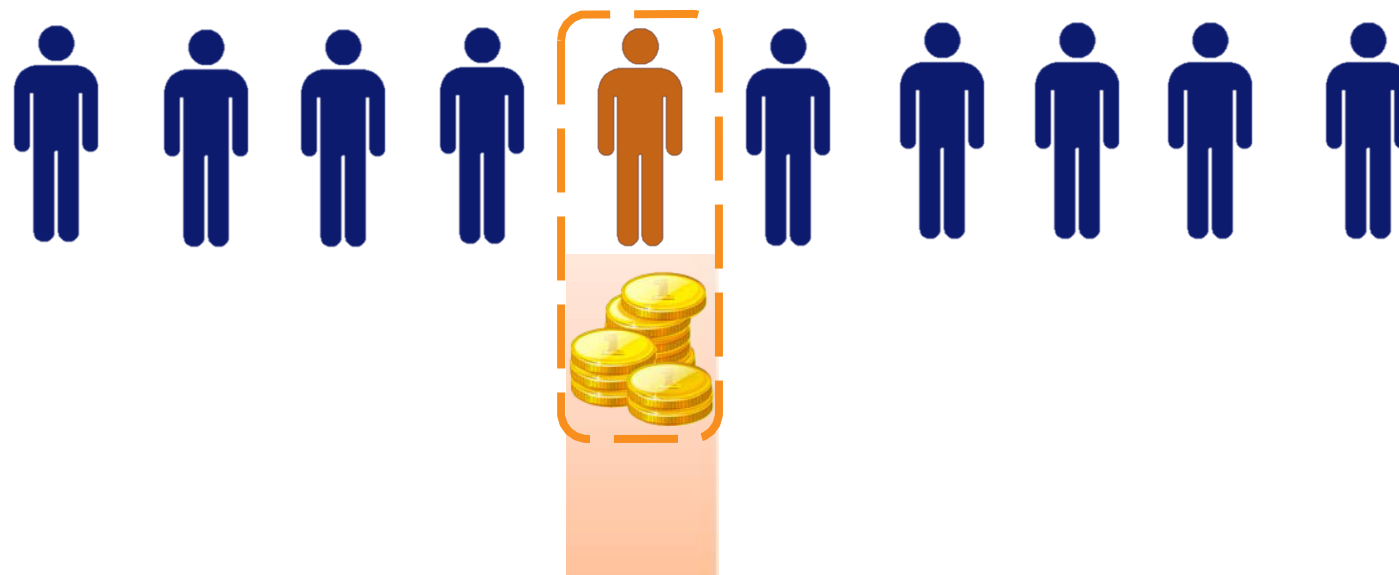
Personal
health
services

Non-
personal
health
services

RESOURCE GENERATION

Without Risk Pooling

Let's say we have 10 people. 1 person becomes ill during the year.



