HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

1: Health system - Wikipedia

As supporters and opponents of the Affordable Care Act debate the best way to overhaul a clearly broken health care system, it's perhaps helpful to put American medicine in a global perspective.

These types of causal loops magnify the need for new ways of evaluating and incorporating evidence not only from research studies, but also from the real-world experience of obesity initiatives undertaken not just within a particular country but around the world. Future Choices Project was used to inform a cross-government strategy for England that was part of a sustained program to reduce obesity and support healthy weight maintenance Cross-Government Obesity Unit, A systems perspective broadens the traditional approach to locating, evaluating, and assembling evidence which generally limits the evidence to results of rigorous randomized controlled trials to encompass evidence that reflects the complexity of the problem. Users of the framework are encouraged to approach every aspect of decision making with a comprehensive lens, considering the complex context in which programs and policies will be implemented and how it may affect their implementation and impact. A systems perspective enables the decision maker to understand interactions among smaller systems within the larger system and identify potential synergies or harms that should be explored before implementation. The Importance of Taking a Systems Perspective. Bridging the Evidence Gap in Obesity Prevention: A Framework to Inform Decision Making. The National Academies Press. To fully realize the potential application of systems theory to obesity prevention, a number of strategies will be required. First, current and future leaders should be trained in the science and understanding of systems and their application to the obesity crisis. This training would include causal mapping, conceptualization of interventions, and computational and simulation modeling techniques. The application of these methods to the obesity epidemic will be challengingâ€”there will be important data that are not yet available, uncertainty about a number of assumptions, and many key mechanisms whose inner workings are unknown Hammond, In some cases, smaller systems will have to be studied independently, perhaps with relatively homogeneous populations, before being integrated into a more comprehensive model. Various combinations of models can then be explored and tested against the same outcome data, building slowly toward a model that encompasses the full breadth of the system by integrating all those narrower models. Second, empirical research should be funded and executed using systems theory as a guide. Focused studies can be used to confirm and quantify relationships and to test their effects. Ideally, this research would be carried out in conjunction with modeling studies to produce the most informative data and to guide future research. Third, both knowledge generators and users must work collaboratively with different disciplines to build interdisciplinary capacity. Caution will be necessary regarding the use of models and the need to link their application with empirical research. The interplay between systems theory and research requires high-quality experimental and quasi-experimental designs. Systems thinking puts researchers in a better position to ask the right questions. Research applications allow a systems model to make the right predictions. Rather, it requires interdisciplinary integration of approaches to public health aimed at understanding and reconciling linear and nonlinear, qualitative and quantitative, and reductionistic and holistic thinking and methods to create a federation of systems approaches NCI, Comprehensive smoking cessation policy for all smokers: In Ending the tobacco problem: A blueprint for the nation, edited by R. Transdisciplinary tobacco use research. Nicotine and Tobacco Research 5 Supplement 1: Boosting population quits through evidence-based cessation treatment and policy. American Journal of Preventive Medicine 38 3, Supplement 1: Page 85 Share Cite Suggested Citation: Oscillatory fluctuations in the incidence of infectious disease and the impact of vaccination: Journal of Hygiene London 93 3: Health promotion dissemination and systems thinking: Towards an integrative model. American Journal of Health Behavior 27 Supplement 3. Systemic transformational change in tobacco control: In Innovations in health care: A reality check, edited by A. Initial results of a systems thinking inventory. System Dynamics Review President announces clear skies and global climate change initiatives. California Air Resources Board. Zero emission vehicle program. Best practices for comprehensive tobacco control programsâ€”April Healthy weight, healthy lives: Future choiceâ€”Project report, 2nd edition. Government Office for Science.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

System dynamics and the lessons of 35 years. In The systemic basis of policy making in the s, edited by K. Model of genetic variation in human social networks. Behavioral science at the crossroads in public health: Extending horizons, envisioning the future. Social Science and Medicine 62 7: Host immunity and synchronized epidemics of syphilis across the United States. Complex systems modeling for obesity research. Preventing Chronic Disease 6 3: Systems modeling in support of evidence-based disaster planning for rural areas. International Journal of Hygiene and Environmental Health How system dynamics helped a community organize cost-effective care for chronic illness. System Dynamics Review 20 3: Page 86 Share Cite Suggested Citation: A systems-oriented multilevel framework for addressing obesity in the 21st century. BMI screening and surveillance: Pediatrics Supplement 1. Developing a strategic framework to prevent obesity. The foundations of hedonic psychology. Systems thinking and modeling for public health practice. American Journal of Public Health 96 3: American Journal of Preventive Medicine 35 2, Supplement 1: The role of public policies in reducing smoking prevalence and deaths caused by smoking in Arizona: Results from the Arizona tobacco policy simulation model. Journal of Public Health Management and Practice 13 1: Modeling the impact of smoking-cessation treatment policies on quit rates. American Journal of Preventive Medicine 38 3, Supplement 1. Reaching Healthy People by Interdisciplinarity and systems science to improve population health. American Journal of Preventive Medicine 35 Supplement 2. Massachusetts Department of Public Health. BMI screening guidelines for schools. Places to intervene in a system. Philosophy, methodology and practice. Background on system dynamics simulation modeling with a summary of major public health studies. System dynamics simulation in support of obesity prevention decision-making.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

2: Japan's Universal and Affordable Health Care: Lessons for the United States?

An International Perspective The U. Rather than operating a national health service, a single-payer national health insurance system, or a multi-payer universal health insurance fund, the U. In , 48 percent of U. The federal government accounted for 28 percent of spending while state and local governments accounted for 17 percent. Among the insured, In , nearly It will then outline some common methods used in other countries to lower health care costs, examine the German health care system as a model for non-centralized universal care, and put the quality of U. Of the member states, the U. In North America, Canada and Mexico spent respectively On a per capita basis, the U. Prohibitively high cost is the primary reason Americans give for problems accessing health care. Americans with below-average incomes are much more likely than their counterparts in other countries to report not: The first is the cost of new technologies and prescription drugs. Nationally, health care costs for chronic diseases contribute huge proportions to health care costs, particularly during end of life care. Their findings suggest that this holds true even when controlling for socio-economic disparity. Further, the government outsources some of its administrative needs to private firms. The aim is to improve administrative efficiency by allowing doctors and hospitals to bundle billing for an episode of care rather than the current ad hoc method. Uneven Coverage While the majority of U. Average annual premiums for family coverage increased 11 percent between and , but have since leveled off to increase five percent per year between and Between and , single coverage deductibles have risen 67 percent. The lack of health insurance coverage has a profound impact on the U. The Center for American Progress estimated in that the lack of health insurance in the U. While the low end of the estimate represents just the cost of the shorter lifespans of those without insurance, the high end represents both the cost of shortened lifespans and the loss of productivity due to the reduced health of the uninsured. Forty million workers, nearly two out of every five, do not have access to paid sick leave. Experts suggest that the economic pressure to go to work even when sick can prolong pandemics, reduce productivity, and drive up health care costs. Experts attribute this sharp decline in the uninsured to the full implementation of the ACA in Firms with higher proportions of low-wage workers are less likely to provide access to health insurance than those with low-proportions of low-wage workers. However, the percentage of part-time workers without insurance was The uninsured rate among those who had not worked at least one week also decreased from Among all small firms workers in , only 56 percent offered health coverage, compared to 98 percent of large firms. Beginning in , the Affordable Care Act banned this practice, as well as denying coverage for pre-existing conditions. From to , average annual health insurance premiums for family coverage increased 61 percent, while worker contributions to those plans increased 83 percent in the same period. Union workers are more likely than their nonunion counterparts to be covered by health insurance and paid sick leave. In March , 95 percent of union members in the civilian workforce had access to medical care benefits, compared with only 68 percent of nonunion members. In , 85 percent of union members in the civilian workforce had access to paid sick leave compared to 62 percent of nonunion workers. In the South, 41 percent of firms reported providing benefits for same-sex partners compared to 51 percent in the Northeast and 20 percent reported offering benefits to opposite-sex domestic partners compared to 46 percent in the Northeast. Provisions included in the ACA are intended to expand access to healthcare coverage, increase consumer protections, emphasizes prevention and wellness, and promote evidence- based treatment and administrative efficiency in an attempt to curb rising healthcare costs. Beginning in January , almost all Americans are required to have some form of health insurance from either their employer, an individual plan, or through a public program such as Medicaid or Medicare. Individuals with incomes between percent and percent of the federal poverty line would be eligible for advanceable premium tax credits to subsidize the cost of insurance. States have the option to create and administer their own exchanges or allow the federal government to do so. Currently, only 14 states operate their own exchanges. A recent analysis by the Commonwealth Fund found that the number of insurers offering health

