

HEALTH SYSTEMS POLICY, FINANCE AND ORGANIZATION

Editor-in-Chief

Guy Carrin

Co-Editors

Kent Buse

Harald Kristian Heggenhougen

Stella R. Quah



HEALTH SYSTEMS POLICY, FINANCE, AND ORGANIZATION

EDITOR-IN-CHIEF

GUY CARRIN

World Health Organization

Geneva

Switzerland



ELSEVIER

AMSTERDAM • BOSTON • HEIDELBERG • LONDON • NEW YORK • OXFORD
PARIS • SAN DIEGO • SAN FRANCISCO • SINGAPORE • SYDNEY • TOKYO
Academic Press is an imprint of Elsevier



ACADEMIC
PRESS

Health Policy: Overview

C Paton, Keele University, Newcastle-under-Lyme, UK

© 2008 Elsevier Inc. All rights reserved.

Introduction

This article provides an overview of health policy, a basis for understanding what it is, and key definitions relevant to the subject; the various factors that can be used to explain policy making; how policy is or is not rationalized in practice; how health policy affects health systems, exemplified by analyzing how they are financed and governed; and the politics of health policy in the world today. A conclusion is then provided.

Clearly health policy is – both in theory and in practice – an application of public policy more generally. It is therefore important to set it in the context of public policy and politics. It is equally important to appreciate that a global review of health policy with potential reference and relevance worldwide must concentrate on generic factors, yet with selective illustrations: principles of analysis, generic global trends, and illustrations of policy making and actual policy in different parts of the world.

Key Definitions

Health

It is crucial to define policy but also to give a brief account of how health is being defined and treated. Doing the latter first, health is defined, in the spirit of this Encyclopedia, in terms of its public aspect: The health of the public and therefore the responsibility and role of government and other agencies to meet public objectives for the public health. Public health is sometimes defined in a more specific way, that is, the particular set of programs and activities that seek to make an impact upon the promotion of better health, the prevention of ill health, and also environmental health.

Rather than the latter definition, this article refers to health policy in the broadest sense – affecting the health of the public – ranging, for example, from the effect of policy upon individuals' access to care, on the one hand, to policy made overtly in pursuit of social goals for both the health-care system and health outcomes for the population, on the other hand. Its focus is upon policy, policy making, and the implementation of policy, but it is as well to be clear at the outset as to policy's scope in terms of health. Policy can be negative as well as positive; for example, different health and health-care systems may affect health care for – and the health of – individuals, groups, and the whole population by what it omits

as well as what it provides. With this in mind, let us turn to policy as the basis for understanding health policy.

Policy

A pragmatic definition of public policy would be what the government does (just as the British Cabinet Minister in the post-war government, Herbert Morrison, defined socialism as what Labour governments do!). This puts the emphasis as much upon public as upon policy: On its own, policy can be used in relation to any organization, public or private (e.g., it is the policy of the firm to specialize in luxury goods). But we need to go beyond such a pragmatic definition in order to unpack and examine the concept.

Politics, Policy, and Administration

Our concern here is indeed with public policy (as the means to understanding health policy). Policy comes from the Greek *polis*, which meant a city or more relevantly city-state and also gave rise to the term polity, i.e., political unit of self-government or the political part of a society, i.e., (in classical terms) the state. Policy came to mean the statecraft of the (modern) state. Etymologically it is bound up intricately with politics. But this is not just of historical curiosity. For public policy is embedded in politics – the politics embodied by the government, the politics of those who advise the government, the political ideologies that shape one's political ideas, the political structures required to pass legislation, and the administrative, managerial, and social structures and personnel required to implement policy (that is, to produce social outcomes from policy outputs).

In the French language, for example, *la politique* can mean either politics or policy; the two are not distinguished (Hill, 1997). In traditional British language referring to the traditional British approach to statecraft, on the other hand, the word was often missing: There was politics, on the one hand, and administration, on the other hand. Hence the salience of the academic subdiscipline, public administration, which persists to this day, even in an age when the real world rather disparages administration, turning first to management and then to leadership. It persists no doubt in part because of convention (see for example the spread from the United States to the rest of the world of MPAs – Masters degrees in Public Administration – even when the subject matter is modern business, management, and leadership). But it may also

persist because there is a healthy scepticism in certain parts of academe about whether or not we should merge (private sector-derived) concepts of management and leadership with the overall terrain of government and its output – which may well be called public administration with some degree of accuracy (Hood and Scott, 2000).

Between these two extremes (French and British) above, there is the domain of public policy, which is different from politics (although intertwined with it) and also different from administration with the connotation of the civil service that takes politics/policy, codifies it, and translates it into systems capable of being implemented in the field. This domain recognizes policy's intimate relations to other domains but still thinks it worthwhile to give it a domain of its own. That is my perspective, broadly, in this article.

Public Policy

Going beyond the pragmatic definition of public policy as what the government does, it can be defined as the outputs from a process geared to making laws, enactments, and even regulations that are intended to affect society, i.e., produce social outputs and outcomes as a result of the outputs from the political system that we may call policy. Note that, in some countries, systems, and cultures, policy even by this definition may not be handled primarily by the politicians, but this is in itself a (political) characteristic of the political system.

On this approach to the process, the inputs are various (Paton, 2006a). They range from ideas and ideologies, through the political culture, through political movements or parties, through the effect of political institutions and structures generally, through social movements, interests, and pressure groups, through dominant modes of behavior (whether rational or otherwise), to the administrative or bureaucratic culture. Below, I examine the key factors involved.

Meanwhile, selectively, the following section defines some more terms.

General Terms

- **Environment/context:** The external climate and actual constraints, or pressures, which influence policy. For example: In the economic environment of global capitalism, it is difficult for individual countries to create or maintain progressive taxation systems with high tax rates, and the prospects for expanding public health-care systems are therefore diminished.
- **Actors/agents/stakeholders:** All those individuals, groups, interests, agencies, and organizations that are involved with, concerned with, or affected by, a specific policy (see Kingdon, 1984; Buse *et al.*, 2005).
- **Agenda:** The terms of debate on which an issue is developed in the policy process, or the prioritizing of one issue rather than another – or none – in the political process, or in an agent's schedule (see Kingdon, 1984).
- **Problem:** Seemingly straightforward (for example, “the primary problem with the British NHS in the 1990s was long waiting times”) but useful when considering how agendas are formed (e.g., is there agreement as to what the problem(s) is/are), and how politics, problems, and policies interact (John, 1999; Paton, 2006a).
- **Power:** The ability of Actor A to win in an overt political battle (Dahl, 1980) (in our case, in the health policy arena) with B; or the ability of A to prevent B from raising an issue (effectively) within the political process (Bachrach and Baratz, 1970); or the ability of A to prevent B from even being aware he has a grievance or should have a grievance (see Crenson, 1971; Lukes, 1974); or the effect of the dominant (or prevailing, or pervasive) discourse upon the perception of issues (in the poststructuralist sense, in terms of the effects of language upon concepts and thought) (Peck and Coyle, 2002: 214–219). Note that the last definition de-centers the actor – power is less a conscious attempt to win, by an agent, than an effect.

Practical Terms for the (Health) Policy World

- **Regulation:** A framework of rules (e.g., a legally backed code) or practices (e.g., by an inspecting agency) that define permitted activity, or type and mode of activity, in a field, as opposed to planning or management, which intervene directly rather than set a framework for self-action. For example, the new regulation in health care sets out the rules for markets or quasi-markets, in formerly directly managed health-care systems. Day and Klein (1987) argued that a regulator is external (so that, for example, a higher tier within a public health-care system does not regulate but instructs or manages).
- **Strategy:** Often contrasted with (on the one hand) tactics, it refers to the means of achieving a direction of travel or goal (as in military strategy), e.g., “the strategy for involving the public more in decision-making is to set up local self-governing units in the healthcare system”; contrasted (on the other hand) with an operational focus on keeping things running, as in “the Health Authority's Director of Strategy will ensure that our plans are consistent with our goal of improving access to the under-served; whereas the Director of Operations will seek to increase throughput in the wards to meet government targets.”
- **Governance:** Within public services such as health care, the adoption of an appropriate structure and culture of oversight of the organization (as in corporate

governance, which seeks to assure that the organization is run and controlled ethically, soundly, sustainably and appropriately; or clinical governance, which is the corporate governance of the clinical process in particular).

Explaining Public Policy

Through one interpretation, actors (e.g., policy makers) are rational. This might be in the sense of either maximizing their utility (the neoclassical microeconomic viewpoint) or planning a coherent – perhaps evidence-based – route to achievement of objectives, i.e., the tailoring of means to ends.

This latter view is found in political and administrative science, e.g., in Allison (1971). The question is begged as to whether such rationality commands consensus (the unitarist view, or Allison's Model 1 when applied to policy making within the portals of central government) or whether different interests, elites, structural interests, or economic classes – either in government or across the wider polity and society – have different objectives (respectively, the pluralist, elitist, corporatist, or Marxist views) (Paton, 2006a). These different objectives might be rational on the terms of the individuals and groups who have them, and they may be pursued rationally in terms of the instrumental tailoring of means to needs. Yet the overall effect is not consensual pursuit of universally acknowledged rational outcomes. Instead there may be pluralism, with compromise as the basis for outcome – leading, perhaps, to incremental, small-scale policy changes overall even when each group or interest seeks radical, large-scale change. (Compromise is a very different thing from consensus, although there may be eventual consensus upon the need for, and nature of, compromise.) Or indeed there may be domination by an elite or ruling class, which creates a dominant agenda. This may look like rationalism, not least in terms of the passage of comprehensive policy rather than cautious adjustment, but is a very different thing, once again.

One may also consider actors seeking to achieve their chosen outputs and outcomes (as defined above), but tailoring their behavior in line with the incentives created or enhanced by the institutions' way of working. This is institutional rational choice (Dunleavy, 1989).

But perhaps the culture created or encouraged by structures, and the behavior they encourage, takes on a life of its own: There is a mobilization of bias (Schattschneider, 1960; Paton, 1990) in policy. This may be due to the effect of external structures upon people's expectations and ways of thinking (i.e., cognitive structures) rather than (just) upon the calculations of autonomous rational actors whose thought processes and agency are unaffected by structures.

Indeed there is a difficulty with assuming that humans have an unchanging, rational, or maximizing nature – what

Archer calls Modernist Man (Archer, 2000). While it has the merit of preventing the agent from being (implausibly) completely subsumed by society, it begs the question as to where this intrinsic nature comes from. Not only are the assumptions behind rational man questionable (an ontological matter), but their origin is too (an epistemological matter).

Structuralism (Peck and Coyle, 2002: 211–214) arguably solves the dualism by going too far in the other direction. It either removes man's autonomy, positing that deep cognitive or real (natural or social) structures dominate agency. Poststructuralism posits that structures are linguistically determined but variable, indeed arbitrary (Peck and Coyle, 2002: 214–219). On this approach, varying discourses and perspectives that are thus based are constitutive of the individual. The paradox is that the agent is no longer determined by deep or unchanging structures but that there seems no basis for agency other than by changing language. On this basis, agents *qua* policy makers are neither rational nor irrational: There is no objective basis for evaluating their actions.

Other approaches point to the actor's autonomy being limited but not eradicated. In public administration, this might provide a useful reminder of the role of cultures, ideologies, and ideas in policy studies.

Particular structures of relevance to health policy are political institutions, governmental and administrative structures, and specific health agencies. We may wish to define culture separately from structure, or to interpret cultures, habits, and beliefs (including ideologies and ideas) as structures for the present purpose – identifying external factors when seeking to explain or influence policy.

The literature concerning the factors that influence, shape, and even cause public policy is now immense. It is necessary to walk the tightrope between theory, on the one hand, and plausible explanation of what is actually happening in the real world, on the other hand. Rhodes (in Stoker, 2000) stated memorably that social science can cope with a lot of hindsight, a little insight, and almost no foresight! Thus it is with explanations of public policy.

The policy process (Hill, 1997) is a phrase that characterizes the story of how policies develop, are implemented, in often unpredictable or even perverse ways, and are amended, in a process that is less linear than (variously) wave-like, stew-like, cyclical, and even circular. It should also be understood to encapsulate how politics both shapes and is shaped by policy and the social outcomes that result from policy outputs.

Explanatory Factors (Illustrated for Health)

The key factors used in political science and public administration to explain outputs and outcomes in public policy are:

1. Political economy (generally, and also embracing regime or regulation theory) (Aglietta, 1979; Jessop, 2002): Political economy can be defined as the way in which wealth is produced and distributed. It is a crucial backdrop to understanding the underlying pressures and constraints upon health policy. The global capitalist economy puts significant pressures upon public health systems, as well as (for some countries) generating wealth and income that can be used for both private and public purchasing of health care. Additionally, effects upon health outside the health-care system altogether can affect health both positively and negatively. How public policy generally and health policy in particular interact in this environment is crucial.

For most but not all countries of the world, current international political economy as opposed to purely national political economy is more important than during the period from 1945 to 1975, which was an era of expansion of economies and of the welfare state in what was then called the industrialized West; expansion which had knock-on effects elsewhere around the globe. Subsequent retrenchment, plus a (related) change in dominant type of political economy (or regime), has had significant effects on health-care systems.

The first wave of global health sector reform in the 1940s and 1950s (WHO, 2000a) consisted in the establishment of national health-care systems in many countries. The second wave (1960s and 1970s) consisted in primary health care as a strategy for affordable universal coverage (given already-experienced cost pressures) in developing countries. The third wave – moving into the 1980s and beyond – consisted in a move away from statist public systems to either public or mixed systems relying more on market, quasi-market, or new public management mechanisms (WHO, 2000a).

2. Socioeconomic factors. These are distinguished from (1), although they are related in that they refer to data and demographics, such as the level of wealth of a country and the distribution of wealth and income. Health and welfare expenditure, for example, has been correlated to the former (see Wilensky, 1974; Maxwell, 1982).

3. Institutional, new institutional, and structural explanations, which give primacy to the effect of political institutions (and the behavior and incentives that they create) in explaining policy outputs (Dowding, 1990; Paton 1990). In health policy, policy may result both from the way institutions operate and also how they create a dependency that constrains future policy or directs it in a particular way.

4. Institution-based rational choice. Individuals may act in groups or share interests which influence their behavior, yet have goals and objectives that are determined independently of political structures (institutions) and of cultural factors (for example, a putative dominant ideology). Nevertheless, their behavior is influenced by institutions and the incentives to which the latter give rise,

as they seek to achieve their objectives in the most rational manner. This is a version of institutional rational choice (which, as Dowding (1990) points out, need not be methodologically individualist).

Original or pure rational choice theory as applied to politics was individualist. Public choice theory was based on the view that both individuals and agencies (collectivities of individuals) are selfish maximizers. The implications were that bureaux and bureaucracies would seek to maximize their budget beyond the point of efficiency or effectiveness. For example, the chiefs of a health department – or publicly funded hospital system – would use the political process (perhaps in coalition with politicians, civil servants, and doctors, all building their empires) to expand.

This was one of the rationales for the purchaser/provider split (Osborne and Gaebler, 1993), which has featured significantly in both the theory and practice of health sector reform since the late 1980s and 1990s. The trend started in developed countries, particularly the UK and New Zealand (Paton *et al.*, 2000). Countries with public or publicly regulated insurance in central Europe systems, such as the Bismarckian systems of social insurance (Paton *et al.*, 2000), always had financier/provider splits in the tautologous sense that payers and insurers were separate entities from providers. But this is merely the traditional system that operated through guilds (self-governing providers, professions, and payers regulated by the state) relating to each other without much competition. It is not the same thing as a deliberately created quasi-market or new public management reform.

The latter has also been used to reform Bismarckian systems by instigating competition between payers and insurers (whether public or private) for subscribers. Providers of services would have to justify their product (effectiveness) and their costs (efficiency) through tendering competitively in order to win a contract, or at least, if competition was not possible, through setting out clearly their services in response to a specification that might be contestable in the longer run if it was unacceptable in cost or quality.

The trouble with this was that purchasing authorities and agencies would also be selfish maximizers if the theory were right. Who would control them? The answer – especially in health care – has often been a system regulator (Saltman *et al.*, 2002). But the same applies to the regulator! So we are driven back to government, as the regulator of regulators. And who controls government? The answer is (idealistically) the people or (realistically) special interests or the ruling class. There is no technical solution – such as purchaser/provider splits – to what is in essence a political problem.

5. Issues of power, of how power is distributed in society and within the political system, and how it influences public policy. For example, is power distributed

pluralistically, or are decisions taken by – or in the interests of – the ruling elite or a ruling class? Here, it is important to distinguish instrumentalism (arguing that, if politics and policy benefit a group, elite, or class, how this occurs must be actually demonstrated) and functionalism (which implies that means that are functional for ends somehow are realized).

An example of using functionalism to defend Marxism, for example, was found in Cohen (1978) A strong variant of functionalism is evolutionism, which draws an analogy with Darwinism in natural science to imply that the policies that come to dominate are those best suited to surviving in their (political) environment (John, 1999).

Functionalism implies that policies develop because they are functional for the external environment, whereas evolutionism implies that policies develop if the external environment is functional for them. Neither stance is satisfactory, as the how is missing. And evolutionism in particular – in social science and policy studies – is either tautologous or vacuous. This is because, unlike in the natural world, the environment is human-made and mutable and can be made functional for policies. Anything can therefore be explained in this manner.

The classic example of power in health policy has concerned the medical profession and its relationship both with other actors in health-care systems (especially managers) and with the state.

Network theory, whether sociological, political, or managerial, has had prominence recently. To some it is descriptive rather than analytical (Dowding, 1995), although if integrated with power studies (i.e., networks explained in terms of power and influence) it can be useful (Marsh, 1998). At its best, it has the potential to explore how regimes at various levels of government (international, national, and local) are responsible for investment and consumption, and therefore to link political economy with institutional and behavioral analysis.

For example, the corporatist approach – which depicts iron triangles of business, government, and labor in policy decision making (see for example Cawson, 1986) – was extended to depict how national government organizes investment and local government organizes consumption. More recently, in the global and European era, local and regional government and governance are responsible for investment to a greater extent, with national government ironically increasingly controlling or circumscribing consumption. This is related to a (concealed) change in power relations in the economy, with corporatist tri-lateralism replaced with the bilateralism of business and the state.

6. Ideas and ideologies, which are important, but often linked to wider social factors (and political economy), and in complicated ways. An approach emphasizing the primacy of ideas may sound rational. On the other hand, an approach emphasizing ideology may be ambiguous. Ideology can suggest moral goals and a program to achieve them, or it can suggest false consciousness of agents who are cultural dupes. In health, the primary care movement is sometimes seen as ideologically motivated. Equally Navarro (1978) has argued that high-technology medicine is a means of buying off workers given the disadvantages of (and lack of effective public health in) capitalist society.

A Synthesis

Clearly, different factors can be combined in explaining public (and health) policy. Different typologies are available to aid with this task (see **Tables 1** and **2**)

Two examples are provided:

1. Policy may be made for health, or it may be made with other factors in mind (e.g., trade, the economy). We can call these, respectively, internal and external policy.

Table 1 Power

	<i>Pluralism</i>	<i>Elitism/ruling class</i>
Internal	Pluralist conflict within health systems over priorities	Domination of power and resources by the medical profession or business
External	Pluralist conflict within local communities or districts over control of health agencies for political purposes	Use of the health system to benefit the capitalist economy, as in promotion or private provision not for health system reasons but to support or subsidize corporations

Table 2 Type and degree of rationality

	<i>Unitarist</i>	<i>Pluralist</i>
Rationalist	Government pursuing system-wide reform on the basis of agreed objectives	Each interest group or stakeholder pursues its goals rationally, but the overall result has to be a compromise
Incrementalist	Government gradually amending policy on the basis of agreed objectives (perhaps with a conservative bias by civil servants)	Disjointed incrementalism, where mutual adjustment (and its direction) depends upon the resolution of different agendas on the part of different actors behaving incrementally

Additionally, power may be distributed widely in making – or implementing – policy, or it may be concentrated. We can call these, respectively, pluralism and elitism (or ruling class theory).