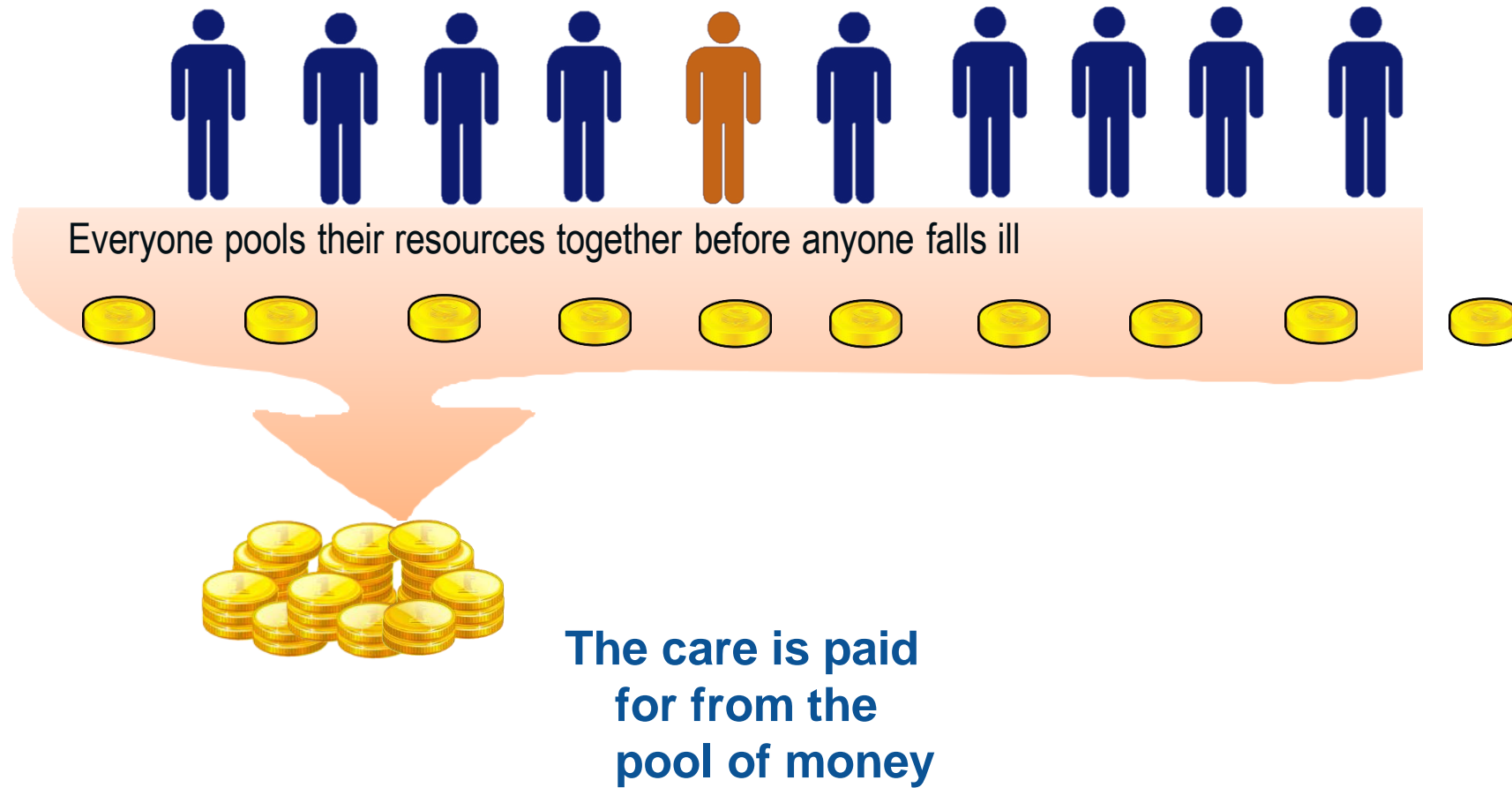
What happens if
this person is
low-income?

This 1 person will bear
the full risk of paying for
his or her care ?



With Risk Pooling

When someone falls ill...



Why is health care so costly?

- Use of expensive new diagnostic tests and treatments
- Increased costs of healthcare services
- Marketing of new drugs, devices, and procedures
- Overuse of specialists
- High administrative costs
- Doctor fees
- Malpractice costs
- Defensive medicine
- Aging of the population



Efficiency in Healthcare

- Technical efficiency: where a given output is produced with the least inputs (i.e. minimizing wastage). This is also known as operational efficiency;
- Economic efficiency: where a given output is produced at least cost. Also known as productive efficiency;
- Allocative efficiency: where the pattern of output matches the pattern of demand.



Cost-effectiveness in healthcare

- **Cost-effectiveness analysis is often used in the field of health care, where it may be inappropriate to monetize health effect.**
- Cost-effectiveness analysis (CEA) is a way to examine both the costs and health outcomes of one or more interventions. It compares an intervention to another intervention or with the baseline by estimating how much it costs to gain a unit of a health outcome, like QALYs gained or DALYs prevented.
- **The most commonly used outcome measures are DALYs and QALYs.**
- **Cost–benefit analysis** assigns a monetary value to the measure of effect.



Who pays for health care?