insurance coverage through the marketplaces increased from to The analysis found only a modest increase in average premiums for the lowest cost plans from to As of November , 30 states have chosen to expand Medicaid. As of , adults with incomes at or below percent of the federal poverty line are now eligible for Medicaid in the states that have adopted the expansion. S healthcare system under the ACA, a number of challenges remain. The bulk of people in the coverage gap are concentrated in the South, with Texas , people , Florida , , Georgia , and North Carolina , having among the highest number of uninsured. The law banned lifetime monetary caps on insurance coverage for all new plans and prohibited plans from excluding children and most adults with preexisting conditions. Among them is the Independent Payment Advisory Board, which will provide recommendations to Congress and the President for controlling Medicare costs if the costs exceed a target growth rate. The administrative process for billing, transferring funds, and determining eligibility is being simplified by allowing doctors to bundle billing for an episode of care rather than the current ad hoc method. Additionally, changes were made to the Medicare Advantage program that would provide bonuses to high rated plans, incentivizing these privately-operated plans to improve quality and efficiency. Furthermore, hospitals with high readmission rates will see a reduction in Medicare payments while a new Innovation Center within the Centers for Medicare and Medicaid Services was created to test new program expenditure reduction methods. While methods range widely, other OECD countries generally have more effective and equitable health care systems that control health care costs and protect vulnerable segments of the population from falling through the cracks. Among the OECD countries and other advanced industrialized countries, there are three main types of health insurance programs: A national health service, where medical services are delivered via government-salaried physicians, in hospitals and clinics that are publicly owned and operatedâ€”financed by the government through tax payments. There are some private doctors but they have specific regulations on their medical practice and collect their fees from the government. Medical services are publicly financed but not publicly provided. Canada, Denmark, Taiwan, and Sweden have single-payer systems. This method is used in Germany, Japan, and France. Such a mandate eliminates the issue of paying the higher costs of the uninsured, especially for emergency services due to lack of preventative care. This has been effectively used by the U. Yet, it has been prohibited by law from traditional Medicare. Savings of up to five percent of total health care expenditures could result from the full adoption of these practices. How Germany Pays for Health Care Germany has one of the most successful health care systems in the world in terms of quality and cost. Some insurance providers collectively make up its public option. The average per-capita health care costs for this system are less than half of the cost in the U. The details of the system are instructive, as Germany does not rely on a centralized, Medicare-like health insurance plan, but rather relies on private, non-profit, or for-profit insurers that are tightly regulated to work toward socially desired endsâ€”an option that might have more traction in the U. Germans have no deductibles and low co-pays. However, they are tightly regulated. Groups of office-based physicians in every region negotiate with insurers to arrive at collective annual budgets. Doctors must remain in these budgets, as they do not receive additional funding if they go over. This helps keep health care costs in check and discourages unnecessarily expensive procedures. The average German doctor also makes about one-third less per year than in the U. Prior to reforms, drug companies set the price for new drugs and were not required to show that the new drug was an improvement over previously available prescription drugs. Pursuant to the reforms effective in , manufacturers could set the price for the first 12 months a new drug is on the market. New drugs without added benefits are available to patients, but the patient has to pay the price difference. For drugs with added benefit, a price will be negotiated between health insurers and the manufacturer. Health Care in an International Context U. However, treatment in the U. In terms of quality of care, the U. Despite the relatively high level of health expenditure, in the U. In , the U. Projections indicate that the U. Therefore, there are provisions in the legislation to increase the number of primary care physicians in the U. There is a significant spatial mismatch within the United States for physicians as well. This is the highest rate among OECD countries. The average for the OECD countries was

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

3: Health care systems in world perspective / Milton I. Roemer | National Library of Australia

According to the UN's World Health Organization, Cuba's health care system is an example for all countries of the world. The Cuban health system is recognized worldwide for its excellence and its.

One study [10] based on data from the OECD concluded that all types of health care finance "are compatible with" an efficient health system. The study also found no relationship between financing and cost control. The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a social insurance program, or from private insurance companies. It may be obtained on a group basis e. In each case premiums or taxes protect the insured from high or unexpected health care expenses. By estimating the overall cost of health care expenses, a routine finance structure such as a monthly premium or annual tax can be developed, ensuring that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is typically administered by a government agency, a non-profit health fund or a corporation operating seeking to make a profit. Many government schemes also have co-payment schemes but exclusions are rare because of political pressure. The larger insurance schemes may also negotiate fees with providers. Many forms of social insurance schemes control their costs by using the bargaining power of their community they represent to control costs in the health care delivery system. For example, by negotiating drug prices directly with pharmaceutical companies negotiating standard fees with the medical profession, or reducing unnecessary health care costs. Social schemes sometimes feature contributions related to earnings as part of a scheme to deliver universal health care , which may or may not also involve the use of commercial and non-commercial insurers. Essentially the more wealthy pay proportionately more into the scheme to cover the needs of the relatively poor who therefore contribute proportionately less. There are usually caps on the contributions of the wealthy and minimum payments that must be made by the insured often in the form of a minimum contribution, similar to a deductible in commercial insurance models. In addition to these traditional health care financing methods, some lower income countries and development partners are also implementing non-traditional or innovative financing mechanisms for scaling up delivery and sustainability of health care, [12] such as micro-contributions, public-private partnerships , and market-based financial transaction taxes. There has been growing interest in blending elements of these systems. Capitation[edit] In capitation payment systems , GPs are paid for each patient on their "list", usually with adjustments for factors such as age and gender. Capitation payments have become more frequent in "managed care" environments in the United States. However, under this approach, GPs may register too many patients and under-serve them, select the better risks and refer on patients who could have been treated by the GP directly. Freedom of consumer choice over doctors, coupled with the principle of "money following the patient" may moderate some of these risks. Aside from selection, these problems are likely to be less marked than under salary-type arrangements. Health care delivery , Health information management , Health informatics , and eHealth Sound information plays an increasingly critical role in the delivery of modern health care and efficiency of health systems. Necessary tools for proper health information coding and management include clinical guidelines , formal medical terminologies , and computers and other information and communication technologies. The use of health information lies at the root of evidence-based policy and evidence-based management in health care. Increasingly, information and communication technologies are being utilised to improve health systems in developing countries through: Health policy , Public health , Health administration , and Disease management health The management of any health system is typically directed through a set of policies and plans adopted by government, private sector business and other groups in areas such as personal healthcare delivery and financing, pharmaceuticals , health human resources , and public health. Public health is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as small as a handful of people, or as large as all the inhabitants of several continents for instance, in the case of a pandemic. Public health is typically divided into epidemiology , biostatistics and health services. Environmental , social, behavioral , and occupational health are also