Table 1 shows four possibilities, with four health examples. The aim is not to develop grand theory but to provide a checklist or an *aide mémoire* when examining empirical possibilities.

2. Policy may be made from a zero base on the basis of seeking means to achieve ends on which there is agreement (either within government or in wider society). This can be called rationalism. Alternatively, it might be made incrementally, on the basis of minor adjustments to previous policy (see the second paragraph in ‘Explaining public policy’ above).

Additionally, policy may be made consensually (or with only one viewpoint featuring, not the same thing), which variants can all be termed unitarism. This in turn can be contrasted with pluralism (defined as in Example 1). This time, the latter refers more to the breadth of influence upon central government than to the nature of social power more generally.

Table 2 shows four possibilities. As with **Table 1**, it illustrates and clarifies rather than helps decide, which must be done on a context-specific basis, i.e., empirically rather than *a priori*.

Explaining Implementation

A framework for explaining implementation can begin simply, analyzing inputs, outputs, and outcomes. Inputs draw on aspects of the explanatory factors described above, translated into concrete terms. It is helpful to categorize these as ideas, institutions, and political behavior (e.g., by political parties). At root the structure versus agency debate in social science (Archer, 2000) is at the heart of the issue: Individuals operating in (structural) contexts, individually or collectively, help to determine outputs and outcomes.

While ideas versus institutions has long been a talking point in policy analysis (King, 1973; Heidenheimer *et al.*, 1975), these inputs produce outputs in the form of public policy. Implementation concerns the process by which such outputs (e.g., laws; an organization’s objectives) are translated into social outcomes. For example, health policy may concern the creation of a publicly funded national health service (NHS). The effect of the NHS upon access to services and health inequalities (for example) occurs as a result of how, where, and when the policy is implemented.

It is possible to have good policy but bad implementation and vice versa (Paton, 2007: Chapter 5). The former may occur when policy is designed (and enacted) rationally, but without taking into account opposition that later is mobilized effectively during the implementation phase. The

latter may occur when policy is enacted after significant, possibly debilitating, compromise, but then implemented in a straightforward manner, as all opposition has already been taken into account.

Regulation is a means of seeking to achieve goals and objectives through a process of implementation, which occurs through self-modification of behavior in response to external rules rather than by direct command and control. Clearly, this is a pertinent issue in health policy, where international trends overtly embrace the new governance through regulation rather than direct control. The recent reorganization of the UK Department of Health (Greer, 2007) (which administers the English NHS but not those of Scotland, Wales, and Northern Ireland) reflects the creation of many quangos (external public agencies) allegedly to replace direct control by government.

There are, broadly, three systems of governance for implementing health policy. Firstly, there is what economists call by the catch-all term of hierarchy (i.e. one word as an alternative to markets) but which may be better described, on examination, as classical bureaucracy or – not the same thing – planning. This is sometimes described as command and control. Often this has pejorative overtones, but it need not: Bureaucracy has advantages in both normative and practical terms. These may include equity, consistency, and transparency (normative) as well as an ability to rationalize systems, reduce inappropriate discretion, and minimize unintended outcomes from local action (practical). Furthermore, the term hierarchy may be inappropriate to describe planning, in health care at least: The latter may eschew the market (see below), but allow considerable devolution of responsibility in meeting goals (Paton, *et al.*, 1998; Paton, 2007).

Secondly, there is the market. Many countries have recently sought to use both market incentives within the public sector (Paton *et al.*, 2000) and private provision to reshape their health-care systems.

Thirdly, there is guild self-regulation. This approach has historically existed in central Europe and also some countries in Latin America as the basis by which the government guarantees access (national health insurance) but providers, payers, and professionals self-regulate to a large extent, often in the context of a corporatism in which quasi-official, nongovernment agencies manage agreement about pay, the prices of services, and market entry.

It has been argued that providers (especially professionals) have knavish as well as knightly tendencies and that guild self-regulation requires both an assumption of altruism (Le Grand, 2003) and the assumption that providers respond to the correct signals in supplying services. Generally policy advocates such as Le Grand (2003) suggest the market as the answer. Yet it is vital to examine what happens when politics meets economics in market-driven health systems, which notoriously produce perverse results (Paton, 2007).

Furthermore, hierarchy, or command, need not be based on the assumption that providers (and managers in health care) only behave in a self-interested (knave) manner. Planning approaches in health care, with official targets, may be a means of coordinating altruistic public service as well as providing material incentives for compliance.

Clinical networks, bringing together professionals from different institutions, may (for example) require both (internal) coordination and (external) compatibility with wider policy and managerial objectives. To replace these with atomized market incentives may encourage knave behavior rather than channel it.

In terms of global health policy, we have the paradox that the ideology of the market sometimes continues to be on the ascendant but that its effects upon implementation are complex and often perverse (Segall, 2000; Blas, 2005).

Policy in Practice

The seemingly random interplay of ideas, groups organized around ideas, interests or advocacy (combining both values and interests; Hann, 1995), and opportunities for policy decisions leads us to the garbage can approach (Cohen *et al.*, 1972). Policy now seems an arbitrary mess. And it may be, at one level or for some of the time. Agendas are successful, in this approach, not because of rationality but because of time or timing and chance (Kingdon, 1984). Policy, politics, and problems are separate streams rather than components of a rational process, and only when they flow together is policy created. This might, for example, be when politicians seize an answer (i.e., a policy) because it is available, trendy, and (coincidentally rather than logically) seemingly an answer to a problem that is perceived to be pressing.

The question then arises: If policies emerge haphazardly, one after another, how is policy rationalized, if indeed it is, to ensure that the aims of the state are realized or that policy outputs, at least to a minimal extent, achieve the social outcomes required for both the legitimacy of the state and the requisite stability of institutions? This is a more fundamental question than one about the aims of government. Clearly individual governments' aims simply may not be realized. Nor should one assume that there is some teleology or functionalism favoring the aims of the state.

My argument is a different one, which can be illustrated from health policy. An institution such as the British NHS is only politically legitimate and economically viable if it satisfies several conditions: Investment in cadres of domestic workers occupying salient niches in the international economy; acceptability to the demanding middle classes, in terms of both quality and financial outlay (i.e., comparable to what they would pay if only insuring themselves); and fulfillment of its egalitarian

founding mission at least to the extent that it seems worth the moral bother of protecting in the first place.

How can action by the state or its agents seek to fulfill these conditions? How in other words does the political realm ensure the compatibility of social institutions (such as the NHS) with economic reproduction? This is the crucial question for the sustainability of public health systems in the era of global capitalism.

There is no inevitability here. The state may act effectively to square the circle – not just of competing social demands in the conventional sense, but of the competing agendas listed two paragraphs above. If it does not or cannot – for example, if a country's public health service does not satisfy employers' needs and demands for healthy employees – employers will seek to finance their own occupational health. If doctors fail to cooperate at least adequately to prioritize the outputs and outcomes that the state requires, then either they will be coerced into doing so within the NHS or they will be disciplined by market forces outside the NHS, as corporations take responsibility for health care on a sectional basis (perhaps taking advantage of European Union law).

What this does, then, is give governments that are sympathetic to preserving at least publicly financed health care an interest in ensuring that the state coordinates policy at the end of the day, so that a complex amalgam of aims can be furthered. There is in practice a major conflict between the garbage can that produces continual waves of incompatible, media-driven policy, mostly in the developed world (Paton, 2006) or policy distorted by the predatory state (Martinussen, 1994), mostly in the developing world, on the one hand; and the need for effective coordination, on the other hand.

The latter means tight control of resources given the ambitiousness and complexity of aims, which means political centralism against all prevailing rhetoric. Most devolution and decentralization in state-dominated health systems is devolution of responsibility for functions, not devolution of power. Again, we can see that, in order to explain public policy outputs, we have to consider, respectively, the backdrop of political economy; social power; the structure of the state and political institutions; and how individuals, groups, interests, and classes behave in the context of the structures they must use.

For example, Allison's (1971) Model 1 posits a unified executive pursuing the national good, having been developed empirically to explain the U.S. government's behavior during the Cuban missile crisis. It is therefore a kind of grounded theory that is context-specific, and therefore the model may be less suitable for wider explanation of social decision making, interest-group politics, and power.

The challenge is to incorporate different explanatory factors at different levels of analysis. These levels can be considered to be a hierarchy in that there is a move from the underlying to the immediate in terms of their causal nature as regards policy outputs, but this is heuristic

rather than wholly empirical. It is important not to be too rigid about (for example) what is undoubtedly a two-way relationship between political structure and social power: The latter will exert itself, except in exceptional circumstances, through different forms of structure, it is true; but the former's mode of channeling power may alter the nature of that power in so doing.

For example, the medical profession was powerful, as a stratum within a social and economic elite in the 30 post-war years of the last century, in both the United Kingdom and the United States. It was capable of exerting its power through the then very different political institutions of the United Kingdom and the United States. In the centralized, executive-heavy UK with (then) a political culture of insider networks that were relatively invisible (like all effective power!), an implicit bargain was made through informal channels between the state and the profession (Klein, 1990), which meant a symbiotic relationship in governing the NHS. In the United States, with its decentralized interest-group politics as the stuff of the system, the profession preserved its power using different institutions in different ways, primarily by blocking reform (in the way that the insurance industry did with the Clinton Plan in the 1990s (Mann and Ornstein, 1995; Paton, 1996), by which time it had replaced the now toothless tiger of the American Medical Association (AMA) as the lobby feared by reforming legislators).

The question that arises is: Is power economically rooted at base, with the decline in the AMA's – and the wider medical profession's – power caused by a surplus of doctors, on the one hand, by comparison with the 1950s and 1960s (when access to health care was extended by government, and the medical profession's fears of socialization were shown to be ideological rather than economic), and by new corporate approaches to purchasing and organizing health care for their workers, on the other hand?

There is clearly truth in this. Yet it is not the whole story. The centralist UK political system was capable of more systematic reform – including the creation of the NHS itself – than in the United States, when the UK state was governed by a strong political party with clear and comprehensive aims, in other words, majority rule rather than the passage of policy by the painstaking assemblage of winning coalitions in the legislature. The latter creates a mobilization of bias (Schattschneider, 1960) away from comprehensive or rationalist reform as opposed to incremental reform, which in turn alters mindsets and limit ambitions. That is, structures can have cultural and ideological effects.

It is important to study an issue such as health policy over a long enough period (subjectively, about 20–30 years, in today's world) to allow different eras to register and therefore the changing salience of different explanatory factors in public policy. In a nutshell, the 1970s was the era of political structures, as the prevailing

political economy was nationally based; the 2000s are the era of political economy, as capitalist globalism reduces the salience of nations and their institutions.

In other words, political economy is at the top of the hierarchy of salient factors in delimiting and explaining public policy. It sets the background, environment, and constraints. Depicting a regime in political economy shows how the state and other elements of the polity come together to steer the economy in a particular way. It is Marxist, in that it prioritizes economic production, situates political viability and legitimacy in terms of the political economy and has crisis as the motivation to move from one type of regime to another (for example, from the Keynesian national welfare state to the Schumpeterian workfare state, in the language of Jessop (2002)). It is, however, post-Marxist or non-Marxist in that regimes vary within capitalism, that is, a regime is less than a mode of production in the Marxist sense.

Institutions and political structures shape behavior, partly by channeling rational behavior (i.e., institutional rational choice) but also by changing cultures and expectations, which feed into future ideas for policy, reform, or whatever, as outlined above. For example, in the United States, the failure of successive attempts at federal health reform, foundering on the rocks of established structures and interests inhabiting them, has lowered expectations for future action on the part of many reformers even without them realizing.

Power is exerted, that is, through institutions overtly and covertly, but the latter equates neither to Lukes' (1974) nor to the poststructuralist vision of dialogues that are enclosed and arbitrary. Loss of ambition in reform ideas is a fatalism, in this sense, rather than a false consciousness, perhaps because elites are systematically lucky (in Dowding's (1990) arresting oxymoron). In the end, it is just that, an oxymoron, because – with reflexivity of actors and even of passive public(s) – those who are systematically lucky are likely to go beyond luck, i.e., to build on it in a deliberate strategy to maximize their instrumental power.

Political structures and institutions vary between countries (as well as sub- and supranational levels). Thus executives vary in structure, scope, salience, and power, within the political system in general and state in particular. Regimes are more than governments and less than state systems. In health policy, regimes embody the prevailing orthodoxy in ideas (or ideology) as adapted to, and amended by, political institutions and social structures.

Policy for Financing Health Care and Structuring Health Systems

We can illustrate how health policy reflects a variety of different influences by examining how health systems may be financed and governed.

Financing Options

The main options for financing health care (ranged along a continuum from private to public) are as follows:

1. private payment (out of pocket), including partial private payment, i.e., co-payments (coinsurance or deductibles) (coinsurance means the consumer paying a proportion of the cost, e.g., 20%; a deductible means the consumer paying a fixed amount on each claim, e.g., £50);
2. voluntary private insurance, including partial versions (e.g., supplementary and complementary insurance, to be discussed below);
3. statutory private insurance regulated by the state (including partial versions such as substitutive insurance, meaning – in this option – mandatory private contributions by certain categories of citizen (generally the better-off) toward core rather than supplementary or optional health services. That is, everyone is covered, but the better-off pay a form of insurance that is obligatory);
4. community pooling;
5. public/social insurance;
6. hypothecated (earmarked) health taxation;
7. general taxation.

Assessment of Options Against Criteria

A specific policy analysis would assess options, one by one, against identified criteria and (perhaps) incorporate a weighting procedure to rank the options. From the viewpoint of understanding how policy is actually made, however, this would only be part of the picture.

It might constitute an attempt at rational policy making, that is, an attempt to provide a basis for scientific consensus among the key actors holding power in either the policy process generally or government in particular. Alternatively, it might seek to build in to the criteria for judging options (or even, to the options themselves) pragmatic or political factors (such as the political feasibility of an option in a particular political context).

Either way, it is important to be explicit about the range of factors likely to affect a policy's success as regards both enactment and implementation (i.e., outputs and outcome, respectively), as explored in the sections titled 'Explaining public policy' and 'Policy in practice'. Otherwise, there is a divorce in the policy dialogue between what might be termed technocrats (such as economists), on the one hand, and political scientists on the other. The divorce between such worlds is often responsible for extremes of optimism and disillusionment, respectively, in assessing policy *ex ante* and *ex post*, as with recent health reform programs in England, for example.

Governance

There are fundamentally three categories of system:

1. statist systems;
2. market systems (whether private, public, or mixed);
3. self-governing systems (with varying degrees of state regulation) (Arts and Gelissen, 2002), in which either guilds or organized functional interests or networks (of providers, financiers, and employees) organize the delivery of care.

Statist systems have replaced the market with public planning, whether it is dominated by politics, the public, or experts. Market systems rely on either private markets that have evolved historically or on the creation of market structures and incentives within (formerly) publicly planned systems. Self-governing systems are systems where central state control is limited or weak or both, but where guild-like relationships rather than market relationships between key actors predominate. For example, physicians' associations, insurers' associations, and the state will thrash out deals in a corporatist manner, with corporatism meaning (in this context) the institutionalization of major social interests into a reasonably stable decision-making machinery overseen by – but not dominated by – the state.

Clearly most advanced health-care systems are hybrids in varying degrees. The question is whether the degree of hybridity is dysfunctional or not, i.e., whether cultures and incentives are adequately aligned throughout the system.

Using the language of incentives, it is important to distinguish between macro and micro incentives. Statist systems, for example, are generally good (often too good!) at macro cost control; their record in terms of micro-level allocations (e.g., to providers or clinical teams) to achieve objectives is variable (a statement that should be taken at face-value; some are good at it; others are not). Those systems that allow meso-level planning authorities, such as regions, to avoid the excesses of both central control and local capture by unrepresentative interests, often have the capacity to square the circle in terms of incentives, as long as attention is paid to steering the system to achieve desired outcomes.

While all systems are likely to be hybrids, it is important to ensure that the dominant incentives, geared to achieving the most important objectives agreed by government on behalf of society, are not stymied by cross-cutting policies with separate incentives. This has been an occupational hazard of (for example) England in recent years, arguably, with four different policy streams vying for dominance: The purchaser/provider split inherited from the 1990s' old market and deepened by the creation of Primary Care Trusts; local collaboration as an alleged third-way alternative to state control and markets; central

control through myriads of targets; and the new market of patient choice implemented alongside payment by results (Paton, 2005a, 2005b).

In consequence, in considering structures, attention ought to be paid to the central structure, i.e., how the political level is and is not distinguished in terms of governance from the top management, i.e., health executive level. There is no one answer (again, as the United Kingdom and especially England's *volte faces* on whether or not health ought to be managed strategically at arm's length from government or not probably show). Nevertheless, the question ought to be considered in terms of roles and functions of the different levels within a coherent governance structure: Is the system capable of articulating consistent policy?

The Politics of Policy Analysis and Policy Outcomes

Policy studies have evolved the term path dependency to illustrate how historical choices create paths that constrain (although do not necessarily determine) future options. This is sometimes allied with the concept of the new institutionalism, which is actually just a way of emphasizing that agency, ideas, and ideologies are only part of the picture.

For example, policy debates vary from country to country – say, in terms of how to reform health services or with regard to the best type of health-care systems – for reasons that do not involve only the cultural relativism of ideas. There are relatively universal typologies of health-care systems, analyzed along dimensions such as how universal coverage is, how comprehensive services are, and how payment is made. Yet these debates are handled very differently, with different results, in domestic policy communities in different countries, even when these countries might seem fairly similar in global terms (e.g., France, Germany, Switzerland, Sweden, and the countries of the UK). Political institutions and their normal functioning constrain and direct policy (Paton, 1990).

The field of policy studies also analyzes how different policy communities and networks (both insider and outsider) influence policy. Even in an era of globalization and (in particular) global capitalism, “global policy debates arrive at local conclusions.” This observation was made by political scientist Hugh Hedo in commenting on a book by Scott Greer (2004), which explores how – even within the United Kingdom – territorial politics and local policy advocacy after devolution have produced diversity within the UK's National Health Services. This is such that one can now talk about four distinctive NHSs (England, Scotland, Wales, and Northern Ireland).

To make an analogous observation, a rational approach to policy analysis may seek to combine (for example) universalism, comprehensiveness, and prepayment (whether by tax or insurance) in different ways. In the abstract, there may be little to choose, for example, between a rationally designed NHS and a rationally designed social insurance system.

Yet the proof of the pudding is in the political digestion. How viable a system is in practice depends not just on technical factors such as efficiency (which are rarely only technical, in any case), but also upon how the politics of both policy design and policy implementation play out. It could be argued, for example, that England's confused and overloaded health reform agenda is destabilizing its NHS, unlike, say, in Finland. Or that France's social insurance system is being adapted to reap the benefits of an NHS-type system. Globalization constrains, but policy and implementation are affected by politics and political structures. As a result, whether or not a system is viable in the global era depends upon practice as well as theory. For example, is an NHS capable of spending money efficiently and effectively enough to make the requisite taxation rates for a comprehensive service viable? The answer, in theory, is yes. The answer, in practice, is we do not know until we have examined if and how different policy objectives, and policy strands, are rendered compatible (Paton, 2006).

The Politics of Health Policy in the World Today

In order to analyze health policy, it is necessary to analyze politics in health, a better phrase than the politics of health. That is, while there may be certain respects in which the politics of health is unique to health, it is generally true that the effect of general political factors upon health, health-care systems, and the delivery of health care is more significant. In other words, political economy (both national and international), political structures, and political systems condition health-care systems and indeed the prospects for health.

Control and conflict over resources for both health and health care put health at the center of politics. Consider also the role of the state. Moran (1999) has talked of the health-care state, with echoes of the welfare state, and the implication both that the state affects health care (and health) and that health-care systems in turn affect the state and political life more generally. The traditional concerns of political science – ranging from normative political theory (concerning the nature of the good society and the role of the state) to both analytical political theory and public administration analyzing the nature of, distribution, uses, and consequences of power – are fairly

and squarely replicated in analyzing the field of health and health care.