- The following are the main payers:
 - a) Government programs
 - b) Private health insurance plans (some through employers)
 - c) The person's own funds (out-of-pocket).
- ✓ Because health expenditures of individuals on health are unpredictable, prepayment systems (a & b above) with universal coverage protect from extreme poverty due to health care expenditures.
- ✓ Prepayment based on ability to pay allows for cross-subsidy from the rich to the poor and from the healthy to the sick.
- ✓ Health systems financed by the government provide the greatest potential for pooling risk.



Health care financing models



National Health Services systems (Beveridge model)

- Named after William Beveridge
- Health care is provided and financed by the government through tax payments.
- Many hospitals and clinics are owned and run by the government.
- There are also private hospitals and doctors who collect their fees from the government.
- Low costs per capita, because the government controls what doctors can do and what they can charge.
- Beveridge model: Great Britain, Spain, most of Scandinavia , New Zealand. Hong Kong and Cuba which represents the extreme application of the Beveridge approach; it is probably the world's purest example of total government control.



Social Insurance systems (Bismarck model)

- Named after Chancellor Otto von Bismarck and it was found in Germany
- This model has an insurance system. The insurers are called “sickness funds”
- Multi-payer model ; Germany has about 240 different sickness funds
- Financed jointly by employers and employees through payroll deduction.
- Cover everybody, and not for profit.
- Doctors and hospitals tend to be private in Bismarck countries.
- Tight regulation gives government much of the cost-control.
- The Bismarck model is found in Germany, of course, and France, Belgium, the Netherlands, Japan, Switzerland, and, to a degree, in Latin America.



The National Health Insurance Model

- Has elements of both Beveridge and Bismarck.
- Uses private-sector providers, but payment comes from a government
- The government runs an insurance program that every legal resident pays into.
- No need for marketing, no financial motive to deny claims and no profit.
- Cost effective and administratively simple.
- The single payer (the government) has considerable market power to negotiate for lower prices and control costs by limiting the medical services they will pay for.
- Patients waiting to be treated is one of the cons.
- The classic NHI system is found in Australia, Canada, but some newly industrialized countries — Taiwan and South Korea, for example — have also adopted the NHI model.



Mixed Health systems

- Most of the Low and Middle Income (LMIC) Countries governments are too disorganized or too poor to provide universal healthcare.
- Health care in a majority of LMIC is delivered by a mixed health system.
- It is a health system in which out-of-pocket payments and market provision of services predominate as a way of financing and providing health services.
- Publicly-financed government health delivery coexists with privately-financed market delivery.
- Insufficient state funding for health and weak governance
- A regulatory environment that enables the private sector to deliver health services without an appropriate regulatory framework
- This triad of determinants acts together to compromise the quality of public services and defeat the equity objective