important subfields. A child being immunized against polio. Today, most governments recognize the importance of public health programs in reducing the incidence of disease, disability, the effects of ageing and health inequities , although public health generally receives significantly less government funding compared with medicine. For example, most countries have a vaccination policy , supporting public health programs in providing vaccinations to promote health. Vaccinations are voluntary in some countries and mandatory in some countries. Some governments pay all or part of the costs for vaccines in a national vaccination schedule. The rapid emergence of many chronic diseases , which require costly long-term care and treatment , is making many health managers and policy makers re-examine their healthcare delivery practices. Its incidence is increasing rapidly, and it is estimated that by the year , this number will double. A controversial aspect of public health is the control of tobacco smoking , linked to cancer and other chronic illnesses. The World Health Organization , for its World Health Day campaign, is calling for intensified global commitment to safeguard antibiotics and other antimicrobial medicines for future generations. Health systems performance[edit] See also: Health services research Percentage of overweight or obese population in , Data source: Having this scope in mind, it is essential to have a clear, and unrestricted, vision of national health systems that might generate further progresses in global health. The elaboration and the selection of performance indicators are indeed both highly dependent on the conceptual framework adopted for the evaluation of the health systems performances. In complex systems path dependency, emergent properties and other non-linear patterns are under-explored and unmeasured, [23] which can lead to the development of inappropriate guidelines for developing responsive health systems. Recognizing the diversity of stakeholders and complexity of health systems is crucial to ensure that evidence-based guidelines are tested with requisite humility and without a rigid adherence to models dominated by a limited number of disciplines. Although many deliver improved healthcare a large proportion fail to sustain. Numerous tools and frameworks have been created to respond to this challenge and increase improvement longevity. One tool highlighted the need for these tools to respond to user preferences and settings to optimize impact. In using this approach, HPSR offers insight into health systems by generating a complex understanding of context in order to enhance health policy learning. List of countries by quality of health care , List of countries by health expenditure covered by government , Health systems by country , Health care prices in the United States , and Healthcare in Europe Chart comparing health care spending left vs. Health systems can vary substantially from country to country, and in the last few years, comparisons have been made on an international basis. The World Health Organization , in its World Health Report , provided a ranking of health systems around the world according to criteria of the overall level and distribution of health in the populations, and the responsiveness and fair financing of health care services. There have been several debates around the results of this WHO exercise, [34] and especially based on the country ranking linked to it, [35] insofar as it appeared to depend mostly on the choice of the retained indicators. Direct comparisons of health statistics across nations are complex. The Commonwealth Fund , in its annual survey, "Mirror, Mirror on the Wall", compares the performance of the health systems in Australia, New Zealand, the United Kingdom, Germany, Canada and the United States Its study found that, although the United States system is the most expensive, it consistently underperforms compared to the other countries. The OECD also collects comparative statistics, and has published brief country profiles.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

4: Health Care Around the World â€" Global Issues

A national health insurance system, or single-payer system, in which a single government entity acts as the administrator to collect all health care fees, and pay out all health care costs. Medical services are publicly financed but not publicly provided.

Health care in wealthy countries All industrialized nations, with the exception of the United States, implement some form of universal health care. Universal health care in all wealthy countries except US The main ways universal health care is achieved in wealthy nations include: Government run tax funded systems, e. With the worsening global financial crisis hitting America hard, more are likely to lose medical insurance which is often associated with a job. The US does, however, through Federal law provide public access to emergency services, regardless of ability to pay. However, the emergency services system has sometimes felt strain due to patients being unable to pay for emergency services and many who cannot afford regular health care either use emergency services for treatment, or let otherwise preventable conditions get worse, requiring emergency treatment. The New York Times reports that life expectancy disparities are mirroring the widening incoming inequality in recent decades. Other health issues that are pronounced in the US, such as obesity, high cost of medical drugs, lack of access for large numbers of people, have been concerns for many years. The US has not seen health as a human right, but as a privilege. However, President Barack Obama has tried to challenge this view, with proposed reforms to provide universal health care through health insurance for all. This has been met with wrath from the right wing, even thoughâ€"as the charts above showâ€"the US spends the most per person in the world on health care, yet does not get the best for all that money; most other industrialized nations get better, faster and cheaper health care. In the previous link, author and former Washington Post reporter, T. Reid, looks at 5 myths that many Americans have about health care around the world and concludes: In many ways, foreign health-care models are not really foreign to America, because our crazy-quilt health-care system uses elements of all of them. The government provides health care, funding it through general taxes, and patients get no bills. Premiums are split between workers and employers, and private insurance plans pay private doctors and hospitals. Everyone pays premiums for an insurance plan run by the government, and the public plan pays private doctors and hospitals according to a set fee schedule. This fragmentation is another reason that we spend more than anybody else and still leave millions without coverage. Which, in turn, punctures the most persistent myth of all: In terms of results, almost all advanced countries have better national health statistics than the United States does. In terms of finance, we force , Americans into bankruptcy each year because of medical bills. In France, the number of medical bankruptcies is zero. Large pharmaceutical companies are known to have enormous influence in the US. They have also had a lot of influence on various international trade policies such as those on intellectual property, sometimes to the detriment of poorer countries facing health crises as described in the global health overview page on this web site. In the US, high drug prices have been an issue for many years, with some people even going across the border to Canada to get more affordable medicines. While that sounds like a large amount, according to investigative reporter Greg Palast, it is actually an agreement that drug companies will reduce the amount by which they increase their drug costs over the next 10 years, locking in a doubling of costs. Inter Press Service , who adds that the media has given little or no information about the demographics of the polls being conducted, and whether respondents include the estimated one in three citizens who lacked health insurance at some point in While tax-funded and government run, it provides access to all citizens and is mostly free at point of use. The British system includes free primary care paying doctors and running hospitals through decentralized trusts. Almost all treatment is free. For working age citizens, prescriptions are obtained with a flat fee with pharmacists often telling patients if the same drug is cheaper over the counter than through prescription. Dentist and optician visits typically have some fee associated with them, with dentistry having been increasingly privatized for many, many years. There is a parallel private health option but is used by a small percentage of the population usually the wealthy, by definition. Over the years, the NHS has changed in various ways, but even the parties traditionally hostile to big government the Conservative party typically state

at least publicly support for the institution. There have been a number of problems within the NHS, which the right wing in the US are keen to expose even if it includes exaggerating or bending the truth about NHS problems. There are also concerns that under the guise of necessary reforms due to the effects of the global financial crisis , a privatization agenda is being pushed onto the NHS. SpinWatch, for example, claims that private healthcare companies have built a dense and largely opaque network of political contacts in the UK with one aim â€" to influence policy in their interests and get the reforms they want: Web of private healthcare influence Private Healthcare Network Map , March Click for larger version Using favorable terms such as freedom and choice , some of the reform plans have been intensely criticized, such as giving GPs General Practitioners â€" also known as Family Doctors more control over their budgets. At first glance this sounds ideal: However, GPs themselves are worried about this because they have not been consulted on this plan as it would not just meant they have to also become accountants â€" without extra budgets to do this â€" but that they would end up having to ration limited resources and some people may not be able to get treatment as needed, while diluting the power of the NHS as a universal system throughout the country. For an overview of health systems in various other countries, try the following:

5: Comparisons of Health Care Systems in the United States, Germany and Canada

Health Care Costs and Financing in World Perspective ï»¿ Roemer, Milton I. () National Health Systems Throughout the World: Lessons for Health System Reform in the United States ï»¿.