Political history is also important. The twentieth century saw the expansion of health systems, often (especially in the developed world, including the communist block, but also in much of South America) into universal systems (i.e., open to all) if not always fully comprehensive (i.e., covering people for everything). (The United States was a notable exception.) This in itself reflected the politics of the twentieth century in which (from a Western perspective) *laissez-faire* gave way to the interventionism of either social democracy or at least increased government activism. While this may seem like a characterization of the developed world, in the developing world, the expansion of schemes of health insurance in South America and the export to colonies and ex-colonies in Africa and Asia of health-care systems from the developed world make it a broader picture.

Health Sector Reform

The logic of globalization has been transmitted directly to the world of health policy (even if the detail that emerges is politically conditioned). For example, a think tank of leading businessmen from multinational corporations in Europe in the mid-1980s, setting out just this rationale (Warner, 1994), had as one of its members a certain Dekker, from the Phillips group in the Netherlands, who also chaired the Dutch health reform committee leading to the Dekker plan of 1987 (which was partially implemented over the 1990s albeit in a restricted form).

The Dutch model of managed competition became the prototype for reform of Bismarckian social insurance schemes in Europe and beyond (including South America), as well as for the failed Clinton Plan in the US (Paton, 1996). The UK model of internal markets and purchaser/provider splits in tax-funded health systems became the prototype for reform of NHS and government systems both in developed and developing worlds. It was devised by right-wing political advisers and politicians who advocated commercialization in the public sector. This model (shared with health sector reform in New Zealand) even became the prototype, somewhat incredibly, for health system reform in the poorest countries of Asia and Africa. Later in the 1990s and early 2000s, the World Bank sought to broaden the framework by which reform ideas and criteria were assessed, but the watchwords were still competition, market forces, and privatization.

The World Health Organization has sought a broader basis for evaluating (and therefore, implicitly, exporting) health system reform. The WHO (2000b) has sought to evaluate health systems around the world by a variety of criteria, including quality, cost-effectiveness, acceptability to citizens, and good governance. The World Bank's

approach, as stated, is heavily influenced by the neoliberal economic agenda applied to health and welfare, an agenda itself influenced by public choice theory (Dunleavy, 1989), especially purchaser/provider splits between buyers and sellers of health services, managed competition, and quasi-commercial providers.

The assumption is that publicly funded health care has to be delivered more efficiently, or cheaply, and has to be more carefully targeted. In Western countries such as the Netherlands, the latter could be done by advocating publicly funded universal access for a restricted basket of services (i.e., universality but not comprehensiveness).

In the developing world from the 1980s onward, usually under the aegis of multilateral agencies such as the World Bank and bilateral aid departments such as Britain's Overseas Development Administration (which became the Department for International Development in 1997), Western policies promoting market forces in health care have been advocated and partially implemented. In other developing countries, the watchword has been decentralization, but the political intention has frequently been both to limit the role of the state in health care and to make communities more responsible for their own health (which sounds culturally progressive but is likely to be fiscally regressive).

As for the whole world, the key question for developing countries is: How is better health (care) to be financed? The options range from private payment through private insurance, through community self-help or cooperative activity, through public insurance, to national systems financed from government revenues, whether operated from the political center or from devolved, decentralized or deconcentrated agencies. (The last refers to field agencies of the central government.) In developing countries, the infrastructure for modern tax-based or national insurance systems often does not exist.

Moreover, the decline of tax and spend in the developing as well as developed world means that third-way solutions (meaning neither traditional state or fully public services nor unregulated markets) are also sought in the third world, irrespective of the names or slogans used. In health, the poorest countries have focused upon building social capital (as in the West): Communities, with aid from bilateral and multilateral agencies as well as nongovernmental organizations (NGOs), have sought to create mutual or cooperative local (informed) insurance schemes.

The priorities for investment in health are often set through a mixture of expert-based needs assessment and local choice via rapid appraisal of local people's needs. Not surprisingly, this offer leads to a focus upon the key determinants of public health such as sanitation, immunization, reproductive and sexual health (embracing maternal and child health), and so on.

Regarding access to more expensive and acute or secondary health services, the key issues are the availability

of pharmaceuticals at affordable prices (with both state and market solutions such as parallel imports being attempted); the provision of integrated primary and secondary care, often through actually siting primary care facilities at hospitals; and the charging policy of public hospitals (i.e., should they be free, should they implement user charges, and if so, how can equity be protected?).

Politics is important in all of these areas. For example, if the private sector in hospital provision is encouraged, it may undermine public hospitals' ability to raise revenue from user charges for better-off patients.

The Changing Capitalist State and Health System Reform

Paradoxically, the capacity of the health-care state (Paton *et al.*, 2000) is increasing in proportion to the complexity of social regulation, while the state's autonomy from economic interests is diminishing. Either the new managerialism (i.e., business systems to replace public administration (Exworthy and Halford, 1999) or direct politicization of public sector targets (Paton, 2006)) is used to seek to tailor health services to both economist needs and economically filtered social needs. Use of the central state to extract maximum additional surplus value for private business from health-care provision can reach its apotheosis in the NHS model. Two paradoxes therefore arise. Firstly, the most progressive and egalitarian model for health services (the NHS model) is also the most easily subverted. (The central state can be used and abused.) Secondly, where the NHS model is off the political agenda (as in the United States) because of a pro-business ideology, the surrogate policy for taming health care in the interests of business (i.e., managed care) is much less cost-effective.

Consider the hypothesis that state-funded health services (such as the NHS) are a cheap means of investment in the workforce and the economy. If firms derive extra profit (surplus value) as a result of healthier workers that is due to social spending, then that extra profit can be thought of as the total extra income minus the costs of the social spending (e.g., corporate tax used to contribute to the NHS) that firms make. The residual – the extra profit – is composed of two elements: The contribution that workers make to their own health-care costs and social expenses (e.g., through tax), which increases their productivity and firms' profits; and the exploitation, i.e., surplus value extracted from, for example, health-care workers. This latter element, if it exists, derives from the incomes of health-care workers being less than the value they create, i.e., the classic Marxist definition of surplus value.

It might be objected that governments do not plot such a scenario or situation. But sociopolitical pressures help to produce such an underlying reality. The changing socioeconomic structure of Western societies, and

the international class structure produced under global capitalism, leads to pressures on publicly financed health systems. This is *inter alia* because more inequality and more complex differentiation of social structures leads to different ability and willingness to pay tax and/or progressive social contributions on the part of different strata. Either private financing of (say) health care will increase or public services will have to please affluent consumers and satisfy corporate expectations for their employees, as well as investing in health on behalf of the economy's needs. The latter may not be equitable, if equity means equal access to services on the basis of equal need. Put bluntly, health-care consumption demands by the richer and investment in the health of skilled, scarce employees, will conflict with egalitarianism in health services.

Greater social inequality plus the absence of a left-of-center electoral majority thus puts pressure on egalitarian policy and institutions such as an NHS available to all irrespective of ability to pay. Attempts to defend such a service tend to be forced onto the terrain of economic justifications, to the argument that international competitive advantage requires a healthy workforce. But the workforce is not the same as the whole of society. Nor is a post-Fordist workforce (i.e., a national class structure shaped by international capitalism) an undifferentiated structure: Some workers are more equal than others when it comes to prioritizing health for economic reasons. It is here that arguments about social capital are sometimes used: A healthy workforce requires a healthy civil society. But this in turn may be a zero-sum game between regions and communities.

At this point, it is worth bringing in the classic Marxist dispute about the nature of the state: Is it a (crude) committee of the bourgeoisie and does it manage the long-term viability of capitalism; or is it an area of hegemonic struggle. In health and health care, what would the rational capitalist state do?

If the state is the rationalizing executive board of the capitalist class, one can imagine the board's secret minutes saying, it makes economic sense for us for the state to fund and provide health care. That way, we will pay less than if we directly provide health benefits for our workforce, company by company or industry by industry. It makes sense because taxation is less progressive than it used to be (so workers pay more; we pay less); the state can force hospitals and other providers to do more for less, i.e., exploit the health workforce to produce additional surplus value for most of us; and the said public services can invest in the productive using allegedly technocratic means of rationing.

At this point, however, if the country's health-care providers were private, for-profit concerns, they might object, on the grounds that the broader interests of (the majority of) capitalists went against their interests,

namely, to derive as much profit as possible from a generously funded health system (broadly, the U.S. position). Equally corporate insurers in the United States resist a single-payer or statist model. Note that such a situation does not pertain in the United Kingdom, with the commercial sector in health care being less economically and therefore politically salient and essentially content with marginal income from the NHS (important as that is in its own terms). Additionally, leaving investment in the workforce to individual firms means a system whereby there is a problem of collective action: Firms will not do it for fear of simply fattening up workers who then move to another firm; or rather, they will only do it in order to recruit and retain the most valuable workers. Again, this is broadly the U.S. situation.

On the other hand, if the state finances and provides a common basket of health services for all (the European model), mechanisms will have to be put in place to limit that basket and to increase productivity in its production. This will mean that wider benefits will be sought privately by individuals or employers. This, very broadly, is the agenda driving European health system reform.

If the state is more than a committee of capitalists (whether with or without the health-care industry) then ironically the hard-nosed longer-term agenda of competitiveness may be easier to implement; hence the continuing viability of the British NHS on economic as opposed to ethical lines, rather than the messy and expensive U.S. system. (Note how New Labour – in defending the NHS – points to how European social insurance taxes business directly.)

The choice between state health care to promote selective investment rather than equitable consumption is glossed over in the rhetoric of the third way, whereby the former becomes social investment and the latter is downplayed either as old tax and spend or as failing adequately to emphasize health promotion, and so on.

Overall, the state in the developed world balances the claims of individual firms, the overall capitalist system and particular laborist or welfarist claims. But in today's international capitalism, securing inward investment is the crucial imperative. Health policy is not determined by political economy, but it is influenced and constrained by it. This occurs in two ways: It affects the money available and its distribution, and policy regimes (associated with regimes in political economy) influence governments and policy makers, with policy transfer across ministries.

Conclusion

This article has defined and explored public policy, applying general concepts to ensure that health policy is not treated in too exceptional or parochial a manner. It

has gone on to explore some of the complexities in making (and understanding) policy and in implementation.

Policy analysis can be defined in two ways. The first is the systematic but normative examination of situations and options in order to generate choice of policy. The second is the academic analysis of how policies originate and where they come from; who and what shapes them; how power is exerted; and what the consequences or outcomes are.

There is often confusion between those two domains both in theory and in practice, perhaps based on the fact that the two meanings are linked psychologically if not logically. Analysts and advocates who wish to find an analytical basis for policy choice (first domain) often have a subconscious picture of the policy process as rational. That is, they assume there is some basis through which evidence can create consensus as a direction or a decision.

Yet the reality is often that interests, ideologies, or both determine policy choice. These choices (by individuals, groups, or classes) may be rational in that the means are chosen (the policies) for the ends or goals. It is just that there is no scientific basis for adjudicating among ends, especially now that teleologies such as Marxism do not hold sway and would-be universal values such as capitalist liberalism are revealed to be partisan rather than universal.

That is, health policy, like public policy generally, is made as a result of the interplay of powerful actors influencing politicians to make decisions (politics), on the basis of policies that are available and currently salient, either because they are trendy or because they are seen as convenient solutions to those problems that currently dominate agendas. Rationality, in the sense of evidence-based tailoring of means to ends, is only consensual if the key decision makers agree as to ends. This may occur if there is wide and genuine social consensus, or – a very different state of affairs – if those who disagree are excluded from a powerful role in the policy process.

In health policy, as in other spheres, we see – locally, nationally, and globally – that orthodoxies wax and wane over decades. (For example, in what used to be called Western countries, the era of public administration gave way to the new public management in the 1980s, 1990s, and beyond, with the latter subsequently being influenced in a harder market direction by both globalization *per se* and the mission of supranational block such as the European Union.) We may call these orthodoxies policy regimes. They are regimes because they combine elements of the dominant political economy and the (usually related) current political orthodoxies i.e., they are more than just a policy yet less than an evidence-based certainty.

See *also*: Agenda Setting in Public Health Policy; The State in Public Health, The Role of.

Citations

- Aglietta M (1979) *The Theory of Capitalist Regulation*. London: New Left Books.
- Allison G (1971) *Essence of Decision*. Boston, MA: Little, Brown.
- Altenstetter C and Björkman J (eds.) (1997) *Health Policy Reform, National Variations and Globalization*. London: Macmillan.
- Archer M (2000) *Being Human: The Problem of Agency*. Cambridge, UK: Cambridge University Press.
- Arts W and Gelissen J (2002) Three worlds of welfare capitalism or more? A state of the art report. *Journal of European Social Policy* 12: 137–158.
- Bachrach P and Baratz M (1970) *Power and Poverty*. New York: Oxford University Press.
- Bell D (1960) *The End of Ideology*. Glencoe, IL: Free Press.
- Blas E (2005) *1990–2000: A Decade of Health Sector Reform in Developing Countries*. Göteborg, Sweden: Nordic School of Public Health.
- Buse K, Mays N, and Walt G (2005) *Making Health Policy*. Buckingham, UK: Open University Press.
- Cawson A (1986) *Corporatism and Political Theory*. Oxford, UK: Basil Blackwell.
- Cohen G (1978) *Karl Marx's Theory of History: A Defence*. Oxford, UK: Clarendon.
- Cohen M, March JG, and Olsen JP (1972) A garbage can model for rational choice. *Administrative Science Quarterly* 1: 1–25.
- Crenson M (1971) *The Un-politics of Air Pollution*. Baltimore, MD: Johns Hopkins University Press.
- Dahl R (1980) *Dilemmas of Pluralist Democracy*. New Haven: Yale University Press.
- Day P and Klein R (1987) *Accountabilities. Five Public Services*. London: Tavistock.
- Dowding K (1990) *Power and Rational Choice*. London: Edward Elgar.
- Dowding K (1995) Model or metaphor? A critical review of the policy networks approach. *Political Studies* XLIII: 136–158.
- Dunleavy P (1989) *Democracy, Bureaucracy and Public Choice*. London: Harvester Wheatsheaf.
- Exworthy M and Halford A (eds.) (1999) *Professionals and the New Managerialism in the Public Sector*. Buckingham, UK: Open University Press.
- Greer S (2004) *Territorial Politics and Health Policy*. Manchester, UK: Manchester University Press.
- Greer S (2007) *The UK Department of Health: From Whitehall to Department to Delivery to What?*. London: Nuffield Trust.
- Hann A (1995) Sharpening up Sabatier. *Politics* 15: 19–26.
- Heidenheimer A, Hecl H, Adams C, et al. (1975) *Comparing Public Policy*. London: Macmillan.
- Hill M (1997) *The Policy Process in the Modern State*. London: Harvester Wheatsheaf.
- Hood C and Scott C (2000) *Regulating Government in a 'Managerial' Age: Towards a Cross-National Perspective*. London: Centre for Analysis of Risk and Regulation, London School of Economics.
- Jessop B (2002) *The Future of the Capitalist State*. Cambridge, UK: Polity.
- John P (1999) *Analysing Public Policy*. London: Pinter.
- King A (1973) Ideas, institutions and the policies of governments. *British Journal of Political Science* 3: 291–313.
- Kingdon J (1984) *Agendas, Alternatives and Public Policies*. Boston, MA: Little, Brown.
- Klein R (1990) The State and the Profession: The Politics of the Double Bed. *British Medical Journal* 301: 700–702.
- Le Grand J (2003) *Motivation, Agency and Public Policy*. Oxford, UK: Oxford University Press.
- Lukes S (1974) *Power: A Radical View*. London: Macmillan.
- Mann T and Ornstein NJ (1995) *Intensive Care: How Congress Shapes Health Policy*. Washington, DC: Brookings Institute.
- Marsh D (ed.) (1998) *Comparing Policy Networks*. Buckingham, UK: Open University Press.
- Martinussen J (1994) *Samfund, stat og marked*. Copenhagen, Denmark: Mellempøkeligt Samvirke.
- Maxwell R (1982) *Health and Wealth*. London: Kings Fund.
- Moran M (1999) *Governing the Health Care State*. Manchester, UK: Manchester University Press.
- Navarro V (1978) *Class Struggle, the State and Medicine*. London: Martin Robertson.
- Osborne D and Gaebler T (1993) *Reinventing Government*. New York: Plume.
- Paton C (1990) *US Health Politics: Public Policy and Political Theory*. Aldershot, UK: Avebury.
- Paton C (1996) The Clinton Plan. In: Bailey C, Cain B, Peele G, and Peters BG (eds.) *Developments in American Politics*. London: Macmillan.
- Paton C (2005a) Open Letter to Patricia Hewitt. *Health Service Journal*, pp. 21. May 19.
- Paton C (2005b) The State of the Health Care System. In: Dawson S and Sausman C (eds.) *Future Health Organisations and Systems*. Basingstoke, UK: Palgrave.
- Paton C (2006) *New Labour's State of Health: Political Economy, Public Policy and the NHS*. Aldershot, UK: Avebury.
- Paton C (2007) Visible hand or invisible fist? Choice in the English NHS. *Journal of Health Economics, Policy and Law* 2(3).
- Paton C, Birch K, Hunt K, et al. (1998) *Competition and Planning in the NHS, The Consequences of the Reforms*. 2nd edn. Cheltenham, UK: Stanley Thornes.
- Paton C, et al. (2000) *The Impact of Market Forces Upon Health Systems*. Dublin, Ireland: European Health Management Association.
- Peck J and Coyle M (2002) *Literary Terms and Criticism*. London: Palgrave.
- Saltman R, Busse R, and Mossialos E (eds.) (2002) *Regulating Entrepreneurial Behaviour in European Health Care Systems*. Buckingham, UK: Open University Press.
- Schattschneider EE (1995) *The Semi-Sovereign People: A Realist's View of Democracy*. London: Holt.
- Segall M (2000) From co-operation to competition in national health systems – and back? Impact on professional ethics and quality of care. *International Journal of Health Planning and Management* 15: 61–79.
- Stoker G (ed.) (2000) *The New Politics of Local Governance*. London: Macmillan.
- Taylor-Gooby P (1985) *Public Opinion, Ideology and State Welfare*. London: Routledge.
- Warner M (1994) In: Lee K (ed.) *Health Care Systems: Can They Deliver?* Keele, UK: Keele University Press.
- Wilensky H (1974) *The Welfare State and Equality*. Berkeley, CA: University of California Press.
- World Health Organization (2000a) *The World Health Report*. Geneva, Switzerland: World Health Organization.
- World Health Organization (2000b) *The World Health Report 2000 Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization.

Further Reading

- Braverman H (1998) *Labour and Monopoly Capital*. New York: Monthly Review Press.
- Department of Health (2002) *The NHS Plan: Next Steps for Investment, Next Steps for Reform*. London: Department of Health.
- Galbraith JK (1992) *The Culture of Contentment*. London: Sinclair-Stevenson.
- Gough I (1979) *The Political Economy of the Welfare State*. London: Macmillan.
- Gray J (1998) *False Dawn: The Delusions of Global Capitalism*. London: Granta.
- Jessop B (1994) The transition to post-Fordism and the Schumpeterian workfare state. In: Burrows R and Loader B (eds.) *Towards a Post-Fordist Welfare State?* London: Routledge.
- Lowi T (1964) American business, public policy, case studies and political theory. *World Politics* XVI: 677–715.
- O'Connor J (1973) *The Fiscal Crisis of the State*. New York: Harper and Row.