Universal Health Coverage



Health as a human right

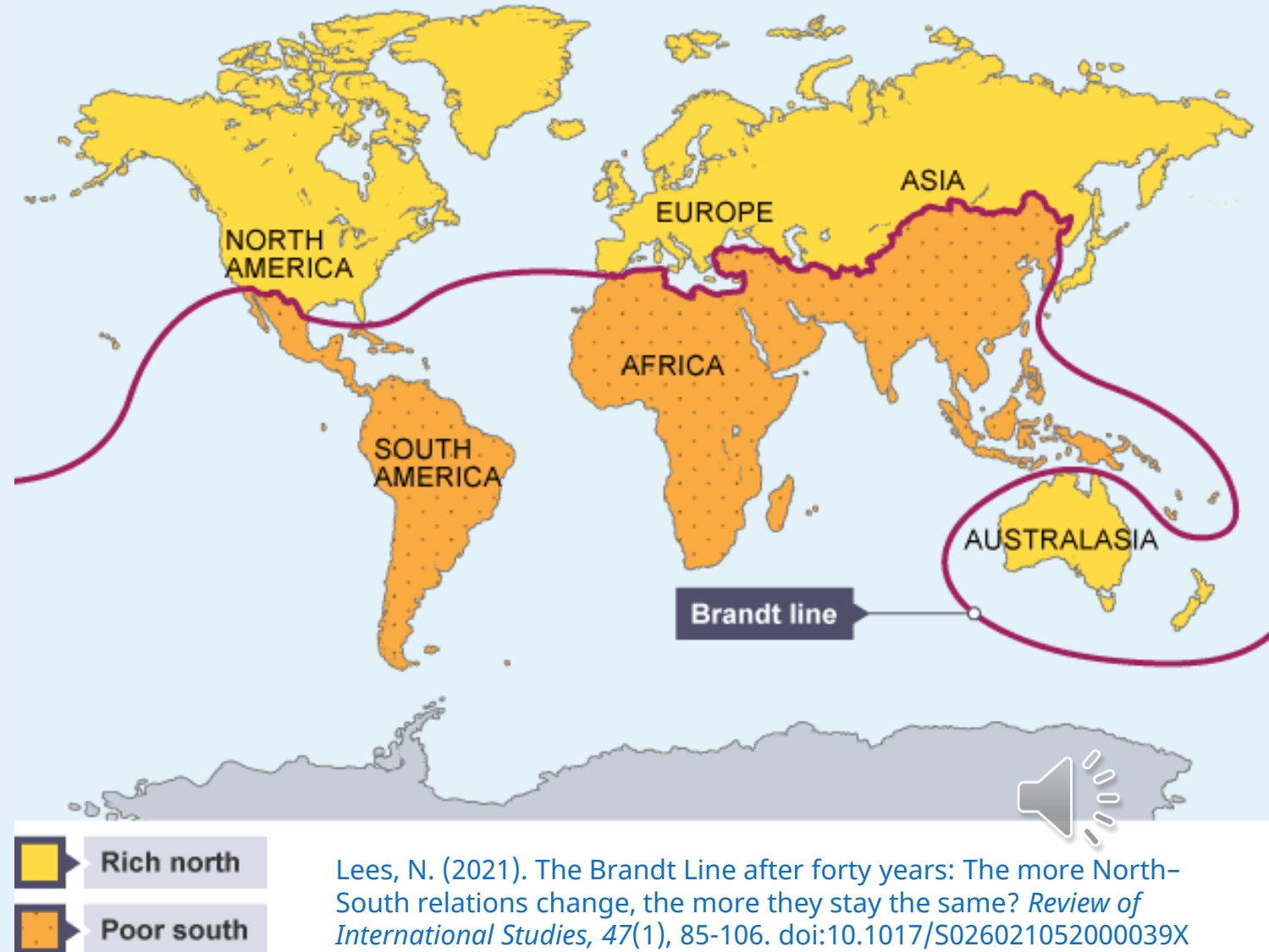
- ☂ *“There can be **no** real growth without healthy populations.*
- ☂ ***No** sustainable development without tackling disease and malnutrition.*
- ☂ ***No** international security without assisting crisis-ridden countries.*
- ☂ *And **no** hope for the spread of freedom, democracy and human dignity unless we treat health as a basic human right.*
- ☂ ***Our networked world means that we are only as strong as our weakest link”***

GRO HARLEM BRUNDTLAND

First woman Prime Minister of Norway; former Director-General of WHO. From a speech delivered at the [World Leaders Forum: Global Health Security](#) at Columbia University in New York, on 24 September 2019.

The gap between the Global North and the Global South

- In 1980, the **Brandt Line** was developed as a way of visualizing the world that highlights the **disparities** and **inequalities** in development and wealth between the prosperous North and the poorer Global South.



Lees, N. (2021). The Brandt Line after forty years: The more North-South relations change, the more they stay the same? *Review of International Studies*, 47(1), 85-106. doi:10.1017/S026021052000039X

Is the Brandt Line still valid ?

- The evidence from the literature suggests that the Brandt Line is largely intact after forty-four years of its dissemination
- Although the economic power has risen, still the North–South divide is lingering.
- Despite the significant development gains globally that pulled millions of people out of absolute poverty, still the gap between the world's richest and poorest countries is widening.




Universal Health Coverage (UHC)

“Universal health coverage is the single most powerful concept that public health has to offer”

- Dr. Margaret Chan, the 7th Director General of the World Health Organization (WHO), addressing to the 65th World Health Assembly, May 2012



What is UHC?