The committee has adapted a four-level model by Ferlie and Shortell to clarify the structure and dynamics of the health care system, the rough divisions of labor and interdependencies among major elements of the system, and the levers for change. A brief description of the model follows. Conceptual drawing of a four-level health care system. The Individual Patient We begin appropriately with the individual patient, whose needs and preferences should be the defining factors in a patient-centered health care system. The availability of information, the establishment of private health care spending accounts, and other measures reflect an increasing expectation that patients will drive changes in the system for improved quality, efficiency, and effectiveness. Overall, the role of the patient has changed from a passive recipient of care to a more active participant in care delivery. Unfortunately, most people do not have access to the information, tools, and other resources they need to play this new role effectively. The level of responsibility patients and their families assume differs from patient to patient. In either case, however, patients need a free exchange of information and communication with physician s and other members of the care team, as well as with the organizations that provide the supporting infrastructure for the care teams. Synchronous communication between patient and physician could improve the quality of care in a number of ways. Communication technologies also have the potential to change the nature of the relationship between patient and provider, making it easier for patients to develop and maintain trusting relationships with their clinicians. Asynchronous communication also has the potential to significantly improve quality of care. The easy accessibility of the Internet and the World Wide Web should enable all but continuous inquiries and feedback between patients and the rest of the health care system IOM, One of the fastest growing uses of the these communication technologies is as a source of medical information from third parties, which has made the consumer i. Some of the improvements just described are available today, some are under study, and some are as much as a decade away from realization. Thus, research is still an essential component in transforming the current system. In addition to the care team, a clinical microsystem includes a defined patient population; an information environment that supports the work of professional and family caregivers and patients; and support staff, equipment, and facilities Nelson et al. Most health and medical services today, however, are not delivered by groups or teams. The role and needs of individual physicians have undergone changes parallel to those of individual patients. The slow adaptation of individual clinicians to team-based health care has been influenced by several factors, including a lack of formal training in teamwork techniques, a persistent culture of professional autonomy in medicine, and the absence of tools, infrastructure, and incentives to facilitate the change. To participate in, let alone lead and orchestrate, the work of a care team and maintain the trust of the patient, the physician must have on-demand access to critical clinical and administrative information, as well as information-management, communication, decision-support, and educational tools to synthesize, analyze, and make the best use of that information. Moreover, to deliver patient-centered care i. At the present time, precious few care teams or clinical microsystems are the primary agents of patient-centered clinical care. All of these can, and do, prevent systems thinking by clinicians, the diffusion of evidence-based medicine, and the clinical microsystems approach to care delivery. Thus, tailoring evidence-based care to meet the needs and preferences of individual patients with complex health problems remains an elusive goal. For care teams to become truly patient-centered, the rules of engagement between care teams and patients must be changed. Like individual care providers, the care team must become more responsive to the needs and preferences of patients and involve them and their families to the extent they desire in the design and implementation of care. Care teams must provide patients with continuous, convenient, timely access to quality care. One member of the care team must be responsible for ensuring effective communication and coordination between the patient and other members of the care team. The Organization The third level of the health care system is the organization e. The organization encompasses the decision-making systems, information systems, operating

systems, and processes financial, administrative, human-resource, and clinical to coordinate the activities of multiple care teams and supporting units and manage the allocation and flow of human, material, and financial resources and information in support of care teams. The organization is the business level, the level at which most investments are made in information systems and infrastructure, process-management systems, and systems tools. Health care organizations face many challenges. In response to the escalating cost of health care, government and industryâ€"the third-party payers for most peopleâ€"have shifted a growing share of the cost burden back to care providers and patients in recent years. As a result, hospitals and ambulatory care facilities are under great pressure to accomplish more work with fewer people to keep revenues ahead of rising costs. In certain respects, management of health care organizations is not well positioned to respond to mounting cost and quality crises. Compared to other industries, health care has evolved with little shaping by the visible hands of management. Historically, most leaders of health care organizations were initially trained in medicine or public health. Moreover, except in the relatively few integrated, corporate provider organizations e. These circumstances have posed significant challenges to the authority of health care management in many organizations, often creating discord and mistrust between health care professionals and health care management. Other challenges to management include the hierarchical nature of the health professions and inherent resistance to team-based care, significant regulatory and administrative requirements e. The Political and Economic Environment The fourth and final level of the health care system is the political, economic or market environment, which includes regulatory, financial, and payment regimes and entities that influence the structure and performance of health care organizations directly and, through them, all other levels of the system. Many actors influence the political and economic environment for health care. State governments, which play a major role in the administration of Medicaid, also influence care systems. Private-sector purchasers of health care, particularly large corporations that contract directly with health care provider organizations and third-party payers e. Federal regulations influence the structure, level, and nature of competition among providers and insurers. They can also affect the transparency of the health care system by setting requirements related to patient safety and other aspects of the quality of care. By exercising its responsibility to monitor, protect, and improve public health, the federal government shapes the market environment for health care. Federal agencies, the primary sources of funding for biomedical research, influence the research and technological trajectories of health care, and, with them, the education of health care professionals and professionals in other areas invested in the health care enterprise. At present, many factors and forces at the environmental level, including reimbursement schemes for health care services and some regulatory policies, do not support the goals and objectives of patient-centered, high-performance health care organizations or the health care delivery system as a whole. Although the federal government, the single largest purchaser of health care services, principal regulator, and major research patron, is, in many ways, best positioned to drive changes in the health care delivery system, some private-sector payer organizations and state governments are better positioned to experiment with new mechanisms and incentives for improving the quality of care and making health care more affordable see papers by De Parle and Milstein in this volume. Each unit has considerable freedom to set standards of performance and measure itself against metrics of its own choosing. In addition, cottage industries do not generally attempt to standardize or coordinate the processes or performance of Unit A with those of Units B, C, and so on. Indeed, this is an apt characterization of the current health care delivery system. Each unit must not only achieve high performance but must also recognize the imperative of joining with other units to optimize the performance of the system as a whole. Moreover, each individual care provider must recognize his or her dependence and influence on other care team members e. These are the underlying attitudes that support a systems approach to solving problems. Nevertheless, a concerted, visible commitment by management will be necessary to achieve this new way of thinking as a giant step toward the improvements identified in Crossing the Quality Chasm IOM, Optimization It is easy to show mathematically that the optimization of individual units rarely, and only under highly improbable circumstances, results in optimization of the whole. Optimization is determined by a variety of metrics, including the productivity of a unit, the quality of service, the use of physical resources, or a combination of all of these. Optimization of the whole requires a clear understanding of the goal of the overall