- Paton C (1995) Present dangers and future threats: Some perverse incentives in the NHS reforms. *British Medical Journal* 310: 1245–1248.
- Paton C (2000) *World, Class, Britain: Political Economy, Political Theory and Public Policy*. London: Macmillan.
- Paton C (2001) The state in health: Global capitalism, conspiracy, cock-up and competitive change in the NHS. *Public Policy and Administration* 16(4): 61–83.
- Poulantzas N (1973) *Political Power and Social Classes*. London: New Left Books.
- Price D, Pollock A, and Shaoul J (1999) How the World Trade Organization is shaping domestic policies in healthcare. *Lancet* 354: 1889–1892.
- Skocpol T (1997) *Boomerang: Health Care Reform and the Turn Against Government*. 2nd edn. New York: W.W. Norton.
- Stockman D (1986) *The Triumph of Politics*. New York: Harper and Row.

Agenda Setting in Public Health Policy

J Shiffman, Maxwell School of Syracuse University, Syracuse, NY, USA

© 2008 Elsevier Inc. All rights reserved.

Introduction

Definitions

The public policy process, in simplified form, can be understood as a sequence of four phases: agenda setting, formulation, implementation, and evaluation. Agenda setting is the first phase, the issue-sorting stage, during which some concerns rise to the attention of policy makers while others receive minimal attention or are neglected completely. The importance of this phase lies in the fact that there are thousands of issues that might occupy the attention of policy makers, but in practice only a handful actually do gain their consideration.

Research in this field investigates how issues emerge on the policy agenda, defined (Kingdon, 1984, p. 3) as ‘the list of subjects or problems to which governmental officials, and people outside of government closely associated with those officials, are paying some serious attention at any given time.’ Kingdon (p. 4) distinguishes between the governmental agenda, the list of subjects that are getting attention, and the decision agenda, the subset of issues on the governmental agenda that are ‘up for an active decision.’

Agenda Setting and Priority Setting

The subject of public policy agenda setting has inspired considerable research, but little of that is in the field of public health. There has been much greater attention in public health scholarship to a concept that is related to but distinct from agenda setting: priority setting. While those investigating priority setting in health have studied how scarce resources are allocated among health causes, their predominant concern has been how scarce resources should be allocated, a normative issue. Often they are motivated by uneasiness that resources and attention are

not fairly distributed. For instance, the Global Forum for Health Research monitors resource commitments for health research. It is committed to redressing what it calls ‘the 10/90’ gap – a concern that only 10% of the world’s research funds are being applied to conditions of the developing world that account for 90% of the world’s health problems (Global Forum for Health Research, 2004).

An assumption in much, if not all, of this research tradition is that there are objective facts about the world – such as the burden caused by a particular disease and the cost-effectiveness of an intervention – that can be used to make rational decisions on health resource allocation. As Reichenbach notes (2002), one example of priority-setting research is cost-effectiveness analysis, which seeks to evaluate alternative interventions based on how much health improvement can be purchased per monetary unit. A second example is the disability-adjusted life year (DALY), a measure of the number of years of healthy life lost due to individual conditions, enabling comparisons across diseases. Its developers have used DALYs to identify the ten diseases posing the greatest burden globally: perinatal conditions, lower respiratory infections, ischemic heart disease, cerebrovascular disease, HIV/AIDS, diarrheal diseases, unipolar major depression, malaria, chronic obstructive pulmonary disease, and tuberculosis (Lopez *et al.*, 2006). Researchers have also combined studies of DALYs with cost-effectiveness analysis to inform a disease control priority project that offers recommendations concerning which interventions should be prioritized globally (Jamison *et al.*, 2006).

In contrast to priority-setting research, inquiry on agenda setting is concerned primarily with explaining how attention and resources actually are allocated (although agenda-setting researchers often are motivated by normative concerns). Central to their inquiry is an interest in power. They investigate matters such as which actors are able to put issues on the agenda, how they come to hold this

Health System Organization Models (Including Targets and Goals for Health Systems)

F C J Stevens, University of Maastricht, Maastricht, The Netherlands

J van der Zee, NIVEL, Netherlands Institute for Health Services Research, Utrecht, The Netherlands

© 2008 Elsevier Inc. All rights reserved.

Introduction

A health-care delivery system is the organized response of a society to the health problems of its inhabitants (Van der Zee *et al.*, 2004). Societies differ significantly in the way they organize their response, and because of this they can be very well subjected to comparative analysis and research. This article describes health-care systems from a comparative perspective. It aims to answer the following three questions:

- What do we consider a health-care system?
- Why do health-care systems differ and how can we fruitfully group them?
- What health-care systems innovations can we expect in the future?

What Is a Health-Care System?

Usually, health care is rather loosely referred to as a system, without paying much attention to the term itself. Terms like sector and system are often used as synonyms, while the phrase 'health system' is habitually little more than shorthand for health-care (delivery) system. Philipsen (1995), in studying the neighboring but very contrasting health-care systems of Belgium and the Netherlands, noted that the term system should not be applied too loosely. Instead, for comparison reasons, he suggested using the term system as an essential analytic tool. Referring to the writings on systems of Parsons (1951) and Habermas (1981) he indicates that systems have four typical characteristics:

1. Functional specificity – systems have shared operational goals;
2. Structural differentiation – systems have a distinct division of labor between elements (persons, organizations);
3. Coherence among the composing elements – systems are subjected to coordination, planning, and organization;
4. Autonomy – systems are self-regulating to a certain degree, notwithstanding open borders to other systems (e.g., education, welfare, industry, legal system) and to the general environment.

These four systems characteristics are not just present or absent but vary in degree. Applied to health care,

Philipsen suggests that one health-care system can be far more 'systematic' than another. In his two-countries comparison, he illustrates that according to the four characteristics, the Dutch health-care system was more 'systematic' than the Belgian one (Philipsen, 1985).

Such observations will be very familiar to students involved in comparative health (care) systems research. Countries vary considerably in the degree of central coordination of their health-care system, especially regarding the weaker or stronger role of the state (e.g., compare the UK and United States regarding coordination, planning, and organization). Also, the fuzzy boundaries between health care and social services make up, in degree of autonomy, a distinctive system characteristic. The boundaries between health and welfare are a notorious impediment for comparative analysis, specifically when studying health care for the elderly. So indeed, the 'system' concept and its features are a useful analytical tool for understanding international differences.

Why Do Health-Care Systems Differ?

As noted, health-care systems are societies' organized response to their health problems. So logically, when health problems vary between populations, it is likely that also their health-care systems vary. This is very obvious when contrasting health problems of countries at different levels of income (low-income, lower-middle-income, upper-middle-income, and high-income economies) (World Bank, 2007). Low-income countries are faced with many problems that impede health directly or indirectly. These include childhood diseases, negative maternal conditions, HIV/AIDS, malaria, and tuberculosis. Infectious diseases are the major cause of premature deaths and reduced life expectancy. In developed countries chronic diseases form the major causes of death. Consequently, the health-care systems in these two groups of countries are fundamentally different and thus pursue different approaches to health care: in developing countries the focus is mostly on hygiene and preventive care, whereas in the developed world the emphasis is on extensive curative care.

Besides observing such crude but evident health-related systems differences one also can, at least among

high-income countries, differentiate between types of health-care systems that are *not* grounded in essential health problem differences. These systems differences have more or less grown historically. The essential difference between groups of health-care systems in high-income countries is grounded on their way of funding and the degree of governmental (state) influence on health-care delivery. Two typical groups are often dubbed after their founding fathers: Bismarck (Germany) on the one hand and Beveridge (UK) on the other. Bismarck, the first chancellor of united Germany ‘invented’ social security at the end of the nineteenth century and helped to create and foster mutual funds (sick funds) to protect the fund members against loss of income due to illness and disability. The social security system is mainly funded by earmarked, wage-dependent premiums. Beveridge, the founder of the British National Health Service (NHS) in 1948, created a state-dominated, tax-funded health services system for all British citizens that soon served as an example for many countries all over the world. Beside these two major types, two others should be mentioned. One is the market-based American health-care system, with limited government influence and funding. The other is the full-blown opposite of this, the health-care system in the former Soviet Union and its satellite countries (the Shemasko model, named after its founder) with strong governmental influence and extensive funding (Marrée and Groenewegen, 1997).

In the following sections of this article we first go deeper into the impact of societal transitions and the impact on differences between low-income countries and (lower and upper) middle-income countries on the

one hand, and high-income countries and their health-care systems on the other (i.e., health care in a transitional perspective). Then we further elaborate on the basic elements of the four types of health-care systems prominent in high-income countries.

Health Care in a Transitional Perspective

To understand current health-care delivery systems from a longitudinal perspective three types of transition are significant: (1) the socioeconomic growth of a society, (2) its demographic expansion, and (3) its epidemiological development (**Figure 1**). Modern societies developed over the ages from agricultural economies through industrialization to service economies (Van der Zee *et al.*, 2004). They initially focused on survival and self-sustenance of the smallholder and his extended family, but later on developed into economies creating surpluses (wealth) and added value to products that could be traded. Commonly, the surpluses of these trades were used to institute new roles and occupations, which were not necessarily productive. Typical examples are priests, soldiers, tax collectors, and different kinds of healers. In this societal transition the surpluses were accumulated over long periods, in which stages of prosperity alternated with periods of hardship, due to war, food crises, and pandemics. As societies further developed and modernized, more structures and institutions came into existence that reduced the health and social risks of daily life. The widespread, kinship-based arrangements to cope with these risks were

Agriculture (rural)	→	Societal transition	Industry (urban)	→	Services (sub-urban)
Multi-generation family	→		Nuclear family	→	Individual households
Demographic transition					
Infectious diseases	→	Main health issues	Declining fertility	Aging population	→ Chronic diseases, diseases of civilization
Declining mortality			Epidemiological transition		
Hygiene, public health, informal care	→		Emerging curative care, social security, welfare state	→	High-tech care, professional home care
		Focus of care			

Figure 1 Health care and the societal, demographic, and epidemiological transitions. Adapted from Van der Zee J, Boerma WGW, and Kroneman MW (2004) Health care systems: Understanding the stages of development. In: Jones R, Britten N, Culpepper L, Gass DA, Grol R, Mant D, and Silagy C (eds.) *Oxford Textbook of Primary Medical Care*, vol. 1: pp. 51–55. Oxford: Oxford University Press.

gradually supplemented and replaced by collective arrangements (De Swaan, 1988).

In the wake of this societal transition a demographic transition took place, as it proved no longer essential to have many children as a provision against the risks of becoming dependent on kin when growing old or living in poverty. One of the later consequences was that fertility dropped.

In Europe, by the end of the nineteenth century, social security systems against loss of income due to accidents and disabilities came into existence, first in Germany, then later in other countries, including public pension schemes several decades later. In addition to these collective arrangements, financial surpluses were the foundations for economic growth and the expansion of educational and health-care facilities, which also generated more services and typical professions such as teachers, physicians, nurses, judges, lawyers, engineers, architects, and so on. In Europe, premium collection and taxes were the primary mechanisms and financial resources for these collective arrangements.

In the course of this modernization process the epidemiological transition took place, reflecting a gradual shift from the sheer necessity to overcome malnutrition and infectious diseases toward dealing with chronic diseases (primarily affecting the elderly). Today, health-care delivery systems in high-income societies are largely focusing on lifestyle diseases (obesity, diabetes mellitus), chronic diseases, and the subsequent changing needs and demands of an aging population. During the past century, in high-income countries, a dramatic shift in the cause of death has taken place, from infectious diseases and malnutrition to cardiovascular diseases and cancer. Chronic disease deaths now exceed mortality from infections and malnutrition.

In many high-income societies the societal, demographic, and epidemiological transitions took place during the course of many years. This went together with the coming into existence of more organized and institutionalized 'systems' of care, which replaced earlier fragmented services of competing health professionals and health institutions. In low- and middle-income countries we often see, in a shorter time frame, incomplete and more compressed transitions. This is manifested in less health-care systems coherence (i.e., coordination, planning, and organization). Organized health-care systems in lower-income countries – in particular on the African continent – were often copies of Western models and were habitually implemented and enforced as part of the colonization processes. In addition to this, many low-income countries inherited from colonial occupation health-care legislation that was not up-to-date. In the beginning, organized health care, with a strong emphasis on hospital care, was primarily oriented toward the military, civil servants, and settlers. It was only later that more community and primary health-care services came into existence for the local population. Today, health

facilities are usually unequally distributed usually because of insufficient investments in human resources. Lower-income countries have three to four times less doctors and nurses than high-income countries per unit of the population, which is evidence that human resources is one of the most neglected components of health system development (Breier and Wildschut, 2006; Hongoro and McPake, 2004).

Access to clinical services is still primarily reserved for limited groups (armed forces, civil servants, and wealthy people). Health services are often organized through a set of vertical programs, addressing specific health problems. The advantage is that health-care delivery is assured; the disadvantage is that service provision is often fragmented and inefficient. Community health-care workers act as first-line contacts of the health system in these countries, where basic conditions for improving health often fail (e.g., poverty, protection of mother and child, birth intervals, education, basic maternity care, and immunization). Major health-care providers are the state and nongovernmental organizations.

In upper-middle-income economies, such as in South Africa, there is a high diversity of facilities with high-tech private hospitals for those who can afford it at one side of the continuum, and, for those who can't afford it, unqualified practitioners at the other, and everything else in between. Existing social insurance arrangements are mainly available and affordable for state employees (military, civil service). For example, South Africa has implemented mandatory insurance for civil servants, which can be seen as the kernel of a future social health insurance scheme. However, getting mandatory insurance for all formally employed, or setting up an affordable model for low-income beneficiaries, will take at least another decade, as there are many political and practical hurdles to tackle (McIntyre and Doherty, 2004). The ongoing debate includes what such health insurance plans should look like, for example, whether low-income countries should have a voluntary insurance plan, a private one, or a mix of both.

In low- and middle-income countries the bulk of health-care expenditure has to come from direct household (out-of-pocket) spending, taxation, and deficit spending. So what is often seen is a hodgepodge of facilities and means of health-care provision, formal, as well as informal, including a huge variety of traditional healers paid out-of-pocket or in kind.

The coming into existence of a modern health-care delivery system with a highly developed division of labor, a high degree of structural complexity, and means for coordination and planning requires extensive financial resources. Only affluent economies are able to put sufficient resources aside, and the extent to which these can be generated for health care signifies a nation's stage of economic development. Indeed, there is a strong

association between health and wealth, not only at the level of the individual person, but on the macro level too. Put another way, the richer the country, the more health care is a 'system.'

As can be seen in **Figure 2**, the average life expectancy is plotted against per capita income in a large number of countries for the years 1900, 1930, 1960, and 1990, respectively (World Bank, 1993). From the early 1990s (see **Figure 2**), the highest health gain is found in the lowest income range, where societies move from 'poor' to 'less poor.' The initial increase in life expectancy is mainly due to reductions in infant mortality. But having reached a certain level of prosperity, life expectancy tends to stabilize. Evidently, in more affluent societies a point is reached beyond which substantial growth of life expectancy is unlikely to happen.

So, as **Figure 2** also demonstrates, the wealth of a nation has a major impact on health. At the beginning, when the wealth of a nation increases, its level of health improves, directly, by public health improvement, and indirectly by schooling and the increase of income level (in particular of mothers). Later, when economic wealth has further increased, lifestyle and chronic diseases tend to amplify. In affluent societies people are more likely to manifest unhealthy behavior and, as people grow older, the magnitude of chronic disease increases. Obviously, the overall impact of wealth on health is not linear. And because of this it is harder to improve on health in affluent societies than in poorer ones (provided, of course, resources for health care are sufficiently available and adequately distributed).

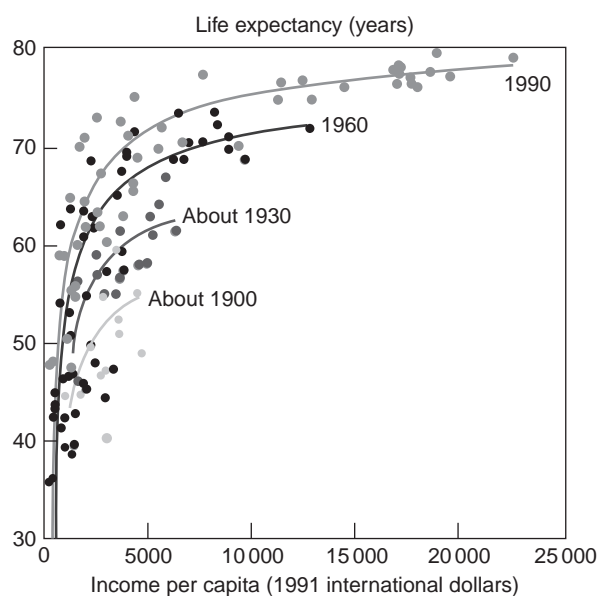


Figure 2 Life expectancy and income per capita for selected countries and periods. Reproduced from World Bank (1993) *Investing in health*, World development report 1993, p. 34. Oxford, UK: Oxford University Press.

The relationship between health and wealth is also reciprocal. Economic growth and wealth improve health, but good health stimulates economic growth as well. In mature economies a successful health-care sector encourages skilled employment, domestic production, building, and the consumption of service goods. Wealth also defines health-care targets. And again, the wealthier a nation, the more probable it is that it has a systematic health-care system.

Four Models of Health-Care Systems: Free Market, Social Insurance, NHS, and Socialist

Typically, high-income countries are characterized by public poverty and private wealth. There is an excess of energy consumption with environmental pollution as a resulting health threat. Pockets of relative poverty are manifested at the dark side of society's individualization, leading to problems of anomy, loneliness (in particular among the elderly), and suicide. Combating lifestyle-related illnesses, cost containment, unequal health-care access, preventing unnecessary or overtreatment, rationalizing pharmaceuticals and providing a dedicated mix of health and social services to the elderly are considered major health-care policy issues in all high-income societies. In time there has been a gradual extension of curative services from the wealthy to the population as a whole, with emphasis on specialist/hospital care and primary care as a counterbalance. Also, the focus has shifted from preventive to curative services, and later on again to preventive services (preventing lifestyle diseases).

Because of these similar health-care problems in high-income countries their health-care systems look more or less alike. They can be typified as mixed private-public systems, however, their origins differ. Based on their funding and degree of state intervention four models of health-care systems can be distinguished. These four models vary on a continuum between health care seen as a *commodity* to be bought on the free market on the one hand, and health care as a *public good* or *right*, independent of a person's income, on the other.

Free Market Model

The free market model applies when the state conducts a policy of noninterventionism and restricts its interference in health-care matters to the bare essentials, leaving the rest to private funding and corporate provision (e.g., health maintenance organizations, or HMOs). This is the typical situation in the United States, except for Medicaid (which is for the indigent) and Medicare (for the elderly) state interventions. Private insurance fills the gap to some degree, however, a large proportion of the U.S. population is still uninsured against health-care costs or loss of income due

to illness and disability. The basic (original) model of the United States health-care system is a voluntary reimbursement model, with four actors playing a key role (Hurst, 1992). First-level (general practitioners, or GPs) and second-level providers (hospitals) deliver services to patients who will be reimbursed for their medical bill, in part or in whole. Patients pay a voluntary risk-related premium to voluntary insurers, who reimburse them for medical expenses. Typically, there is no, or minimal, interaction between insurer and provider. Only the patient interacts with both parties. The private reimbursement model has two major drawbacks (Hurst, 1992). One is that it does not have built-in incentives to restrict demand and supply. Therefore, it is often accompanied by cost sharing. Another drawback is that it does not have built-in mechanisms to prevent inequities. For reasons of profit maximization, private insurers have an incentive to select against poor risks. Moreover, access to voluntary insurance is only open to those who are willing or can afford to pay. This has enormous consequences for health-care insurance coverage in the United States. Whereas the vast majority of the Organisation for Economic Co-operation and Development (OECD) countries have achieved universal health-care coverage, the United States has the largest percentage of citizens without government-assured health insurance. The most recent figures show that, in 2005, 15% of the population (nearly 45 million people) were without health insurance. This varies between 8% for the population of Minnesota, and 24% in Texas (U.S. Census Bureau, 2007). This problem has been put on the political agenda again and again, but still has not seen any substantial improvements.