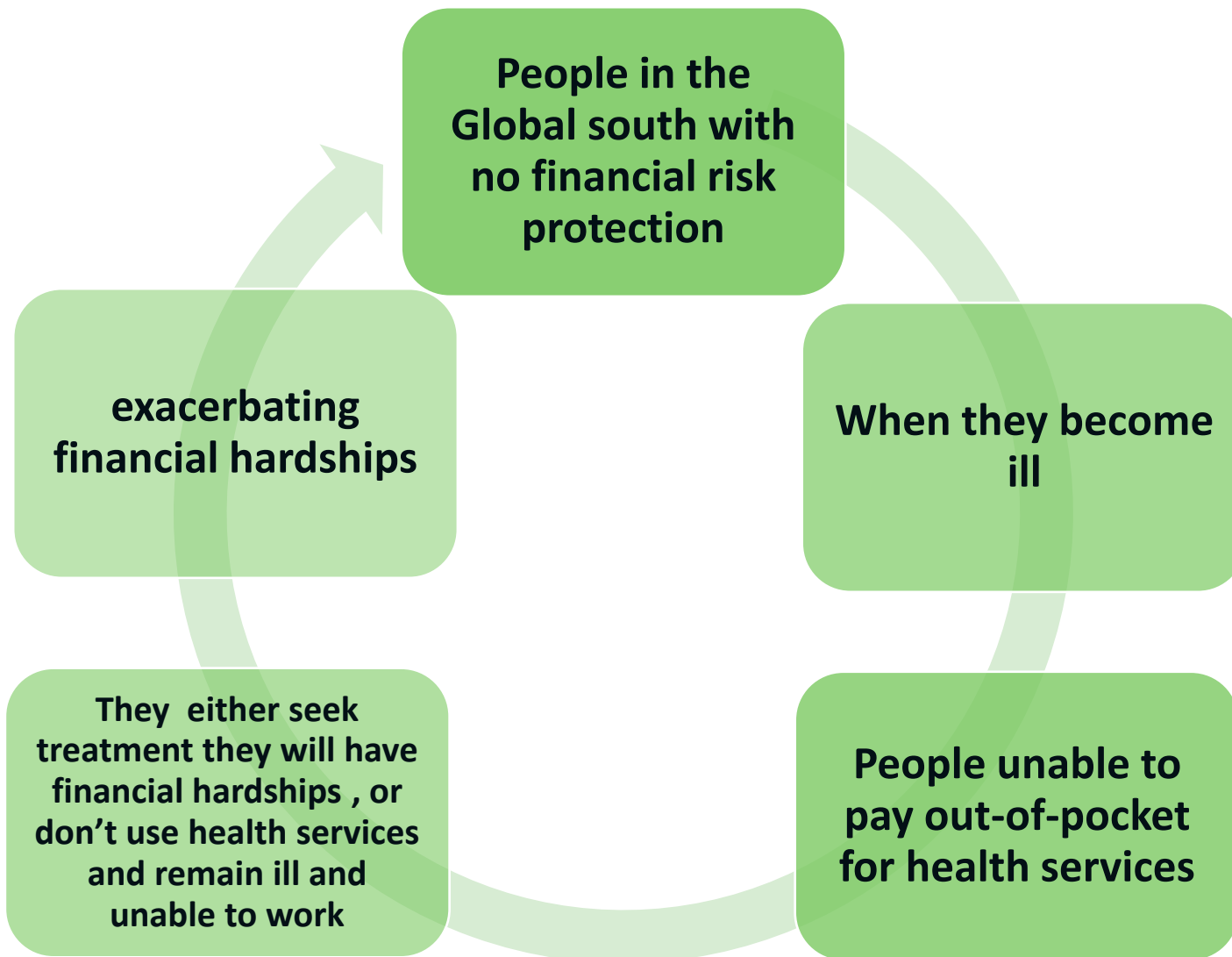
- ☂ The idea of universal health coverage is based on the WHO constitution of **1948** declaring **health as a fundamental human right** and on the **Health for All** agenda set by the **Alma Ata Declaration in 1978**.
- ☂ UHC means that “All individuals and communities have the right to receive the health services they need without suffering financial hardships”
- ☂ UHC includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course. 