system, as well of interactions among the subsystems. The whole must be recognized as being greater than the sum of its parts Box Optimization of the performance of a large system is often attempted through the optimization of each sub-element of the system. A handful of health care organizations have embraced the systems view e. These significant exceptions to the general rule demonstrate that the systems view is applicable to health care and could be a model for other health care organizations. The goal of this report is to identify existing tools that can be used to address problems and to suggest areas for further exploration. In any large system that has many subsystems, achieving high operating performance for each subsystem while taking into account the mutual influence of subsystems on each other and on the system as a whole can be a daunting task. A simple pictorial description of interacting elements in a system may be helpful for understanding how the system works. However, a deeper understanding invariably involves creating a mathematical description of subsystems, their performance, and their interactions. This, in turn, requires a model, that is, an abstract representation of how the system operates a mathematical form that can be used to analyze the system that includes parameters that determine the performance of each sub-element of the system, as well as descriptions of interactions. The model is a tool for simulating the performance of the actual system. For example, if a change is planned in the layout of a facility, a model can be used to determine if it will improve the flow of people and equipment through the facility. A model might help determine how much inventory must be kept at Station A to ensure that it can respond to an emergency in less than five minutes. A model might also reveal if a different communication system might reduce the required inventory or the best way to assign a nursing staff when 10 percent of the nurses are not available. Because the health care system involves a myriad of interacting elements, it is difficult, or even impossible, for any individual to have a complete picture of the system without using special tools to perform a systems analysis. The model must include the role of each process in health care delivery and its interactions with other processes in the system. But clinical elements are not the only important elements in an analysis. The interaction between administrative elements e. All processes must be quantitatively described to be included in the model. Any attempt to optimize the performance of a system must take into account objectives that are difficult to quantify and that may, in fact, conflict with each other. Quantifying the quality of care, for example, can be difficult, largely because the meaning of quality varies depending on whether the patient, the health care professional, or the clinic or hospital is assessing it. Improvements in productivity may mean an increase in the number of patients that can be accommodated or a decrease in waiting time for the average patient. IOM identified safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity as proper quality objectives for the health care delivery system. In addition, potentially conflicting goalsâ€”for example, cost containment and patient-centerednessâ€”can also be analyzed. With incredible advances in computational speed and capacity and parallel advances in computer software, clinical information and communications systems can provide immediate access to information, including patient-based information e. Chapter 3 provides descriptions of a large portfolio of systems-engineering tools and concepts with the potential to significantly improve the quality and cost performance of the health care system. These tools have been widely and effectively used to design, analyze, and control complex processes and systems in many major manufacturing and services industries. In Chapter 4 opportunities are described for accelerating the development and widespread diffusion of clinical information and communications systems for health care delivery that can support the use of systems tools and improve the connectivity, continuity of care, and responsiveness of the health care system as a whole. Improving the quality of health care in the United Kingdom and the United States: PMC] [PubMed: Building a learning organization. National Academy Press; Crossing the Quality Chasm: A New Health System for the 21st Century. National Academies Press; A Bridge to Quality. The quality of health care delivered to adults in the United States. New England Journal of Medicine. Building a quality future.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

6: The Most Efficient Health Care Systems In The World (INFOGRAPHICS) | HuffPost

Note: Citations are based on reference standards. However, formatting rules can vary widely between applications and fields of interest or study. The specific requirements or preferences of your reviewing publisher, classroom teacher, institution or organization should be applied.

The Cuban health system is recognized worldwide for its excellence and its efficiency. Despite extremely limited resources and the dramatic impact caused by the economic sanctions imposed by the United States for more than half a century, Cuba has managed to guarantee access to care for all segments of the population and obtain results similar to those of the most developed nations. According to Margaret Chan, the world should follow the example of the island in this arena and replace the curative model, inefficient and more expensive, with a prevention-based system. It reflects, instead, a lack of political will on the part of leaders to protect their most vulnerable populations. The organization cites the case of the Caribbean island as the perfect counter-example [3]. Moreover, in May , in recognition of the excellence of its health care system, Cuba chaired the 67th World Health Assembly [4]. With an infant mortality rate of 4. This is also demonstrated by the quality of its health care system and the impact it has on the well-being of children and pregnant women. The infant mortality rate in Cuba is lower than it is in the United States and is among the lowest in the world. On the average, Cubans live 30 years longer than their Haitian neighbors. In , Cuba will have the highest proportion of its population over the age of 60 in all of Latin America. Indeed, since , Cuba has sent doctors and other health workers throughout the Third World to treat the poor. Currently, nearly 30, Cuban medical staff are working in over 60 countries around the world. This humanitarian campaign, implemented at the continental level under the aegis of the Bolivarian Alliance for the Peoples of Our America ALBA , operates without charge on the Latin American poor who suffer from cataracts and other eye diseases [8]. In a decade, nearly 3. Initially created for Venezuela, this social program was extended to the entire continent with the objective of operating on a total of six million people. Since its inception in , ELAM has graduated more than 20, doctors from over countries. Currently, 11, young people from over nations follow a career in medicine at the Cuban institution. They remain in place after the crises. Cuba can be proud of its health care system, a model for many countries [13]. This is possible if the political will exists to put human beings at the center of the project. Smith, foreword by Paul Estrade; translated by Larry R. Do you have information you want to share with HuffPost?

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

7: Cuba's Health Care System: a Model for the World | HuffPost

Roemer, Milton I. , Health care systems in world perspective / Milton I. Roemer Health Administration Press Ann Arbor Wikipedia Citation Please see Wikipedia's template documentation for further citation fields that may be required.