A second shortcoming is high spending. In 2004 U.S. health-care spending as a percentage of GDP was 13.3%, compared to 9.2% for neighboring Canada, and 8.1% for the average industrialized (OECD) country (OECD, 2006). United States per capita health spending continues to exceed per capita health spending in the other OECD countries, by huge margins. In the period between 1991 and 2001, the U.S. average annual growth in health spending was 3.1, compared to 2.1 in Canada and 3.0 for the OECD median. Despite managed care initiatives and government attempts at regulation, costs keep increasing in the United States (Anderson, 1997). Lack of (hospital) budget control, fragmented and complex payment systems that weaken the demand side and excessive administrative overhead may account for the high health-care spending (Reinhardt *et al.*, 2004).

Social Insurance Model

The second health systems model is the social insurance system, founded in Germany just over a hundred years ago. Patients typically pay an insurance premium to the sick fund, which has a contract with first-line (GP) and second-line (hospital) providers. The role of the state is

restricted to setting umbrella terms for contracts between patients, providers, and insurers. The social insurance system is funded by premiums paid and controlled by employers and labor unions. These, however, have little inference with the provision of services, which is left to the professions, specifically to the medical profession and to professionalized care organizations (e.g., home nursing, home help). Basically, continental European health-care systems originate from the German social health insurance model, founded at the end of the nineteenth century by the German Chancellor Wilhelm Bismarck. Earmarked premiums were paid to a sick fund, which was jointly controlled by employers and employees (labor unions). From this sick fund health-care provision from hospitals and from individual practitioners was paid.

For people with lower- and middle-class salaried incomes collective and enforced arrangements are available (sick funds). Founded in Germany, the social security model was quickly adopted by Czechoslovakia, and during the Austrian-Hungarian rule, by Austria, Hungary, and Poland. During the Second World War it was forced on the Netherlands (1941), and later on it was adopted by Belgium and France. The social insurance system survived two world wars and national socialism, and, in essence, still exists, although in a modified fashion, in Germany, the Netherlands, Belgium, France, Austria, Switzerland, Luxembourg, and Japan. Formerly it existed in other countries as well: Greece until 1982, Italy until 1977, Portugal until 1978, and in Spain until 1985 (Saltman and Figueras, 1997).

National Health Services (NHS) Model

The third model, typically found in the UK and Commonwealth nations, is the taxed-based National Health Services (NHS) model. First introduced in 1948, it is centralized and funded by means of taxation, while the state is responsible for the provision of institution-based care (hospitals). The medical profession has a rather independent position. Self-employed GPs are the gatekeepers in primary health care. Before visiting a hospital or a medical specialist one needs a referral from a GP. The NHS model leaves some room for private medicine. Until 1995 state hospitals and individual GPs were paid from this NHS taxation.

Through processes of diffusion and adaptation, the NHS model was first adopted in Sweden, and then by the other Scandinavian countries: Denmark, Norway, and Finland. At present, the NHS model applies to the United Kingdom, Ireland, Denmark, Norway, Sweden, Finland, Iceland, and outside Europe by Australia and New Zealand. Four Southern European countries adopted the tax-based model more recently: Italy, in 1978; Portugal, 1979; Greece, 1983; and Spain, 1986 (Saltman and Figueras, 1997).

Socialist Model

The fourth, most centralized systems model, the Soviet socialist model, was invented by Shemasko, a Minister of Health, and dates from 1920. It is characterized by a strong position of the state, guaranteeing full and free access to health care for everyone. This is realized by state ownership of health-care facilities, by funding from the state budget (taxes), and by geographical distribution and provision of services throughout the country. Health services are fully hierarchically organized. They are provided by state employees, planned by hierarchical provision, and organized as a hierarchy of hospitals, with outpatient clinics (polyclinics) as lowest levels of entrance. Among the nations that, until recently, had a health-care system based on the Soviet model were Russia, Belarus, the Central-Asian republics of the former USSR, and some countries in Central and Eastern Europe. Many former Soviet Republics, however, are in a process of transition toward a social insurance-based system.

The Cuban health-care system also underwent shortages following the collapse of the Soviet Union. But while Cuban secondary and tertiary care suffered from the crisis, the well-functioning universal and equitable health-care system from before the crisis remained largely intact, due to the government's support and grassroots organizations-based networks of solidarity (Nayeri and Lopez-Pardo, 2005). The Chinese health-care system, created in 1949, was also a typical example of now largely extinct twentieth-century communist societies. By the early 1980s the Chinese government virtually dismantled it (Blumenthal and Hsiao, 2005). Its way of financing was dramatically changed by reducing government's investments, the imposition of price regulation, and the decentralization and underfinancing of its public health system. China now has a private health-care system, with its typical failures: a large part of the population uncovered by health insurance (about 70%), unaffordable services for many, high national spending, overuse of (profitable) pharmaceuticals, and high-tech care (Blumenthal and Hsiao, 2005). Currently, the government is trying to repair the damage done, which ultimately may result in a mixed public-private system. Cuba and China prove, positive and negative, that government involvement in health care is essential to keep the health-care system intact, to protect patients, and to provide affordable access to services.

The four models make up a continuum in terms of their 'system' character, with state interventionism and centralized health care at one end, and noninterventionism at the other. Centralized systems provide the best mechanisms for cost control, while absence of state intervention appears less fruitful, as soaring costs in the United States make clearly evident. But the four health systems models are to be seen as pure types that can be

found in many combinations and varieties. They further reflect stages and outcomes of a historical process, so that system models that came into existence in highly developed economies in the first half of the twentieth century can still provide useful options to choose from in developing countries or transitional economies, for example, in Eastern European societies.

Health-Care Delivery Systems Innovations

While the models presented reflect the major ones that can be found in high-income countries, none of them fully complies with only one of these. For example, in the 1960s and 1970s social insurance-based health-care delivery systems and the entrepreneurial system of the United States started to be faced with problems of rising costs. In the 1970s and 1980s the NHS delivery systems and Soviet-like delivery systems of Eastern Europe had problems of neglect, underfunding, and extensive bureaucracy, leading to private initiatives next to the NHS and to a flourishing black health-care market in Eastern and Central Europe. Since then, in particular in countries having social security-based health-care systems, this has led to more state regulation to curb the costs of health care. In other countries it resulted in the reversed situation of less state intervention, and in the introduction of different forms of managed competition (**Table 1**). For example, in Eastern Europe, after the fall of the Berlin Wall, there was a demise of state funding and state provision due to economic deficits. In the countries that have adopted the social insurance model there is more state regulation to introduce more planning and to curb the rising costs of health care. One of the consequences has been a more dominant position of hospitals in the delivery of health care. In the UK, however, there is a movement toward more decentralization, which was realized by a split between purchasers and providers, with GPs as the purchasers of hospital care (Saltman and Figueras, 1997).

Just like in other high-income societies, health-care reforms in the United States are essentially focusing on cost containment. Managed care initiatives, for example, HMOs, were developed to increase competition, to change methods of payment for medical services, and to curb the power of the medical profession. The fundamental model of the HMO is typified as a voluntary contract model (Hurst, 1992). It involves contractual relationships between insurers and independent providers, which give these providers an exclusive right to supply complete services, mainly free of charge. Patients pay a voluntary, risk-related premium to voluntary insurers who have contracts with providers. The difference with the

Table 1 Health systems models – their strengths, weaknesses, and innovations

<i>Model</i>	<i>Definition of health care</i>	<i>Role of the state</i>	<i>Funding</i>	<i>Budget control</i>	<i>Strengths</i>	<i>Weaknesses</i>	<i>Major innovations</i>
Socialist (Shemasko) (Communist countries; former Eastern Europe, Cuba)	Health care as state-provided public service	Very strong; owns facilities pays providers directly	Government funding	State/Party	Full and equal access, low costs, full coverage	Bureaucratism, rigidity, corruption	Total collapse (fall of Berlin Wall)
National Health Service (Beveridge) (UK, Australia, New Zealand, Canada, Nordic countries, Spain, Italy)	Health care as a guaranteed, state-supported consumer service	Strong; controls and finances facilities	Taxation	Ministry of Health	Equal access to comprehensive services, low costs	Bureaucracy, underfunding, rigidity	Referral market purchaser-provider split (GPs as hospital services purchasers)
Social Security (Bismarck) (Germany, Japan, Netherlands, France, Belgium)	Health care as a guaranteed, insured good	Intermediate; regulates the system	Earmarked premiums	Employers and employees	Client-friendly, professional autonomy, earmarked budgets	High costs difficult to control	Cost control by macro budgeting, introduction of market principles
Free Market (United States, South Africa, Switzerland)	Health care as a commodity	Weak (except for specific groups); providers are mainly private entrepreneurs	Private and state/federal government financing	For-profit insurers and government	Provider-friendly, professional, autonomy, flexibility	Consumerism, high costs, fragmentation, unequal access and uninsured	HMO

Van der Zee J, Boerma WGW, and Kroneman MW (2004) Health care systems: Understanding the stages of development. In: Jones R, Britten N, Culpepper L, Gass DA, Grol R, Mant D, and Silagy C (eds.) *Oxford Textbook of Primary Medical Care* vol. 1. Oxford, UK: Oxford University Press.

voluntary reimbursement model is that insurers now have contractual relationships with providers. Managed care models are all aiming at controlling the costs of health care by monitoring the work of doctors and hospitals, and by limiting the use of second-level hospital care. In practice, this is often done by means of a ‘case manager,’ who, on behalf of the insurer, is authorized to decide whether the care to be rendered is effective and efficient. Another feature is that patients are only allowed to see a specialist after they have visited a general practitioner. This gatekeeper role of the primary care physician to the use of specialist care is similar to the role of GPs in European countries like Denmark, Norway, Italy, the Netherlands, Portugal, Spain, and the UK.

Health-Care Systems Environment: The Impact of Society

As noted in the introduction to this article, health-care systems have ‘open’ borders to their environment. So it goes without saying that health-care systems are impacted by the values and social structure of their societies (Helman, 1996). Based on history, traditions, belief systems, and so on, health-care systems reflect the way in which societies define and deal with health and illness. Health and health care are imbedded in value systems, which explains how in specific cultures health problems are dealt with. This may explain why, in some societies, health care is considered as a collective good for the benefit of all citizens, while in others, health care is considered more a ‘commodity’ – a calculable resource that can be bought or sold on a free market (Gallagher, 1988). The notion of health care as a commodity has not been rooted everywhere. Its most evident example can be found in the essentially market-oriented organization of the U.S. health-care system. But also in Europe it has become more widespread in political thinking, as a wide range of health-care reforms has shown (Saltman and Figueras, 1997). Regrettably, the cultural embedding of health care in societies is a well-acknowledged but rather underresearched topic (Saltman and Figueras, 1997; Stevens and Diederiks, 1995). There is surprisingly little empirical evidence grounding core values underlying health-care systems. But evidently, a society’s emphasis on hospital care versus home care or care for the elderly, on individual responsibilities, or on the degree of solidarity between people reflect general value orientations that mirror societal priorities (Hofstede, 1991; Philipsen, 1980). As obvious differences in value orientations between North and South Europe, and between Europe and the United States show, it would be a useful endeavor for coming health services research to explain differences in health-care systems from a cultural perspective.

Conclusions: What Can We Expect in Future Developments?

As we showed in the previous sections, health-care systems in low- and middle-income countries differ considerably, as health problems do, from health-care systems in high-income countries. Future developments will differ accordingly.

Low- and Middle-Income Countries

One of the conclusions to be drawn from the famous World Bank graph (see **Figure 1**) about the relationship between ‘health’ (life expectancy at birth) and ‘wealth’ (average income per capita) in the period 1900–1990, is that ‘we’ all got substantially richer over those years. The corrected income figures for inflation and purchasing power quintupled between 1900 and 1990 (PPP, or purchasing power parities, is a technique to make financial data comparable over time and between countries by controlling for purchasing power differences). Many countries that were previously in the lowest income group can now be considered as middle-income countries. One of the health-care challenges in this economic stage is to introduce curative care for an ever-increasing number of citizens. As we pointed out, there are several ways to do so. One can introduce a (limited and partial) form of health services funded by taxes with a dominant role for the state in health-care funding and provision (the Beveridge model), stretching, as it were, available supply and resources as thinly as possible. Equity is the leading principle.

The other option is a pluralistic and gradual approach, where the state has the role of providing rules and laws regulating the system and leaves much to health-care insurers, providers, and consumers (the Bismarck or social security model). The latter model starts with some (economically) advanced groups in society (e.g., skilled workers) and with a limited benefit package. Later, in better economic circumstances, both the benefit package and the number of beneficiaries are extended until universal coverage (almost) will have been reached.

The current health-care systems in Europe are partially planned, such as the introduction of the NHS in the UK in 1948 and in Southern Europe at the end of the 1970s and beginning of the 1980s. But some were not planned: some developed incrementally by innovative adaptations while others were forced on a society (e.g., the German occupation spread Bismarckian principles in WWII).

Middle-Income Countries

Middle-income countries can consider the choice for a Bismarckian or Beveridgean as a serious and high-impact policy option instead of going into an incremental policy process and making a deliberate choice. A focus on equity

and cost control and a positive attitude toward an active role of the state, makes a choice for Beveridge probable. Introducing earmarked health insurance premiums for a limited part of society (that is taxable anyway) creates more inequalities initially but might also stimulate economic growth, which, as we already stated, starts an upward cyclical process, gradually bringing the population as a whole under the social security-based health insurance coverage (De Swaan, 1988).

High-Income Countries

For high-income countries several processes take place simultaneously. First, internal changes occur in the Beveridgean and Bismarckian health-care systems such as splitting health-care purchasing and provision and creating an internal market in the British NHS, or increasing state influence in general in the Bismarckian health-care systems (Germany is a good example). Another example of several simultaneous processes is the introduction of managed care (HMOs) in the U.S. private insurance system. Last, there is the ultimate change to the system – the disappearance of it altogether – like the Soviet-based health-care systems in Eastern Europe. All these changes cause convergence, both in appearance and in performance (Van der Zee and Kroneman, 2007; on convergence, see also Stevens, 2001), especially in health outcomes of the systems.

Second, in spite of these long-term convergency trends Beveridgean health-care systems cost less than Bismarckian ones and better contain the costs (Saltman *et al.*, 2004; Van der Zee and Kroneman, 2007). But citizens tend to appreciate Bismarckian health-care systems more than Beveridgean ones. Kroneman and colleagues (2006) showed that the GP gatekeeping model may be responsible for these types of appreciation differences. Remarkably, health-care systems that have stronger system characteristics (e.g., more coordination, stricter labor differentiation) seem to have less popular support in general, with substantial exceptions.

Third, the European Union (EU) has its specific influences on the convergence of health-care systems. Case law produced by the European Court of Justice favored reimbursement of health-care cost due to purchasing health care in other EU-member states in spite of initial refusal by national health insurers or health-care authorities. The argument that such a liberal attitude (of the European Court of Justice) might hamper national health-care cost control, was countered by valuing the free movement of goods, services, and persons higher than national cost-control interests (under certain conditions). The case law started with the reimbursement of a set of spectacles, than went on by way of orthodontic services to specialized treatments; the end is certainly not yet there. New cases are in process.

Fourth and finally, voices get louder about the sustainability of both models (the NHS and the social

security-based health-care system). Precisely due to the last decades' increases in wealth, some politicians are thinking aloud that the conditions under which governments created and extended welfare state arrangements (like universal health-care insurance and other social security elements) do differ substantially from current circumstances. Whether this will lead to shifting part of the responsibility to health-care consumers is not sure, however. The recent changes in the Dutch health insurance (with 62% publicly insured and 38% privately insured before 1 January 2006 and 100% publicly insured since) showed that an overwhelming majority (95%) of the formerly private patients, who had a wide variety of policy options, opted for a zero-deductible policy (De Jong and Groenewegen, 2007).

So what does all this mean for the future? First, we expect that for high-income countries (e.g., the members of OECD) NHS-type of health-care systems will have a tough future. These hierarchical, systematically organized systems – the most 'systematic' in Philipsen's (1985) terms that we discussed in the introduction – are superior in cost control, but they are not very popular. Social security-based health-care systems will fit better into the consumer-led, demand-led policy trend. But this will have a price tag, too; most probably at least a part of the cost burden will be shifted to individual households, as is already the case in the United States.

Second, we expect low- and middle-income countries to see a rift in the tendency to favor NHS-like solutions for their growing health-care systems, and we expect them to opt for some social security-based model. This happened in Eastern Europe, after the collapse of the Soviet system. Eastern Europe overwhelmingly returned to a Bismarck model (Marrée and Groenewegen, 1997). External factors, like EU case law, will stimulate further convergence of the European health-care systems.

For Europe, the challenge will be resisting the temptation to neglect the poorest groups in society; for the United States, the test will be to make the uninsured or partially insured join the health-care system. For the world, however, the effort will be to provide health-care services and health insurance for whole populations, including the very poor.

See also: Public/Private Mix in Health Systems.

Citations

- Anderson GF (1997) In search of value: An international comparison of cost, access, and outcomes. *Health Affairs* 16(6): 163–171.
- Blumenthal D and Hsiao W (2005) Privatization and its discontents—the evolving Chinese health care system. *New England Journal of Medicine* 353: 1165–1170.
- De Jong J and Groenewegen PP (2007) *Percentage overstappers van zorgverzekeraar valt terug. Collectiveren zet door.* Utrecht,

- The Netherlands: NIVEL, Netherlands Institute for Health Services Research.
- De Swaan A (1988) *In Care of the State. Health Care, Education and Welfare in Europe and the USA in the Modern Era*. Cambridge, MA: Polity Press.
- Gallagher EB (1988) Modernization and medical care. *Sociological Perspectives* 31: 59–87.
- Habermas J (1981) *Theorie des Kommunikativen Handelns*. Frankfurt, Germany: Suhrkamp.
- Helman CG (1996) *Culture, Health and Illness*. London: Wright.
- Hofstede G (1991) *Cultures and Organizations. Software of the Mind*. London: McGraw-Hill.
- Hongoro C and McPake (2004) How to bridge the gap in human resources for health. *Lancet* 364: 1451–1456.
- Hurst J (1992) *The Reform of Health Care. A Comparative Analysis of Seven OECD Countries*. Paris, France: Organisation for Economic Co-operation and Development.
- Kroneman MW, Maarse H, and Van der Zee J (2006) Direct access in primary care and patient satisfaction: A European study. *Health Policy* 76: 72–79.
- Marrée J and Groenewegen PP (1997) *Back to Bismarck: Eastern European Health Care Systems in Transition*. Aldershot, UK: Avebury.
- McIntyre DE and Doherty JE (2004) Health care financing and expenditure—progress since 1994 and remaining challenges. In: Van Rensburg HCJ (ed.) *Health and Health Care in South Africa*, pp. 377–411. Pretoria, South Africa: Van Schaik.
- Nayeri K and Lopez-Pardo CM (2005) Economic crisis and access to care: Cuba's health care system since the collapse of the Soviet Union. *International Journal of Health Services* 35: 797–816.
- Organisation for Economic Co-operation and Development (OECD) (2006) *Health Data 2006: Statistics and Indicators for 30 Countries*. Paris, France: OECD.
- Parsons T (1951) *The Social System*. New York: The Free Press.
- Phillipsen H (1985) Gezondheid en gezondheidszorg in België en Nederland (Health and health care in Belgium and the Netherlands). *Gezondheid en Samenleving* 5: 223–231.
- Reinhardt UE, Hussey PS, and Anderson GF (2004) U.S. health care spending in an international context. *Health Affairs* 23: 10–25.
- Saltman RB, Busse R, and Figueras J (eds.) (2004) *Social Health Insurance Systems in Europe*. Buckingham, UK: Open University Press.
- Saltman RB and Figueras J (1997) European health care reform. *WHO Regional Publications, European Series*. Copenhagen, Denmark: World Health Organization, Regional Office for Europe.
- Stevens FCJ (2001) The convergence and divergence of modern health care systems. In: Cockerham WC (ed.) *Blackwell Companion to Medical Sociology*, pp. 159–176. Oxford, UK: Blackwell Publishers.
- Stevens FCJ and Diederiks JPM (1995) Health culture: An exploration of national and social differences in health-related values. In: Lüschen G, Cockerham W, and Van der Zee J (eds.) *Health Systems in the European Union. Diversity, Convergence, and Integration*, pp. 75–88. Munich, Germany: Oldenbourg.
- US Census Bureau (2007) Statistical Abstract of the United States. Washington, DC; USA: <http://www.census.gov/statab/www>.
- Van der Zee J, Boerma WGW, and Kroneman MW (2004) Health care systems: Understanding the stages of development. In: Jones R, Britten N, Culpepper L, et al. (eds.) *Oxford Textbook of Primary Medical Care* vol. 1, pp. 51–55. Oxford, UK: Oxford University Press.
- Van der Zee J and Kroneman MP (2007) Bismarck versus Beveridge: A Beauty Contest between Dinosaurs. *BMC Health Services Research* 7:94.
- World Bank (1993) *Investing in Health, World Development Report 1993*. Oxford, UK: Oxford University Press.