The main pillars of UHC

- **Equity in access:** everyone who needs health services should get them, not only those who can pay for them.
- **Sufficient quality:** health services should be good enough to improve the health of those receiving services.
- **No undue financial risk:** The cost of using health services should not put people at risk of financial harm.



Direct relation between health and wealth



- Health is a fundamental **human right** and it is also the foundation of economic prosperity and security.
- **UHC is a triple win:** It improves people's health, reduces poverty, and fuels economic growth.

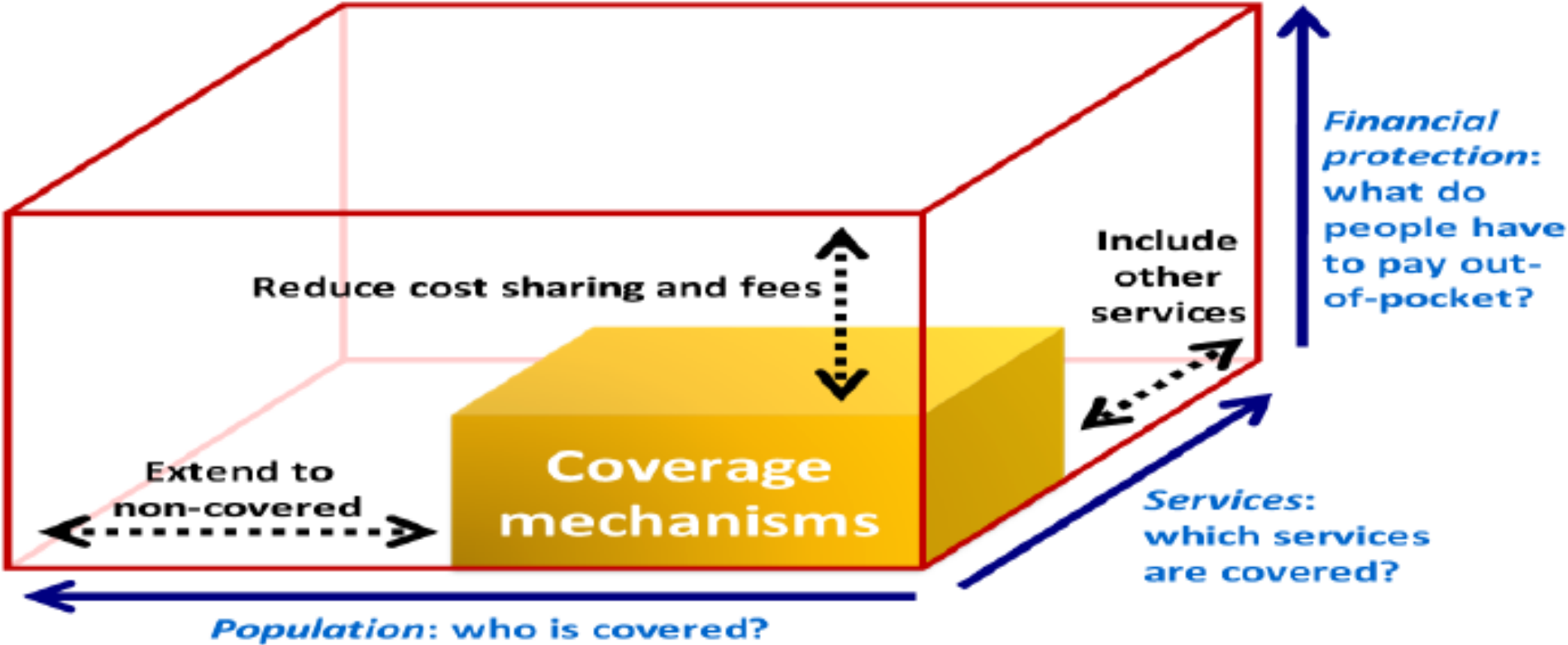


Global commitment towards UHC


- In 2010, the WHO released a call for all countries to move towards UHC.
- **The 2030 Agenda for Sustainable Development Goals (SDGs) that was adopted in 2015 by all United Nations Member States, included under SDG 3.8.1: to achieve universal health coverage by 2030, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.**








How to assess the progress towards UHC ?