Data provided by Toshiro Murase at the Japan Society conference. Medicare rates are for the New York area. These charges apply to physicians who do not accept the Medicare rate as payment in full. Second the organization of medical care in Japan is heavily centered around hospitals. Third, 81 percent of hospitals are privately owned, and the have had few restrictions on their capital investments. Fourth because hospitals have competed fiercely with one another, expansion has served as a key strategy to gain a competitive edge. Finally, al least until the mid s, the Ministry of Health and Welfare has not played an active role in containing the total number of hospital beds. Close to 90 percent of hospital facilities with 20 or more beds are classified as "general hospitals. General hospitals are dominated by small, privately owned and operated "nonprofit" facilities. The average number of beds in a Japanese hospital is -slightly fewer than the in an average American hospital - and half have fewer than beds. With beds, the average public hospital is larger than its private counterpart. Although 19 percent of hospitals are public, they account for 33 percent of all beds. About 75 percent of public hospitals are under the jurisdiction of municipal and prefectural governments the remainder are national institutions. About 1 percent of hospitals are owned and operated by quasi-public agencies and organizations such as the Red Cross, social insurance agencies and employment related groups. Despite these distinctions, all hospitals in Japan tend to be viewed as recuperative centers rather than as merely therapeutic institutions, Even large teaching hospitals do not limit themselves to providing acute-care services. Hospitals have traditionally functioned, in part, as long-term care facilities. Of the nearly hospitals that have more than beds, only about 60 percent have adult intensive care units, and only 30 percent of them have neonatal intensive care units, the majority of which have only five to seven beds. As a result of this orientation, patients in Japanese hospitals have the longest average length of stay in the world. In addition to the nursing home functions played by hospitals, other factors accounting for the lengthy stays are probably the large number of beds, the low admission rates, the per diem form of hospital reimbursement, and the emphasis on recuperation over invasive medical and surgical interventions. As is the case with intensive care units, there are far fewer emergency rooms in Japan than in the United States. But while Japan has roughly half the population of the United States, it has only 7 percent of the murders, 2 percent of the reported rapes, and 0. An integrated system of primary, secondary and tertiary-level emergency facilities appears to meet the need for emergency and trauma care. Increasingly, the public perceives these facilities as preferred sites for receiving medical care. A recent innovation for the delivery of high-tech medical care has been the establishment of officially designated centers for such procedures as open-heart surgery. Most often, highly advanced medical procedures are performed at teaching facilities. Clinics and Ambulatory Care Japanese physicians have traditionally operated on a small scale, working out of their homes to provide health care services to their community. Although these clinics have typically provided a low-level intensity of care, many have recently acquired a wide range of sophisticated medical equipment including ultrasonic testing and gastrointestinal fiberscopes. Although the number of clinics has increased from about 50, in to more than 80, in , the number of clinics with beds decreased by almost 20 percent during the s and s. Larger hospitals are attracting both young doctors and outpatients with their sophisticated technology and services. First, clinic physicians do not have admitting privileges to hospitals. These barriers give clinic physicians an incentive to put off hospitalization. First, clinic physicians are remunerated under the fee schedule each time they write a prescription for a dispensing pharmacist. Second, they make an average profit of 26 percent of the reimbursement rate every time they prescribe - and sell - a drug to their patients. This finding supports the contention that clinic physicians maximize their income by prescribing and selling more drugs. Patients are typically told little about their diagnoses, and doctors explain away problems in "soothing terms without necessarily providing precise information about what exactly the problem is. Such practices were recently supported by a court decision that doctors need not share the full details of a diagnosis with a cancer patient.

Most clinic physicians operate in solo practices without hospital privileges, thus making it difficult to collaborate with specialists as well as with peers. Standards of practice, professional competence and patient care are neither monitored nor evaluated in any formal way. In addition, as in the United States, Japanese physicians do not typically subscribe to the idea of "comprehensive primary health care and often fail to respect the person as a whole person operating in a complex social and economic environment. With the economic growth of the s came demands for the expansion of social benefits that could not be ignored. In , the government responded to social pressures by creating an almost free medical care system for the elderly, the national insurance plan administered by local governments. In , in response to rising health care costs, the Health and Medical Service Law for the Aged established the national pooi to subsidize medical care. In general wards, no distinction is made between acute and long-term care facilities. Seventy-five percent of the institutionalized elderly are in hospitals and clinics, for example, and survey data indicate that 45 percent of elderly inpatients are hospitalized for more than six months. There are also three other types of facilities that serve the elderly in Japan: There are long waiting lists for admission to nursing homes-applicants commonly wait for more than a year. First, medical practice generally tends to emphasize passive care and bed rest. Second, a lack of space at home to accommodate elderly relatives pushes more of the frail elderly into hospitals and clinics. Finally, women, the traditional care givers for the elderly, are entering the work force in increasing numbers. In , 26 percent of Japanese will be over 65, compared to The Golden Plan is a year national health care and welfare plan for the elderly agreed upon by the Ministries of Health and Welfare, Finance and Home Affairs in The plan relies on four principal strategies to build the infrastructure necessary to accommodate the growing needs of the elderly: Expansion of existing services by increasing the number of home helpers from 40, in to , in and the number of nursing home beds from just over , to ,; 34 Creation of a more diverse range of services by defining the respective roles of corporations and of the national, prefectural and municipal governments; Decentralization through an increased role for municipalities in the design of programs; Reduction of fragmentation by developing government entities to provide services, support research, disseminate information and coordinate the regional administration of model projects. In addition to expanding infrastructure for the elderly, the Golden Plan seeks to rationalize services. It aims to reduce the geriatric population of hospitals and to increase capacity in skilled nursing homes and particularly in new institutions known as geriatric rehabilitation centers. In addition, it calls for a three-fold increase in government-employed visiting homemakers, a fold growth in adult day centers, and a fold increase in respite care centers. If the plan is implemented, the bedridden elderly will be shifted over the next decade away from hospitals toward home care support services, informal support services and nursing homes. When the elderly were first covered under national health insurance in , their copayments were set at 50 percent of the allowed fees. Free medical care for the elderly was established in and lasted until When reinstated, the copayment was kept at a low level, far lower than the pre levels of patient contribution. Moreover, the government is now emphasizing programs that draw on family resources. In contrast to inpatient services, local governments now ask the children of residents in nursing homes and geriatric hospitals to contribute toward the cost of care. Cited by Yoshikawa et al. Stanford University, Spring At the conference, Nobuharu Okamitsu pointed out that a new policy was introduced last year requiring patients to obtain a referral from primary-care doctors before going for outpatient services to large hospitals. Without a referral, patients would have to make larger copayments. However, at this time we have no information on the extent to which this policy has affected the flow of outpatient visits to large hospitals. Only two hospitals are currently slated to participate in this program beginning in September

8: Health Care Systems in World Perspective

Eric C. Schneider, M.D., and David Squires, M.A. Many Americans believe that the United States has the best health care system in the world, but surprisingly little evidence supports that belief.

For example, in and , two of the largest health care systems in southeastern Michigan i. These closures result in additional strains on remaining hospitals, creating even greater stresses for an already fragile system. While hospital closings and mergers create many issues and concerns, both the declining number of beds and the declining number of admissions is related to a significant decline in the number of in-patient surgeries. By , the respective percentages of in-patient and out-patient surgeries were 42 percent and 58 percent. While the cost savings to insurers is real, although difficult to calculate, the impact on formal and informal after-care services and in home health care is equally difficult to estimate. Now many more patients return home on the same day of their surgeries. For individuals with familial and social supports this reality may not be as challenging as for patients who live alone and have little if any family or social network on which to depend. It is calculated by the Institute for the Future that 40 percent of sickness is related to life style and health behavior choices. Clearly education and early case finding are paramount. Prevention has proven effective for individuals or families who have made life style and health behavior changes. However, for many patients, changing to a managed care program, or switching between managed care programs, changes and limits the choices of providers to those on preferred panels. In many plans, if a patient wants to see a provider with whom he or she is familiar, but who is not included as a provider in their "new" plan, an option may exist for obtaining "out of network" services, but it almost always comes with a significantly higher out-of pocket co-pay. Some employers are covering fewer persons. Some are passing the increases on to employees and requiring higher levels of employee contribution. And some employers are just doing away with health care benefits all together. While reductions in the "value" of an existing plan adversely impact employees, the ability to contain insurance costs helps for more people to at least remain covered in some fashionâ€”even if their coverage is only for very serious illnesses. The number of people in the population without health care has increased. Currently it is estimated that 42 million people, or 16 percent of the population, is without any form of health care insurance. The Institute for the Future projected that the number of uninsured will reach 48 billion by While this statistic usually rises during times of recession and decreases in times of expansion, the number of uninsured has increased even during the expansion of the late s and early s. The Institute for the Future also reported that the number of non-elderly persons covered by employment related health insurance dropped from In Michigan, for example, the Access to Health Care Coalition reported that between and the percent of residents without health insurance decreased from However, given the relationship between the economy and the availability of health insurance, this decrease appears temporary. An increase is expected in the number of uninsured, especially in light of the economic downturn of While not all eligible children have been enrolled in these programs, a considerable number are not eligible based on family income exceeding a percentage of the Federal Poverty Level FPL. Mirroring national trends, Michigan is struggling with rising unemployment, a budget deficit, and growing demands for health services and insurance coverage. Often the underinsured and uninsured use the emergency room, the most expensive form of health care service, for any illness. Weiss and Lonnquist reported that uninsured emergency room care visits totaled 93 million in In approximately half of the cases, urgent care was not needed, nor did the individuals seeking care have a regular physician or other option for gaining access to health care services. Their observations are summarized below: The first group represents 38 percent of the population. It consists of empowered consumers with considerable discretionary income, who are well educated and use technology, including the Internet,, to get information about their health. Usually they are able to make choices in their plans and coverages. They are able to educate themselves about health behaviors as well as health care issues and concerns. They are likely to engage in shared decision making with physicians and other allied health professionals. Their primary concern is benefit security and the issue of value as plans become more restrictive. People included in this group include those with unstable job security, both employers and employees, and also early retirees who are