Primary Health Care

D Sanders, N Schaay, and S Mohamed, School of Public Health, University of the Western Cape, South Africa

© 2008 Elsevier Inc. All rights reserved.

Introduction

Building on the article by Bryant and Richmond which outlines the history of primary health care, this article aims to reflect on some of the successes and failures of its implementation over the past 30 years, and attempts a glimpse into the future in terms of some of the key challenges and opportunities.

The Alma Ata Declaration: Background, Focus, and Implications

The concept of primary health care (PHC) evolved during the 1970s, influenced by and influencing the basic needs approach to social development. Informed on the one hand by the disappointments experienced in implementing the basic health services approach, and on the

other by the remarkable progress in improving health in China, as well as by the achievements of many small, mostly NGO-inspired, community-based health-care initiatives in developing countries (Newell, 1975), WHO and UNICEF elaborated the strategy of primary health care as the means to achieve *Health for All by the Year 2000*.

The concept of PHC had strong sociopolitical implications. It explicitly outlined a strategy that would respond more equitably, appropriately, and effectively to basic health-care needs and also address the underlying social, economic, and political causes of poor health. Certain principles were to underpin the PHC approach (PHCA), namely, universal accessibility and coverage on the basis of need; comprehensive care with the emphasis on disease prevention and health promotion; community and individual involvement and self-reliance; intersectoral action for health; and appropriate technology and cost-effectiveness in relation to the available resources.

National Health Systems: Overview

N Goodwin, King's Fund, London, UK

© 2008 Elsevier Inc. All rights reserved.

Introduction: What is a National Health System?

There is no single definition of what might comprise a 'national' health system. According to the World Health Organization (WHO, 2000), for example, it comprises "all activities whose primary purpose is to restore and maintain health ... improving the health of the population they serve, responding to people's expectations, and providing financial protection against the costs of ill-health" (WHO 2000: 5–8). The activities (health actions, according to WHO) of a national health system are thus characterized by the expressed intent of those within it to improve health. The definition is a useful one in that it recognizes that any health system is a combination of resources, organizations, and financing and management arrangements that ultimately culminate in the delivery of health services to a population. Therefore, every country can be said to have some form of national health-care system, regardless of how unstructured or unsystematic its operation.

Building an effective and affordable national health system is a major preoccupation of governments around the world as they attempt to bring together – whether by contractual incentives or through publicly delivered services – the necessary components that are needed to improve health status and provide accessible and responsive services to the needs of individuals, families, and communities. A major difference, therefore, between a health system and a 'national' health system is the involvement of the state (governments and legislative bodies). Consequently, the nature of a national health system is characterized as much by predominant political motivations as it is by the opportunities and/or limitations imposed by the availability of financial and human resources.

As Maxwell (1992) discusses in his six dimensions of quality (Table 1), the principles of all national health-care systems are broadly the same yet the combination of these principles can lead to competition, both politically and financially, depending on which principles are regarded as more or less important. If one was to think of a national health system as an automobile, for example, there are trade-offs to be had between choosing a model that is eco-friendly and economical with one that has a high-performance engine and a higher specification of internal comfort. What aspects of care make a national health-care system more or less effective can, therefore, depend on individual circumstances or point of view. It is because of this that national health systems can be seen to

have varying degrees of success in living up to these different principles and are so readily influenced by political objectives.

The Functions of a National Health-care System

The basic structure of a national health system can perhaps best be illustrated in Figure 1. It reveals that all national health systems are split into four principal functions: financing, purchasing (or resource allocation), service provision, and stewardship. Within each principal function are a number of important subfunctions. For instance, the financing element to a national health-care system requires not only the ability to collect revenue but also a process of managing that revenue collection through, typically, the pooling of resources to ensure that the risk of having to pay for health care is shared across a population rather than by each contributor individually. Similarly, the provision of services can be usefully split between personal services (services that people receive from a health agent, such as a doctor or dentist) and nonpersonal services (programs manifested in public health measures to promote healthy lifestyles or public works that improve water quality and reduce the prevalence of disease). Stewardship, which is represented as a theme working across the three main delivery elements of the system, represents the important process of managing and/or regulating the national health system. This is an important aspect because it is the responsibility of the system to protect the people by ensuring their money is used wisely. Stewardship of the system, through regulation and governance of activities, can also promote efficiency and quality in care delivery practice and may also help to engender a sense of national citizenship. These four principal functions of national health systems are performed very differently internationally. The following sections will illustrate these variances using case examples.

Formal Care and Lay Care

Before embarking on an analysis of the different functions of a national health system, it is important to make a quick distinction between formal and lay (or informal) care. When considering the components that make up

a national health-care system, it is tempting to think immediately of doctors and nurses, of surgeries and hospitals, or of educational and health promotional interventions. However, it is a fact that the majority of health care (over 80%) is administered by one's self (self-care), family members, friends, and 'lay carers.' This is true regardless of a country's level of development. Hence, while a national health system encompasses a wide range of activities with a health improvement goal, the major part of care is provided in the informal setting and is unpaid.

In the United Kingdom, for example, about one-eighth of adults act as 'health carers' to some extent (not including routine parenting such as care for a sick child). Whereas much of this is social care (feeding, washing, dressing, and providing emotional support) the system has begun to invest in 'expert carers' that, for instance, enable more lay people to provide care advice, dress wounds, or give intravenous drugs. That the services provided by lay carers in the UK crosses the boundary with formal care provides recognition that there is a significant gray area in distinguishing between the formal (within the system) and the informal (out of the system).

Financing Health Care

Financing a health-care system is critical to its sustainability and key challenges are faced in ensuring that the necessary organizational and institutional arrangements are in place to raise revenue from which to reward and motivate health-care providers. There are two principal functions to financing: (1) revenue collection, the process by which a national health system receives money, and

Table 1 Maxwell's (1992) six dimensions of quality in a health-care system

1. Access to services
2. Relevance to need (for the whole population)
3. Effectiveness (for individual patients)
4. Equity (fairness)
5. Social acceptability
6. Efficiency and economy

Adapted from Maxwell R (1992) Dimensions of quality revisited: From thought to action. *Quality in Health Care* 1(3): 171–177.

(2) pooling resources, the process by which this revenue is managed to ensure that individual contributors are not exposed to the high costs of having to pay for health care through risk sharing with other members of the pool. According to the World Health Organization (2000), differences in how these functions are administered impact directly on the relative performance of national health-care systems, yet the mechanisms through which financing systems operate can vary dramatically between nations.

In an excellent analysis of the advantages and disadvantages of different funding options, Mossialos *et al.* (2002) show that revenue can be collected from a range of sources, through varying collection mechanisms, and by different collection agents. Examples of funding sources, contribution mechanisms, and collection agents (and their various combinations) can be seen in **Figure 2**. This reveals that the sources of funds – or who pays for health services – can vary from individuals, households, employees, and employers (firms and corporate bodies) to loans, grants, and donations from foreign governments, nongovernmental organizations (NGOs), and charities. In most national health systems, however, funds derive primarily from the population (by individuals and/or those that employ them).

Methods of Revenue Collection

As **Figure 2** shows, there are many different approaches to collecting revenue including taxation, social health insurance, private health insurance, out-of-pocket payments, and loans and donations. National health systems are often defined by their dominant revenue collection. Thus, health systems in France and Germany are known as social health insurance systems because it is that method that generates the principal source of funding. In a similar way, countries such as the United Kingdom or Sweden are often referred to as tax-based systems while in the United States it is private health insurance within a business model of health-care provision that predominates.

In many low-income countries, however, economic hardship means that their ability to collect prepayments by way of social health insurance or tax revenues is

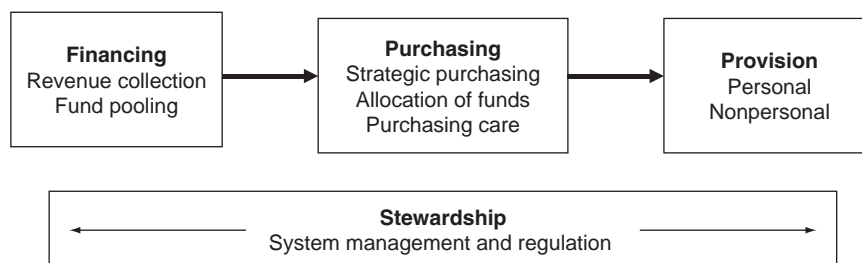


Figure 1 The basic structure of a national health system.

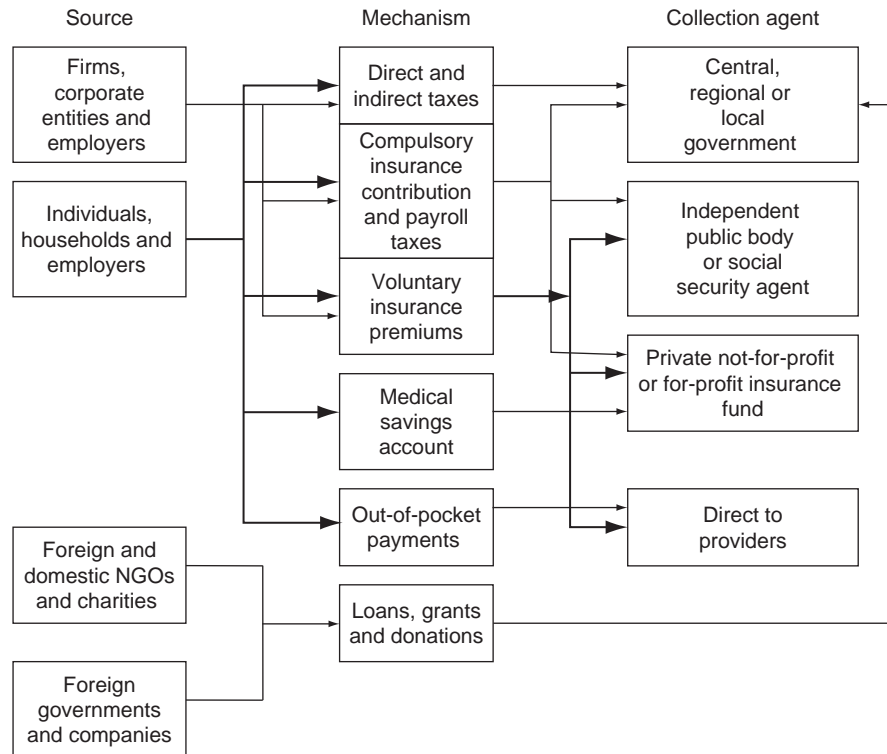


Figure 2 Examples of funding sources, contribution mechanisms, and collection agents within a health system. Adapted from Mossialos E, Dixon A, Figueras J, and Kutzin J (2002) *Funding Health Care: Options for Europe*. Buckingham, UK: Open University Press.

limited, so their systems rely on out-of-pocket charges and donor contributions. Indeed, in lower-income countries around the world, revenue collection methods tend to be less able to finance care through forms of prepayment. For example, in Latin America, most countries employ a mixed model of social health insurance, private health insurance, and taxation for public health services with a higher percentage of out-of-pocket expenditure. In sub-Saharan Africa, out-of-pocket payments are the principal source of revenue, exposing individuals to the risks associated with meeting health-care costs that prepayment schemes that pool funds for a defined population do not.

Taxation

Taxation methods of raising revenue for health systems can vary a great deal. For example, taxes may be raised for general purposes (the proportion allotted to health care to be determined later) or hypothecated such that a certain proportion is earmarked for health purposes. The potential advantage of the latter is that it directly links tax and spending, making it more transparent to the public where tax money is spent. A key disadvantage, however, is that it reduces the ability to be flexible in the prioritization of government tax revenue and limits the range of tax

sources that governments may use to obtain health funding. Taxation may also be ‘direct’ – for example, levied on individuals through an income tax or on businesses by a company tax – or ‘indirect’ such as taxes on goods and services that people buy, import, and export. Whereas direct taxes have the advantage over indirect taxes in their ability to be progressive (high-income earners pay relatively more yet health benefits are available to all) rather than regressive (fixed amounts, e.g., for a vehicle license), certain direct taxes can have the benefit of influencing consumer behaviors. Taxing goods such as tobacco or alcohol may deter consumption of goods regarded to do harm to health and so help improve health itself. Taxes that go to health care are often also raised locally as well as nationally – an approach that is argued to improve accountability and responsiveness to local people because the system provides more transparency since health-care expenditure in a local tax system is usually the largest percentage of what a local authority spends (e.g., up to 70% in Sweden). However, in systems without adequate redistributive mechanisms of tax income between rich and poor localities, inequalities in health-care provision inevitably arise.

A good example of a national health system that is predominantly funded through taxation is Sweden (Figure 3). In Sweden, there are three independent

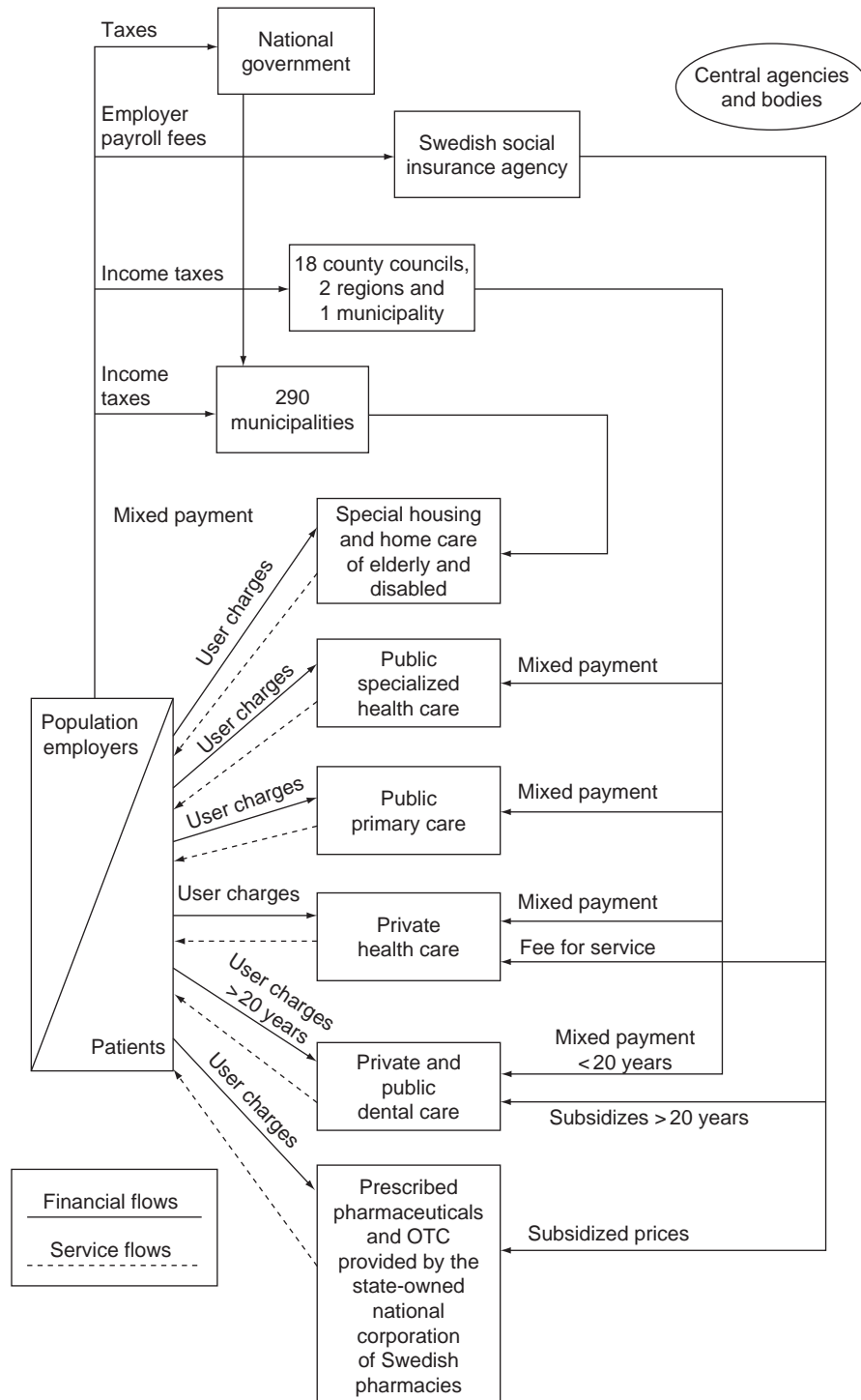


Figure 3 Sweden as an example of a taxation-based national health system. Reproduced from Glenngård A, Hjalte F, Svensson M, Anell A, and Bankauskaite V (2005) *Health systems in transition: Sweden*, p. 2. Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health.

government levels involved in health care: the national government, the county councils, and the municipalities. All three levels play an important role in the welfare system and are represented by directly elected bodies that have the right to levy taxes on the population to

finance their activities. Overall goals and policies are set at a national level by the Ministry of Health and Social Affairs, while both the financing and provision of health-care services are primarily the responsibility of the county councils. According to Sweden’s three basic principles for

public health and medical care – the principle of human dignity, the principle of need and solidarity, and the principle of cost-effectiveness – care should be provided on equal terms, according to need, and it should be managed democratically and financed on the basis of solidarity (Glenngård *et al.*, 2005).

Social Health Insurance

Social health insurance is a system of contributions (usually compulsory) shared between employee and employer who pay a percentage of income to a government-sanctioned insurance fund. Like taxation-based funding, a key advantage is the process of prepayment into a large risk pool (discussed later), and like taxation-based funding, there is tremendous variance in the methodologies employed internationally to collect the insurance payments. Hence, in Germany, ‘sickness funds’ are created both by geographical locality and by occupational group, while in France and the Netherlands, the system is organized through smaller independent funds that provide the population with choices on the types and levels of care coverage they would prefer. Single national insurance funds are also common, such as those that existed in Croatia and Slovakia.

Social health insurance systems are often regarded as preferential to taxation models of funding since budgetary and spending decisions are ring-fenced (that is, funds are reserved specifically for expenditure on health care). In theory, this protects health-care funding from political interference. Moreover, a key element to such systems is the development of social solidarity since the system guarantees the entitlement to individuals of a set level of health-care coverage at a cost that is highly visible to them. However, as Goodwin *et al.* (2006) note, the system is not without its disadvantages. For instance, since eligibility is based on employment, there is the potential for restricted access to the elderly and unemployed. Also coverage tends to focus primarily on personal health care, rather than on the nonpersonal elements of a health system that emphasize public health interventions. Significantly, as costs of health systems in all Western countries rise, social health insurance is less able to adapt to the rising costs of provision. Indeed, as the example of the French health-care system shows (Figure 4), social health insurance systems often include significant elements of taxation-based subsidies, additional voluntary insurance, and various user charges that help to bridge the gap between revenues collected and expenditure.