Evidence based actions for UHC reforms success

- 🌂 Political commitment towards equity and effective stewardship by the government synergized by engaging the private sector.
- 🌂 Investing in a strong, resilient, efficient and well-run health system that meets priority health needs through a people-centered integrated approach
- 🌂 Collaboration of all the stakeholders in knowledge sharing and engaging the community for the public good.
- 🌂 Priority setting using systematic processes based on evidence and stakeholders' agreement before setting the range of the potential health services.
- 🌂 Using steppingstones in progressing towards UHC by using a bottom-up approach, starting with the poor and progressing step by step. 

Evidence based actions for UHC reforms success

-  Quality of services and accountability should be integral to UHC program design.
-  A focus on primary care gatekeeping and referral mechanisms contributes to a more sustainable, accessible, and equitable health system, attaining better health outcomes at lower cost.
-  A sustainable system for financing health services, effective financial management, monitoring, and oversight are essential for the success of UHC.
-  Using novel financing mechanisms for revenue generation, risk pooling, procurement, contracting and purchasing.
-  Establishing a culture of evidence-based policy making built on research and information technology.



No one-size-fits-all recipe

- ☂ There is no “best practice” model capable of accommodating any country at any stage of development.
- ☂ The best path to cover people is through corresponding to the needs of the population within the socioeconomic fundamentals of the country.
- ☂ The quality of UHC programs often improves during the implementation process as they mature.
- ☂ Learning is an essential element for all the countries transitioning towards UHC. UHC skills are progressive capacities that are built during the implementation.
- ☂ Addressing the social determinants of health through a comprehensive PHC care approach is essential.



Ethics and governance are central in the path to universal health coverage

- UHC is a powerful expression of fairness, solidarity and recognition of health as a human right.
- To achieve Universal Health Coverage for all by 2030, countries must recognize the role of Stewardship in ensuring that health care systems are strong and provide quality care to everyone.
- **Whether in providing justification for UHC, identifying the interests at stake in health system reform, or providing guidance in building more robust health systems, ethics and governance both play a central role.**



Discussion topic: Cuba health system

- **Video to watch:** THE CUBAN DOSE: Insights into Cuba's legendary healthcare system

<https://youtu.be/0i7z0S4Ve8c>

Article to read:

- **Health Equity, Cuban Style.** *AMA J Ethics.* 2021;23(3):E258-264. doi: 10.1001/amajethics.2021.258.

<https://journalofethics.ama-assn.org/article/health-equity-cuban-style/2021-03>



Cuba health system example

- Universal
- Free
- Accessible
- Everyone has the right to health protection and care .



Cuba healthcare system

- Health care is a right, available to all equally and free of charge.
- Health care is the responsibility of the state.
- Preventive and curative services are integrated.
- The public participates in the health system's development and functioning.
- Strong comprehensive primary health care that addresses the social determinants of health
- Health care activities are integrated with economic and social development.
- Global health cooperation is a fundamental obligation of the health system and its professionals.



Cuba healthcare system

- Promote health through positive changes in the population's knowledge, sanitary habits, and lifestyle.
- Prevent the emergence of diseases and damage to the population's health.
- Guarantee early diagnosis, outpatient services, and hospitalization, as well as timely, continuous, and comprehensive medical care in the community.



Cuba healthcare system

- Develop community-based rehabilitation for physically or psychologically disabled persons.
- Achieve improvements in neighborhood environmental clean up and in home hygiene.
- Achieve improvements in social relations and integration of neighborhood families.
- Develop studies that respond to the health needs of the population.



Take home message

■ **Ethics matters:**

Governance ethical commitment towards the public good and to health as a basic human right

■ **Priorities matter**

Governance political commitment, a higher (or lower) share that government devotes to health can make a big difference

■ **Context and Policy matters**

There is more to it than just spending levels; how you organize your health system is important