waiting for Medicare to begin. Though they have limited access to information, they are likely to focus on learning more about plans and coverages. They are also likely to become more empowered due to some of the voluntary associations to which they belong who focus on problems in the health care system. The third group represents 28 percent of the population whose main concern is access to health care. It includes people under 65 who are uninsured as well as children who have no coverage or are covered by Medicaid. Access to care for this tier is severely limited because the safety net has frayed. People in this tier depend on the limited resources and strained generosity of safety net funding streams and providers. While some are covered by Medicaid, this plan offers only limited choices and benefits depend on funding which often competes with prisons and schools. Generally poor and lacking education, most people in this tier have serious trouble overcoming the information gap between patients and providers. They may be largely ineffective in changing legislation or the structure of health care. If the problem of access is to be solved, it will need to be driven from the top two tiers. Trust however is another issue. Survey results indicated that only 30 percent of patients in managed care plans trusted that their plan would do the right thing for their care, while 55 percent in traditional plans trusted their plans. Also, fewer than 30 percent of patients trusted their HMOs to control costs without adversely affecting quality of care Dranove, Managed care has a long way to go in persuading the public that managed care is actually care management, although they frequently advertise high quality at a reasonable cost. What Can Be Done? All of this information may be overwhelming, although it represents only a brief overview of the issues and concerns related to our evolving health care system. Nevertheless, there are several practical steps that we can take both individually and collectively: What Does the Future Hold? While trends can be traced and often predicted, there are a significant number of "wild cards" in the future that make the evolution of the American health care system uncertain and volatile. Some of these, according to the Institute for the Future , include Demographic trends and increasing numbers of elderly people in the population; Reimbursement rates for home health care services; new cost containment and cost-shifting strategies; Increasing technology; Economic recessions or expansions; legal and mandatory restrictions on managed care plans; Malpractice insurance, settlements, and jury awards; universal health insurance legislation; and Switching from a private and public insurance model to a national health insurance system. One solution is to learn from other health care delivery models. Perhaps we could benefit both by learning more about other systems especially from countries with high levels of access , and also by beginning to advocate for needed changes in the American health care system. Indeed, the greatest changes may come about as consumers make their concerns known to providers and to state and federal policy makers. It would also make strategic and tactical sense for providers to partner with consumers and policy makers to bring about needed changes. Given our current reality, the focus of change will need to address both access and affordability. References Access to Health Care Coalition Improving access to health care in Michigan. Blue Cross Blue Shield of Michigan. Retrieved March 1, from http: A comprehensive summary of U. A clinical approach 2nd ed. The evolution of American health care. Employer-Sponsored Health Benefits Institute for the Future Health and health care The forecast, the challenge. National Survey of Health Insurance. National health spending trends in Health Affairs, 17, The sociology of health, healing, and illness 3rd ed. Upper Saddle River, NJ: For more information please contact mpub-help umich.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

9: The U.S. Health Care System: An International Perspective â€” DPEAFLCIO

For more information on health care systems, you can view Aaron's Healthcare Triage playlist of videos. Ashish blogs at an Ounce of Evidence. The Upshot provides news, analysis and graphics about.

This article has been cited by other articles in PMC. Abstract The purpose of this research paper is to compare health care systems in three highly advanced industrialized countries: The first part of the research paper will focus on the description of health care systems in the above-mentioned countries while the second part will analyze, evaluate and compare the three systems regarding equity and efficiency. Finally, an overview of recent changes and proposed future reforms in these countries will be provided as well. We start by providing a general description and comparison of the structure of health care systems in Canada, Germany and the United States. Health insurance coverage is universal. General taxes finance NHI through a single payer system only one third-party payer is responsible for paying health care providers for medical services. Consumer co-payments are negligible and physician choice is unlimited. Production of health care services is private; physicians receive payments on a negotiated fee for service and hospitals receive global budget payments Method used by third party payers to control medical care costs by establishing total expenditure limits for medical services over a specified period of time. Most of the population lives within miles of the United States border. From the American point of view, Canada provides a good comparison and contrast in terms of the structure of its health care systems. The Canadian health care system began to take on its current form when the province of Saskatchewan set up a hospitalization plan immediately after WWII. The rural, lowâ€”income province was plagued by shortages of both hospital beds and medical practitioners. The main feature of this plan was the creation of the regional system of hospitals: In , the federal parliament enacted the Hospital and Diagnostic Services Act laying the groundwork for a nationwide system of hospital insurance. By all ten provinces and the two territories had hospital insurance plans of their own with the federal government paying one half of the costs. Since the health care system has moved in different directions. While Canada has had publicly funded national health insurance, the United States has relied largely on private financing and delivery. During this period, spending in the United States has grown much more rapidly despite large groups that either uninsured or minimally insured. The provisions of the Canada Health Act define the health care delivery system as it currently operates. Under the Act, each provincial health plan is administered at the provincial level and provides comprehensive first dollar coverage of all medically necessary services. With minor exceptions, health coverage is available to all residents with no out of pocket charges. Most physicians are paid on a fee for service basis and enjoy a great deal of practice autonomy. Private health insurance for covered services is illegal. Most Canadians have supplemental private insurance for uncovered services, such as prescription drugs and dental services. As a result, virtually all physicians are forced to participate and each health plan effectively serves all residents in the province Henderson Patients do not participate in the reimbursement process, and reimbursement exclusively takes place between the public insurer the government and the health care provider. The monetary exchange is practically non-existent between patient and health care provider. The ministry of health in each province is responsible for controlling medical costs. Cost control is attempted primarily through fixed global budgets and predetermined fees for physicians. Specifically, the operating budgets of hospitals are approved and funded entirely by the ministry in each province and an annual global budget is negotiated between the ministry and each individual hospital. Capital expenditures must also be approved by the ministry, which funds the bulk of the spending. Physician fees are determined by periodic negotiations between the ministry and provincial medical associations the Canadian version of the American Medical Association. With the passage of the Canada Health Act of , the right to extra billing was removed in all provinces. Extra billing or balance billing refers to a situation in which the physician bills the patient some dollar amount above the predominated fee set by third party payer. For the profession as a whole, negotiated fee increases are implemented in steps, conditional on the rate of increase in the volume of services. If volume per physician arises faster than a predetermined percentage, subsequent fee increases are scaled down or eliminated to cap gross billings â€” the product of the fee and the