The French health-care system (see Figure 4) was inspired by the Bismarckian (German health system founded by Bismarck) model, with health insurance funds under the supervision of the state. It relies on a combination of public and private supply, even in the hospital sector. Patients benefit from easy access to care (freedom of choice, direct access to the specialists) and an

abundant supply of self-employed doctors, in particular. Complementary voluntary health insurance to cover the cost of statutory copayments is widespread (Sandier *et al.*, 2004). The financial sustainability of the French health-care system is a perpetual source of concern, particularly due to the fact that actual expenditure consistently exceeds the targets set. Until now, the high cost of the health-care system has been accompanied by high levels of access to health care, but the demographic change expected within the health professions may lead to an increase in explicit rationing in future years. Nonetheless, the French health-care system was ranked the best in the world in the World Health Report 2000 for its effective combination of responsiveness to demands and social equality (WHO, 2000).

Private Health Insurance

Unless you live in the United States, private health insurance is usually of a second order of significance in the funding of your national health system. In low-income countries, for example, private insurance accounts for less than 2% of total health expenditure whereas in high-income countries it rarely exceeds 15%. Private health insurance is obviously least affordable to those on the lowest incomes yet is not necessarily the domain of the most affluent. For example, in both social health insurance and tax-based national health systems, private health insurers are often used by individuals to fill gaps in service coverage that are otherwise excluded from the nationally funded system. This form of private insurance is thus complementary to existing entitlements and is sometimes known colloquially as a top-up policy.

There are two other main forms of private health insurance: supplementary and substitutive. Supplementary insurance takes the form of an additional payment to receive enhanced benefits in addition to those offered through a social health insurance scheme. Hence, it may allow for quicker access to care, can be located in more comfortable surroundings, or be exempt from the costs of copayments such as those levied on drugs or inpatient stays. As Table 2 shows, more than 90% of individuals in the French health system take out supplementary private insurance to protect against the high level of copayments involved in accessing the nationally funded system.

Substitutive private insurance, as the name implies, is an alternative to social health insurance and is taken up by those who may be excluded from public cover. In Germany and the Netherlands, for instance, employees earning above a certain income are excluded from care provided by the social insurance scheme (though not exempt from making payments) and are required to take out ‘compulsory voluntary’ insurance to get the care they

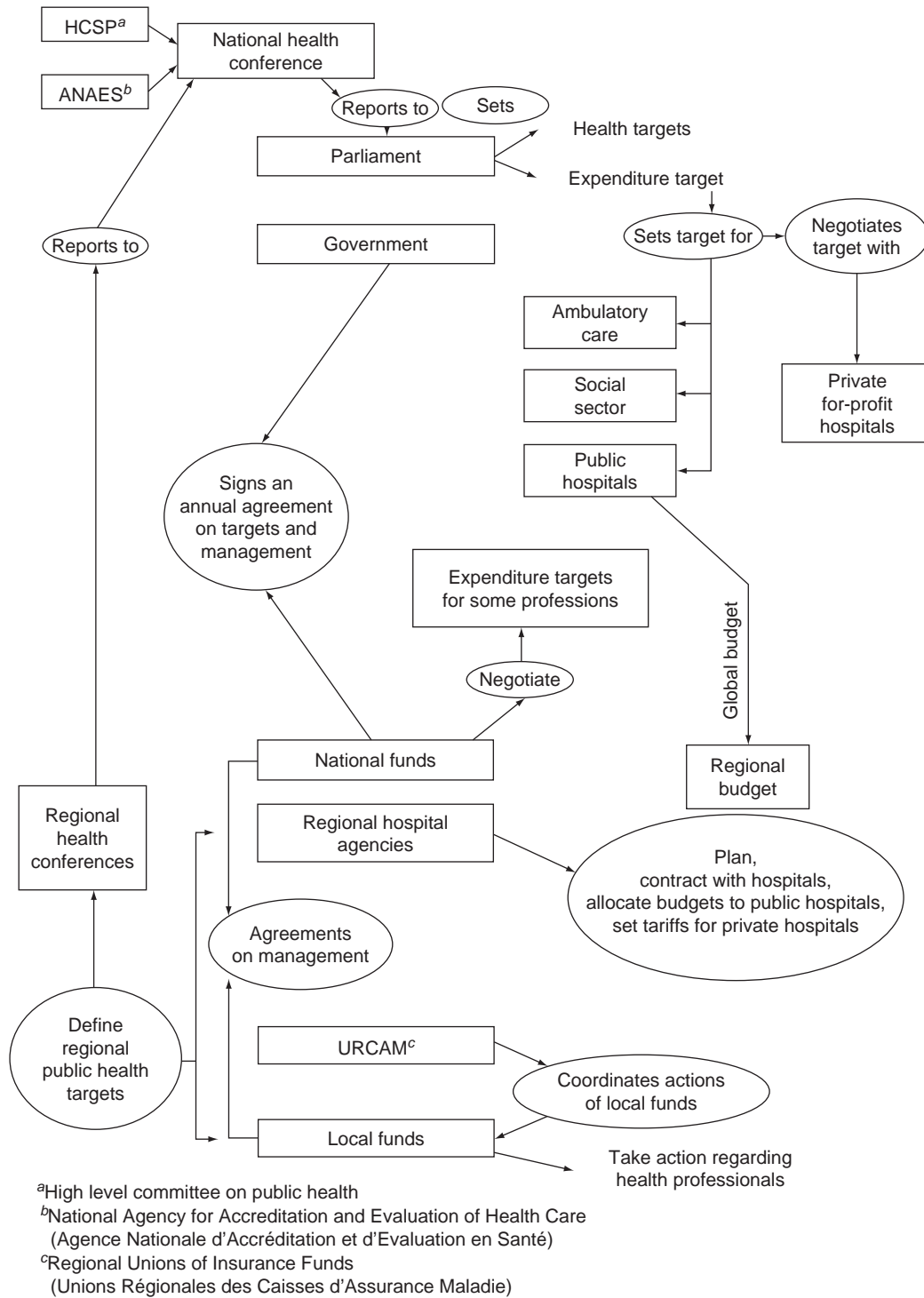


Figure 4 France as an example of a social health insurance-based national health system. Reproduced from Sandier S, Paris V, Polton D (2004) Health care systems in transition: France, p. 21. Copenhagen, Denmark: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.

require. Depending on their level of income and personal choice, individuals may opt back into the national system of social insurance health coverage or seek a private insurance agent. As **Table 2** shows, supplementary, substitutive,

and complementary private health insurance tends to be prevalent in certain types of national health systems.

The United States remains the only Western health-care system whose primary source of funding comes

Table 2 Forms of private health insurance in taxation and social insurance-based health systems

Country	Main source of funding for health system	% population covered by health system	% population with private insurance	Type of private insurance
Denmark	Taxation	100%	28%	Complementary
France	Social health insurance	100%	>90%	Supplementary
Germany	Social health insurance	88%	9%	Substitutive
Netherlands	Social health insurance	64%	29%	Substitutive
Sweden	Taxation	100%	1.5%	Supplementary
UK	Taxation	100%	11.5%	Supplementary

Reproduced from Organisation for Economic Co-operation and Development (OECD) (2004) *Towards high performing health systems: Summary report*. Paris: OECD.

through private health insurance. It is also the only country among the most developed nations without universal health-care coverage. Often referred to as a business model, the health system in the United States comprises a complex array of competing company-based and private for-profit and not-for-profit health insurance agencies offering a range of care plans to consumers and/or their employers. Providers of care, often working in large group practices and/or associations, contract with insurance agents (sometimes exclusively) and are generally paid on a fee-for-service basis. Cost inflation in the U.S. health system – influenced by the predominance of fee-for-service provision, investment in medical technologies, the high cost of medical malpractice claims, and high consumer demands – has resulted in the most expensive health-care system in the world (16% of GDP in 2004). Such rising costs have led to a growing number of citizens who are underinsured or without any health insurance coverage, despite a significant tax-funded component manifest in Medicare (for the elderly) and Medicaid (for the poor and disabled). To counteract these system failures, local managed care systems run by health maintenance organizations (HMOs) developed in the 1980s to provide enrollees with comprehensive care packages through an exclusive and integrated network of providers. However, antitrust legislation and consumer demands for lower-priced health plans have all but led to the demise of the HMO movement.

Out-of-Pocket Payments

Unlike in the previous three prepayment models, where it is possible to pool funds and spread risks among a population, a health system in which people must pay out of their own pockets for a substantial part of the costs of health services clearly restricts access to the more expensive forms of care. In most low-income countries, where prepayment systems are unavailable, out-of-pocket payments are often the only way to raise revenue and cover costs – leaving those who cannot afford treatment at higher health risks. Community financing is a method

often promoted in such countries in an attempt to create pools of funds and reduce risks. For example, the Bamako Initiative – promoted in many parts of Africa since 1987 – helps provide local access to essential primary care services by decentralizing revenue collection and decision making to local communities. The basis of this approach to health system funding is to levy a small out-of-pocket charge when a drug or basic care is provided and then invest this in a fund from which local people prioritize investment into their community's health needs. The approach has been moderately successful and has led to relative improvements in coverage, affordability, and use of care in many parts of Africa (McPake *et al.*, 1993).

In high-income countries, where prepayment models exist, copayments and user charges are often employed as a form of both income generation and also demand management by health system architects faced with the prospect of rising health expenditures resultant from growing consumer needs and demands. Depending on the level at which these user charges are set, and on the use of exemption strategies for at-risk populations, such fees have been criticized for dissuading the poor from using services. They also do not appear to raise revenue to enable sustainable improvements to care and are inequitable.

Loans, Grants, and Donations

External aid is a substantial source of funding for the health sector in many low-income countries where it can account for as much as 90% of the overall health budget. Aid is most often provided by bilateral agencies (donors from a particular country) such as USAID (United States), DANIDA (Denmark), and DFID (UK). Multilateral agencies (pooled donor resources between countries) are also prevalent and include organizations like the World Bank and the United Nations Development Fund (UNDF). Aid from such organizations is often provided as loans or grants to which a set of conditions concerning their use is established by donors; in most cases, these are linked to specific projects that are developed and delivered separately between donors and

national governments. While many projects have been successful, project-based approaches have been seen to lead to fragmentation and duplication of effort and/or time and effort from national governments in responding to the priorities of donors rather than concentrating on wider health sector programs. Moreover, grants do not necessarily lead to greater expenditure in the health sector as governments may view the funding as a substitute for their own expenditure, or as an opportunity to channel resources toward other priorities. Loans, grants, and donations, if not managed carefully, may thus do more harm than good. Aware of this, many donors and governments are beginning to embrace longer-term and strategic support programs; such sector-wide approaches have been seen to be successful in countries such as Bangladesh, Ghana, and Pakistan.

Pooling Resources

Fund pooling is the sharing of risk between contributors. The ability to prepay for care services and to pool funds has significant advantages for a national health system because it enables the equalization of contributions among members, regardless of their risk of needing to use services. Moreover, the approach has the benefit of economies of scale, thus allowing for cross-subsidization. **Table 3** gives examples of how different countries can approach risk pooling, for example, from the development of social insurance funds (sometimes called sickness funds) to smaller community-based pools. As the examples imply, a range of agents might be involved in the pooling process from which a larger central pool is developed or, conversely, pooling might be devolved on the basis of risk-adjusted allocations to regional or local agencies who are then enfranchised to address local health-care needs and priorities.

Larger risk pools are obviously better than small ones because they can increase the overall availability of funds

to improve and develop health services, enable economies of scale in administration, and reduce the levels of contribution to protect individuals against uncertain need. From **Table 3**, it might be predicted that Colombia's fragmented system of small organizations would damage the performance of the health system in these three areas. Evidence from Argentina pre-1996, in which there were more than 300 small pooling organizations in the system – most with fewer than 50 000 members – would support this proposition. The many small pools of funds meant that available health-care packages were very limited (especially in poor areas where low wages limited contribution levels). In West Africa, community financing initiatives to raise local pools of funding to plan and deliver drugs and care to local people have in many cases provided some protection from the risks of out-of-pocket payments, but the low level of pooled resources means such approaches are beset with problems of financial sustainability (Goodwin *et al.*, 2006).

The key lesson to be learned from this section is that the ability of a national health system to prepay for health care, and to develop large resource pools to cross-subsidize care between high- and low-risk people, is fundamental to a national health system's sustainability and operational effectiveness. It should be noted that it is not the number of pools that is the issue, but their size relative to population health-care needs.

Purchasing Health Services

The management of purchasing is essential in ensuring that providers of services meet the goals of a national health system. As Goodwin *et al.* (2006) discuss, purchasers of health services face three fundamental challenges: which packages of care to buy, from whom to buy them, and how to buy them. Size is important for purchasing organizations because larger purchasers not only have

Table 3 National examples of approaches to spreading risk and subsidizing the poor

Country	System	Spreading risk	Subsidizing the poor
Colombia	Large number of small multiple pools	Competing social security	Organizations, municipal health
Netherlands	Multiple pools; mostly private competing social insurance funds	Intrapool via nonrisk-related contribution and interpool via central risk equalization fund	Via risk equalization fund, excluding the rich
Republic of Korea	National health insurance (covers 30% of total expenditure of any member) and Ministry of Health	Intrapool via nonrisk-related contributions. Explicit single benefits package for all members	Salary-related contribution plus supply-side subsidy from Ministry of Health. Public subsidy for insurance to the poor and to farmers
Zambia	Single formal pool held by Central Board of Health	Single benefit package for all financed by general taxes	Intrapool via general taxation. Supply-side subsidy via the Ministry of Health

Reproduced from World Health Organization (WHO) (2000) *The World Health Report 2000. Health systems: Improving performance.* Geneva: WHO.

administrative advantages in terms of economies of scale, but also have more bargaining capacity over both price and quality.

Which Packages of Care to Buy: The Role of Strategic Purchasing

Strategic purchasing requires a continuous search for the best interventions and care packages to purchase. This can be seen to occur at two levels in national health systems – first, at a societal and political level, the extent of health-care coverage and the goals of the system (related to the section entitled ‘Stewardship’ later in this article); and second, the identification of those services and interventions that will meet these goals best. The latter implies responsibility for allocating resources and/or creating incentives and negotiating with providers.

Many countries, especially low-income countries, cannot afford to provide comprehensive health-care benefits for the entire population and face major imbalances in resource allocation – for example, between rural and urban regions, and between rich and poor communities. Defining priorities to achieve maximum health gain for the money that is available to purchase services becomes a key task. Many countries address this through a policy of essential care packages (ECPs) aimed at purchasing services with the greatest potential of reducing the burden of disease. The policy of ECPs has been promoted internationally as the most effective way of channeling scarce resources into interventions with the highest health impact.

How Health Systems Purchase Services

The mechanism through which care is bought – that is, how to purchase services – is crucial because the method of payment establishes different kinds of incentives that providers will react to and the subsequent cost and quality of the services they provide. As Goodwin *et al.* (2006) describe, there are three main methods by which health systems purchase services:

1. Full retrospective reimbursement for all expenses incurred, manifest in fee-for-service payments;
2. Reimbursement for all activity based on a fixed schedule of fees using a tariff, based on a system of health- or diagnostic-related groups (HRGs and DRGs); and
3. Prospective funding based on the expected future expenditure using a fixed budget, manifest in salaried employment, directly managed and/or devolved budgets, and capitation.

Retrospective reimbursement is a payment scheme whose level is determined only after services have been provided. It may involve *per diem* payments, a cost-per-case, or a direct service payment. To health systems, the main problem with this model of purchasing is the

inability to control provider costs effectively due to weak forms of audit and control of activity. In the United States, for example, the cost of Medicare and Medicaid services (tax-based funding for the old and poor) that began in the 1960s could not be maintained beyond 1983 because federal government income did not provide enough revenue to cover costs. It was known as the blank-check era since providers received payment for all care deemed ‘customary, usual, and reasonable.’ As the number of people on Medicare rapidly climbed and costs spiraled the system was replaced with DRG-based funding; a similar policy shift occurred in Germany’s social insurance system in the early 1990s.

Prospective payment requires a tariff to be set to charges agreed in advance with providers, the most common being the DRG. DRGs categorize patients based on their primary and secondary diagnoses, primary and secondary procedures, age, and length of stay. The categories establish a uniform cost, enabling funders to set a maximum amount payable for a suite of care to a patient. Under this system, providers are given the incentive to keep their costs down as they would experience a profit (or surplus) if their costs are below the tariff in the DRG category. National health systems, therefore, benefit from more efficient providers and provider competition based on quality rather than cost. Such a system, called payment by results, has recently been established in the English National Health Service (NHS) to replace traditional capitation-based funding.

Prospective funding is a system that many national health-care systems have in place. Under this system, a global budget for health-care spending is often set within which envelope care can be purchased. Funding agencies acting on behalf of governments then allocate a fixed proportion of that budget to providers. The method of allocation can vary, for example, from political negotiation (a settlement), to provider competition (a bid), or by way of historic precedent and activity. Most countries use more sophisticated combinations of the three, for example, devolving resources to local purchasing agencies based on the needs of local populations based on their demographic profiles (capitation). This approach is favored in most high-income countries of Europe where a fair share of resources through capitation-based formulae is generally mixed with historic local expenditures and political negotiations. Variations to the approach are, therefore, commonplace. For example, budgets in Italy are renegotiated retrospectively; local taxes are raised in Sweden to supplement the national allocation; care is rationed in Norway through waiting lists or entitlement changes; and in most countries, such as Finland, copayments are levied to raise revenue and manage demand.

Types of provider payment mechanisms, therefore, produce different system incentives (Table 4). Fee-for-service and prospective payment mechanisms provide strong incentives to meet consumer demands and deliver

timely services, but are weaker in containing costs and do not necessarily invest in services that prevent health problems. France is a classic example, and the rising costs of the system has led the French to reconsider its strategic priorities including limiting entitlements, increasing the use of copayments, and introducing capitation payments as a way of controlling costs. By contrast, the English NHS, historically highly cost-effective in service delivery terms due to its capitation-based system and primary care-led system of gatekeeping, has encouraged the move to a DRG-style system of funding to encourage providers to become more responsive to patient demands and so reduce waiting lists and improve access. National health systems, therefore, need to combine payment mechanisms if they are to achieve all their objectives. The French and English diversions away from their historical positions show how countries have attempted to change provider behavior to meet system needs – choice and responsiveness (in England) and cost containment (in France).

In national health systems, purchasing needs to be actively managed since the process of making strategic investment priorities can impact on equity and efficiency in provision. The performance of a health system is likely to fall short of its potential if resources are not allocated and spent wisely to gain the best mix of responses from providers that help to satisfy needs and improve care quality.

Providing Health Care

Referring back to **Figure 1**, health-care provision can usefully be split between personal and nonpersonal services. Personal services are those that people receive from a health agent, such as a doctor or dentist, while nonpersonal services are manifest in wider health promotion and disease prevention activities such as public health programs to promote healthy lifestyles or improve local environmental health.

The provision of personal health-care services within a national health system has most often been categorized through a threefold classification – primary, secondary, and tertiary care (**Figure 5**). Primary care is regarded as the first level of contact between individuals, the family, and/or communities with the health system itself. The purpose of primary care services is to bring basic health care as close as possible to where people live and work. Primary care can be delivered by way of a wide range of community-based health professionals, such as family physicians, pharmacists, therapists, and dentists. Primary care forms an integral part of most country's health systems and, as this article will show later, having an effective system of primary care providers is of crucial importance to overall national health system effectiveness. Secondary care, often referred to as the acute sector due to its predominant basis in hospital institutions, can be described as

Table 4 Provider payment mechanisms and provider behavior

	<i>Ability to prevent health problems</i>	<i>Delivering services</i>	<i>Responsiveness to expectations</i>	<i>Containing costs</i>
Salaried/global budget	++	--	+/-	+++
Capitation	+++	--	++	+++
Diagnostic related payment	+/-	++	++	+/-
Fee-for-service	+/-	+++	+++	---

+++ : very positive effect; ++ : positive effect; +/- : little effect; -- : negative effect; --- : very negative effect. Reproduced from World Health Organization (WHO) (2000) The World Health Report 2000. Health systems: Improving performance. Geneva: WHO.