volume of each service â€” at some predetermined target. The possible scaling down of fee increases is supposed to create an incentive for a more judicious use of resources. Physicians enjoy nearly complete autonomy in treating patients e. In spite of the differences it is fair to say that each provincial plan is a public â€” sector monopsony, serving as a single buyer of medical services within the province and holding down medical care prices below market rates. The key element in the Canadian strategy to control overall spending is the regionalization of high â€” tech services. Government regulators make resource allocation decisions. This control extends to capital investment in hospitals, specialty mix of medical practitioners, location of recent medical graduates, and the diffusion of high tech diagnostic and surgical equipment. Access to open heart surgery and organ transplantation is also restricted. That same year the CT scanners in Canada meant one for every , citizens. Recent studies found Canadian deficits in several areas including angioplasty, cardiac catheterization and intensive care. Waiting lists for certain surgical and diagnostic procedures are common in Canada. Nationwide, the average wait for treatment is If care required diagnostic imaging, waiting times are even longer. Canadians are sacrificing access to modern medical technology for first dollar coverage for primary care. Treatment delays are causing problems for certain vulnerable segments of the Canadian population, particularly the elderly who cannot get reasonable access to the medical care they demand, including hip replacement, cataract surgery and cardiovascular surgery. Several lessons can be learned from the Canadian experience. Products provided at zero price are treated as if they have zero resource cost. Resource allocation decisions become more inefficient over time and government is forced either to raise more revenue or curb services. A second lesson from the Canadian experience is that everything has a cost. The Canadian system delegates this authority to the government. Resource allocation is practiced, not through the price mechanism, but by setting limits on the investment in medical technology. Proponents will argue that using waiting lists as a rationing measure is reasonable and fair. Opponents find the lists unacceptable and an unwelcome encroachment on individual decision-making in the medical sector. Proponents of the single payer alternative must deal with the fact that Canadians face waiting lists for some medical services especially for high â€” tech specialty care. To avoid delays in treatment, many Canadians travel south to the United States for more advanced treatment. Critics of the Canadian system must deal with the fact that most Canadians support their version of Medicare. The single most important defense of medical care delivery in Canada is that it works relatively well. The German system of social benefits is based on the concept of social insurance as embodied in the principle of social solidarity. This principle is a firmly held belief that government is obliged to provide a wide range of social benefits to all citizens, including medical care, old age pensions, unemployment insurance, disability payments, maternity benefits and other forms of social welfare. Bismarck saw the working class movement of that time as a threat. This concern led him to advocate the expansion of the existing sickness benefit societies to cover workers in all low wage occupations. In , the Sickness Insurance Act was passed, representing the first social insurance program organized on a national level. The German Democratic Republic East Germany was under the influence of the former Soviet Union and adapted the socialist form of government. The Federal Republic of Germany West Germany maintained its connections with the West and continued to utilize the preâ€”war economic system including the health care delivery system. East and West Germany were reunited in and since that time the former East Germany has been subjected to most West German laws including legislation relating to the medical insurance system. With the combined population of 82 million people, Germany is divided into 16 provinces Laender , each with a great deal of independence in determining matters related to health care. Over the past years the system has grown to the point where virtually all of the population is provided access to medical care. All individuals are required by law to have health insurance. Sickness funds are private, not â€” for â€” profit insurance companies that collect premiums from employees and employers. Those earning more than this limit may choose private health insurance instead. One of every 10 Germans covered by sickness fund insurance also purchases private supplementary insurance to cover co-payments and other amenities. Individual health insurance premiums for workers are calculated on the basis of income and not age or the number of dependents. Premiums are collected through a payroll tax deduction; the average contribution was The social insurance component is organized around some localized sickness funds. The sickness funds are independent

and self â€" regulating. They pay providers directly for services provided to their members at rates that they negotiate with individual hospitals. The sickness funds are required by law to provide a comprehensive set of benefits. These include physician ambulatory care provided by physicians in private practice, hospital care, home nursing care, a wide range of preventive services and even visits to health spas. Patient cost sharing is minimal. The funds, like disability insurance also provide additional cash payments to those who are unemployed as a result of illness. The system is weak in several areas. In particular, public health services and psychiatric services are minimal. As for reimbursement, ambulatory providers are paid on a fee for service basis, hospitals on a prospective basis. Both public and private including for profit hospitals exist, though the public hospitals account for about half the beds. Hospitals tend to use salaried physicians, and unlike the United States physicians in private practice generally do not have admitting privileges. Thus, many doctors have invested in elaborately equipped clinics to compete with hospitals by being able to perform a wide range of procedures. The German experience is especially relevant to the United States. Coverage is provided through a large number of relatively small and independent plans. In this sense, the delivery of health care is similar to that found in the United States where, for the most part, large numbers of employee groups, independent insurers, and providers reach agreements without direct government intervention. Many Americans propose mandated coverage for the working uninsured. Germany relies on a mandated approach where coverage for certain conditions is required by law. Germany also introduced cost controls similar in principle to prospective payment under the U. Government Role and Involvement In the German health care system, each level of government has specific responsibilities.

HEALTH CARE SYSTEMS IN WORLD PERSPECTIVE pdf

Railway organization and management Lotus in a stream Hugging the Trees Spanish for spanish speakers 1 textbook Part Two. Morality Lights and shadows of army life Whatever happened to Hegel? Man and the Earth. Astrology for Today Is there an association between periodontal disease and cardiovascular disease? Truth Is the Only Profound Chapter 1 before history Personal mathematics Mazda 6 haynes manual The Conquest of Abyssinia The Bedazzling Bowl 307 The Last of the Mochicas: A View from the Jequetepeque Valley Isabelles smile was like a whispered secret. / THE FALL OF OPTIMUM HOUSE Dermot OBrien; Or The Taking Of Tredagh 26 Role of Engineering and Science in Sustainable Development in the 21st Century Abdulkarrem Ozi Aliyu Captives: Selected Short Stories (Glas New Russian Writing: Contemporary Russian Literature in English Tr U00a7 24. The Canons and Decrees of the Council of Trent, A.D. 1563 The theory and practice of husserls phenomenology Humor: the last laugh. Gods Promises for You (From the New International Version) AutoCAD, the drawing tool Global privacy protection Fireworks Yearbook 1988 9 : John McEnroes Wimbledons Japan (Blue Earth Books: Many Cultures, One World) Vernacular Drawings Youve got to believe me Strategic US foreign assistance The Astor Lectures on Predestination Drifting Round The World Kenneth E.F. Watt: Tambora and Krakatau. Asthma in childhood Elaine M. Gustafson, Mikki Meadows-Oliver, and Nancy Cantey Banasiak An Attitudinal Shift and Its Implications 305 The miserly knight Mozart and Salieri The stone guest A feast in time of plague