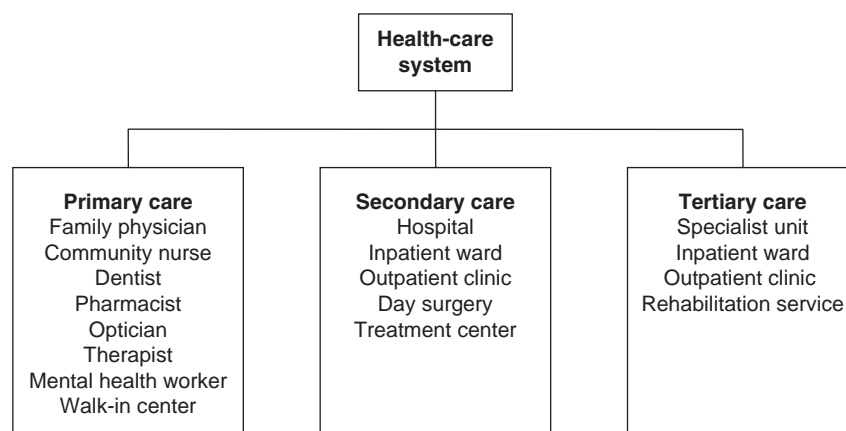


Figure 5 Sectors of 'personal' health care within a national health system.

the episodic treatment provided for an illness or health problem and is primarily curative in nature. Often, secondary care services are accessed through referrals from family physicians and/or through direct access for accident and emergency care. Tertiary care takes the form of more specialized care often within a specialist center serving a larger population or even the whole country.

Across a national health system, the number of patient contacts and episodes decreases as one moves from informal lay care to primary, secondary, and tertiary sectors. Despite the reduced number of patients accessing care in each sector, the proportion of costs of health services provision to the system as a whole tends to rise exponentially. This can be seen in **Figure 6**. However, making generalizations about the structure of health-care provision using the general classifications discussed previously is invidious. In reality, the boundaries between care sectors are often ambiguous and blurred since care can shift seamlessly from one sector to another.

Care Pathways and Disease Management: The Emergence of New Health System Models

There is a constant pressure to address increasing health-care costs in most national health systems by attempting to develop more efficient and appropriate care practices. For example, many national health-care systems have taken the opportunity to redesign and streamline the care process to reduce the number of contacts with the different parts of the system, minimize the numbers of handovers and referrals between providers, and so make more appropriate (and cost-effective) the use of each sector. Purchasing and/or commissioning care delivery across a redesigned care pathway has been claimed to be more efficient in terms of resource use, enabling patients quicker access to treatment and maximizing long-term health outcomes.

An alternative, often linked, approach is based on the greater ability of the system to promote good health and/or

enable the management of illness without recourse to the need for the more expensive forms of care. Indeed, most countries, whether high or low income, seek to promote health and manage illness outside of institutionalized structures. As a consequence, patients are increasingly being prescribed integrated care packages across the previous dimensions of care (such as a disease management program) and/or investment is made in the capacity of primary care providers, and indeed of people themselves ('self-care') to promote good health and provide effective and early interventions that limit the need for people to access the more expensive forms of care.

Disease management as the basis for a health systems design is a concept developed in the United States during the 1990s and has been a growing phenomenon in health systems around the world, although its specific forms strongly depend on the health-care system in which it is applied. A number of definitions for this model of care exist, but roughly it encompasses a systematic, population-based approach to tackling specific diseases and health problems by developing programs of care to advance health system quality, efficacy, and health outcomes. In the United States, disease management programs mainly focus on reduction of costs by targeting short-term interventions to patients currently in relatively good health yet at high risk of using secondary and tertiary care in the near future. In Europe the use of disease management mechanisms is accelerating. For example, in Spain, Insalud (the Spanish National Health Service) has contracted out disease management programs for heart failure and diabetes in Barcelona and Madrid. In Germany, national government has by law introduced disease management programs as a lever to break up the traditional authority of physicians while seeking to reduce rising long-term costs.

Figure 7, adapted from the 'Kaiser Triangle' disease management model of the U.S. managed care organization Kaiser Permanente and later adopted by the Department of Health in England (Department of Health, 2004), describes the type of health-care system that should be provided to people suffering from, or at high risk for, chronic disease. Unlike the care triangle described in **Figure 6**, the health system model is not based on institutional sectors (i.e., primary, secondary, and tertiary care), but on different approaches to manage patients' needs. At the top of **Figure 7** lies case management (the top 5% of people with chronic disease) for people with advanced and acute conditions who require intensive and actively managed care by professionals. At the second level – disease management (the next 15% of cases) – proactive case management by multiprofessional and integrated teams is required, perhaps following specified pathways of care, but including a high degree (about 50%) of support to self-care. For the majority of patients (about 80%), chronic disease remains a condition (or a

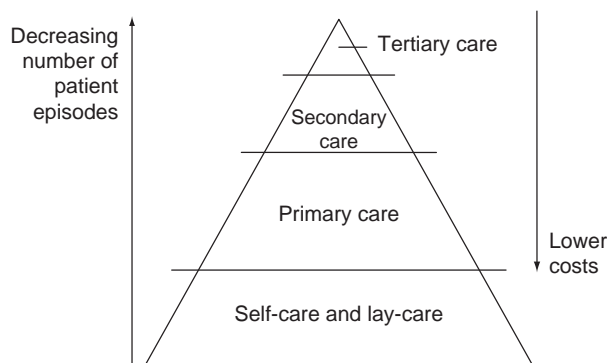


Figure 6 Relationship between health-care expenditure and levels of care.

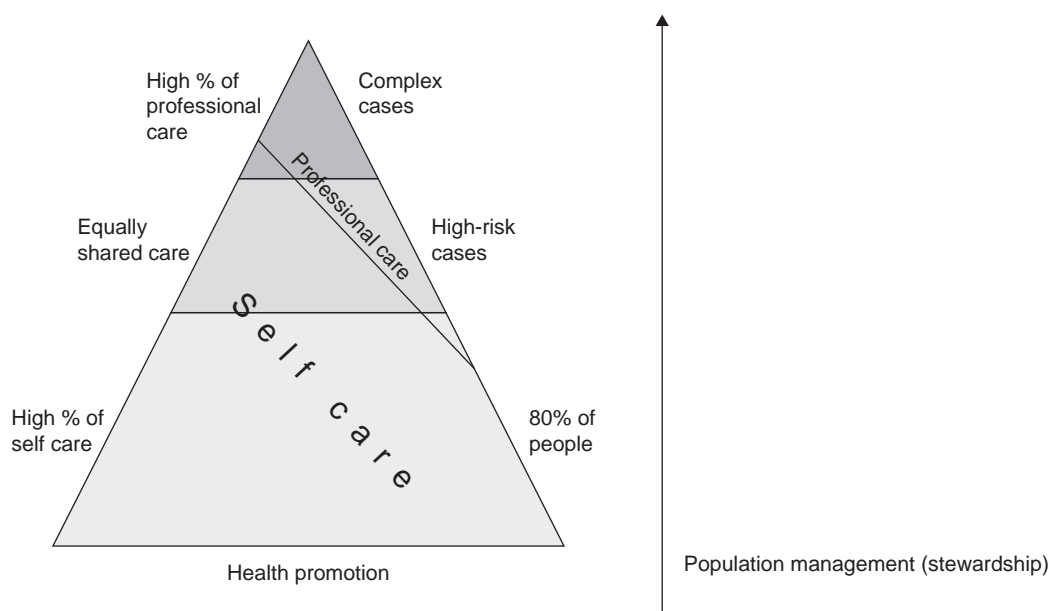


Figure 7 A health-care system model based on the management of chronic diseases and long-term conditions. Adapted from Department of Health (2004) *Improving Chronic Disease Management*. London: Department of Health.

risk) that does not require active professional intervention but can, through the right support, be addressed by engaging patients to be active in the self-management of their conditions and so prevent any deterioration. Given the numbers of people in this part of the triangle (about 80% of cases, or 48% of the whole population) one can see that effective self-care strategies are crucial to the overall effective support for people with long-term conditions (i.e., reducing the numbers of people subsequently moving up the triangle) (Department of Health, 2004).

Figure 7 also shows that for such a health-care system based on disease management to be effective, it requires a significant degree of management to ensure that local services to a defined population are tailored to meeting needs. As the model implies, it is the purchasers' responsibility to ensure that strategies are in place for high-risk groups to help prevent the onset of chronic disease, and to enable self-management for those living with such conditions. The range of self-care support tools that purchasers might seek to encourage, therefore, lies both within and out of the personal health sectors and includes: patient education, self-skills training, self-diagnostic and self-monitoring tools, home adaptations, and peer support networks. As national health systems develop in high-income countries, the needs of an aging population and the rising burden of chronic disease and long-term care needs have begun to shift how care is provided from an acute sector paradigm (based on episodic care in hospital institutions) to one based on disease management (based in primary and community care sectors and blurring the boundary between the formal and informal care sectors).

Public Health

Until the 1970s it was commonly assumed that improvements in health experienced in most countries during the last century occurred as a consequence of advances in medical care. However, the evidence collated in the key work by Wilkinson and Marmot (2003) has shown that the most important factors to improve the health of people, patients, and populations lies primarily outside the formalized system of health care. This led the authors to a key observation that the amount of money spent on health care (in terms of percentage of GDP) is not in itself a direct and causal contributor to a nation's health profile.

Many health-care systems internationally have made fundamental changes to the management and delivery of care in attempts to reduce inequalities in both health status and access to services following the realization that the role of a national health system must extend beyond the formalized systems of medical care to address the wider public health agenda through services and strategies aimed at improving well-being. At present, there is a struggle taking place in many health systems around the world to rebalance their policies and practices. Whereas there is a recurring policy theme internationally in the importance of developing a more proactive public health-based system, the necessary restructuring and reengineering of existing ways of purchasing and providing care services to achieve this implies radical system change (**Table 5**). For example, the core features of a public health system would require the provision of comprehensive public health programs for populations

Table 5 Characteristics of a proactive public health system

Public health at the center of decision making
Public health at the cultural heart of care organizations
Finance, purchasing, and provider strategies integrated to assist health improvement
Ring-fenced resources for public health
Interventions at the earliest opportunity to address avoidable deaths
Preventative initiatives to promote good health and well-being
Responsibility to the citizen by helping fulfill their economic potential to improve health
Primary care organizations to manage patients and prevent ill health
Workforce development and training tailored to meet health improvement agenda

to improve and protect health, public health interventions that are integrated into the daily work of professionals in primary care, and the creation of multidisciplinary public health teams working in community-based managed care networks.

Stewardship

In the view of international agencies that have examined the relative performance of national health systems, it is clear that more effective health-care systems are those which are carefully and responsibly managed (WHO, 2000; OECD, 2004; Davis *et al.*, 2007). Stewardship of a nation's health system is important because it is people who entrust themselves (and their money) to a health service and so, in return, it becomes the responsibility of the system to protect the population by ensuring resources are used wisely. Most organizations cannot be left to themselves to deliver effective and excellent services, and improve quality, safety, and efficiency, so in most national health systems the government must fulfill the task of stewardship – whether through direct regulation of nationally funded providers or by way of the use of independent regulators in a mixed economy of public and private providers.

Stewardship of a health system through forms of regulation and governance can have three main objectives. First, policy makers may wish to stimulate capacity and productivity through entrepreneurial opportunities by encouraging competitive behavior. This might include permitting hospitals to retain operating surpluses, moving payment systems from fixed budgets to fee-for-service, or allowing hospitals to set their own fees. Second, regulators might wish to protect the system from the more negative aspects of competition through activities such as reducing adverse selection by health-care payers and providers, requiring insurance providers to accept all applicants, or setting minimum quality standards through licensing or

accreditation. Third, regulation can concentrate on safeguarding social objectives, such as stipulating minimum waiting times or opening hours, setting uniform prices (tariffs), providing treatment guidelines and protocols, and undertaking quality assurance audits.

Many Western countries have introduced regulatory reforms to alter system behaviors. As a result, there has been a general increase in the number of regulatory bodies and activities at state and local levels in health care. For example, in the English NHS, a statutory duty to assess the performance of health-care organizations and publish performance ratings was established in 2004 by way of the Health Care Commission. The purpose of the approach was to ensure that providers – now enjoying greater entrepreneurial freedom and autonomy from the state – were still meeting core government standards of quality, safety, cleanliness, and waiting times (i.e., safeguarding social objectives). Such ‘steer and channel’ regulation is likely to play an important role in the short and medium term in many countries that are simultaneously encouraging competition but through rules consistent with core social objectives. Hence, well-designed regulatory mechanisms can stimulate needed entrepreneurialism while simultaneously safeguarding social objectives – the essence of stewardship.

The nature of stewardship has an important role to play in defining the characteristics of national health-care systems. Political leadership and legislation practice together defines the principles and conceptual frameworks around which health system financing, purchasing, and delivery operate. For example, in England, the core principles of a tax-funded NHS that is free at the point of delivery to all citizens according to need has remained unchallenged despite far-reaching reforms that have injected private-sector capital and management practices into the system. In France, the principle of *la médecine liberale* remains culturally important to citizens who value freedom of access to specialists within a socially equitable social health insurance-based system. As the WHO (2004) commented, leadership by the state – its vision, direction, and relationship with citizens – tends to define the overall strategic framework in which the component parts of a national health system operate.

What Factors Constitute a More Effective Health-Care System?

In Alan Gillies' (2004) book that examined this question it was suggested that individuals wanted three fundamental things from their national health-care system: first, they wanted to be kept as healthy as possible; second, when this is not possible, they want to be treated and made better as soon as possible; and third, they want care provided at a minimum (or best value) cost consistent with the first two

goals. Hence, Gillies argued that the best health-care systems were those that enabled the greatest possible health improvement and health-care provision within the funding available. In common with international studies examining the factors associated with better health-care systems (OECD, 2004; WHO, 2000; Davis *et al.*, 2007) these observations reveal that it is not the level of spending that counts – as there is no single most appropriate level – but how that spending is used that matters.

Responsiveness and choice have become important criteria in the more affluent nations as they seek to meet personal demands for health care (as opposed to national needs) through patient-led care. However, as Gillies argues, the priorities that have become prevalent in Western countries are for most parts of the world an unrealistic dream. Hence, he argues that it should never be forgotten that the basic responsibility of a national health system is to deliver the basics. Reflecting back to Maxwell's (1992) basic quality measures that define the purpose of national health systems (see **Table 1**), and the realization that no single principle is necessarily more important than another, how might it be possible to objectively measure, on a comparative basis between nations, which type of national health system performs better than another?

The question is problematic because data that may be used to make effective comparisons between countries are fraught with difficulties. For example, comparisons are often made between national health systems based on their respective health expenditure relative to their nation's wealth (as characterized by the percentage of GDP allocated to financing health care). However, understanding what can be, or is actually, purchased with this

funding varies markedly in real terms (purchasing power) or in terms of the coverage and entitlement to care for all citizens. Moreover, meaningful health outcome comparisons can be argued to be confounded by contextual variances in the demographic, geographical, and socioeconomic profiles of different countries. As a result, comparisons have tended to use high-level indicators of performance between countries – such as levels of infant mortality or life expectancy at birth – all factors that we know are influenced more by factors outside the influence of formal health system interventions (Wilkinson and Marmot, 2003).

Perhaps the most famous comparative study is contained in the World Health Report 2000, which compares the health systems of 191 countries based on a ranking of eight key system measures, leading with a composite measure of these systems for overall health system performance (WHO, 2000). More recently, the Commonwealth Fund's comparative analysis of six national health-care systems has added to the debate (Davis *et al.*, 2007). What both uncover is that systems without universal health coverage and/or fragmented rather than coordinated care delivery fare worse in comparison to those that do, regardless of the amount of money spent on health care. For example, the United States (the most expensive health system) was ranked 37th in the World Health Report 2000 and last out of the six nation summary scores (Australia, Canada, Germany, New Zealand, UK, and the United States) in the Commonwealth Fund's assessment (**Table 6**).

The OECD's (2004) study of 29 industrialized nations suggested that the following key factors were associated with high-performing health-care systems:

Table 6 Six nation summary scores on health system performance, Commonwealth Fund (2007)

	AUS	CAN	GER	NZ	UK	US
Overall ranking	3.5	5	2	3.5	1	6
Quality care	4	6	2.5	2.5	1	5
Right care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Coordinated care	3	6	4	2	1	5
Patient-centered care	3	6	2	1	4	5
Access	3	5	1	2	4	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy lives	1	3	2	4.5	4.5	6
Health expenditures per capita*	\$2876	\$3165	\$3005	\$2083	\$2546	\$6102

Note: 1=highest ranking, 6=lowest ranking.

*Health expenditures data are from 2004 except Australia and Germany (2003).

Health expenditures per capita figures are adjusted for differences in cost of living. Source: OECD, 2004.

Source: Calculated by The Commonwealth Fund based on the Commonwealth Fund 2004 International Health Policy Survey, the Commonwealth Fund 2005 International Health Policy Survey of Sicker Adults, the 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians, and the Commonwealth Fund Commission on a High Performance Health System National Scorecard.

Source: Davis K, Schoen C, Schoenbaum S, Doty M, Holmgren A, Kriss J, and Shea K (2007) *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*. New York: The Commonwealth Fund.

- a sustainable and robust financing system;
- care that is provided to all the population and care that is coordinated so recipients are looked after ‘from cradle to grave’;
- a focus on prevention of ill health and the promotion of public health;
- an effective monitoring and regulation system; and
- strategic planning to ensure resources for health care are being put to good use, for example, harnessing the potential of advances in information technology.

Each of these reports can rightly be criticized for the methodological inadequacies in their assessments. Yet, each serves to highlight two central issues we know about the effectiveness of national health systems: first, that achieving good health outcomes in a national health system is more about how the system is designed and not necessarily related to how much is spent; and second, that different health-care systems are simultaneously trading off the achievement of different measures of system quality (e.g., in terms of access, efficiency, equity, and responsiveness).

Regardless of funding type, there is also evidence to suggest that more effective health-care systems have a stronger orientation to health promotion, disease prevention, and the provision of accessible and universal primary and community care-based services. The benefits of such a strong primary care-based component to a health system have been identified through influential analysts such as Barbara Starfield. By ranking the primary care orientation of 12 Western industrialized nations, she concluded that countries with a strong primary care base to their health-care system achieved better outcomes, and at lower cost, than countries in which the primary care base was weaker (Starfield, 1998). In Starfield’s analysis, features that were consistently associated with good or excellent primary care included the comprehensiveness and family orientation of primary care practices, within a wider system in which governments regulated the distribution of health-care resources by way of taxation or national insurance. Given that the burden of disease is shifting to the long-term chronically ill, national health systems must adapt to meet this challenge – a task requiring a move away from episodic care undertaken in specialist hospital institutions to long-term care management and coordination undertaken in the community. The importance of a primary care orientation to health system design with a strong public health component has never been more relevant.

Conclusions

In almost all Western countries, health-care systems are in a state of radical transformation as they simultaneously

attempt to meet the demands of empowered consumers, incorporate evidence-based modes of working, apply disease management principles, and contain costs. The tensions implicit in these changes mean that the relationship between governments, insurance funds, health-care providers, medical professionals, and the public is in constant need of effective stewardship if the espoused goals of a national health system are to be achieved. Such stewardship requires effective regulation of activities to connect together the constituent parts of a national health system and enable, for example, the reconfiguration of personal and nonpersonal services to meet future health-care needs through a shift from a preoccupation with downstream care services to an upstream focus on the health of communities. However, achieving such ideals will be influenced by the two key features controlling the overall nature of a national health system: the involvement of the state (the ability of governments and legislative bodies to respond to system needs) and the limitations imposed by political and resource pressures.

See also: Health System Organization Models (Including Targets and Goals for Health Systems); Urban Health Systems: Overview.

Citations

- Davis K, Schoen C, Schoenbaum S, *et al.* (2007) *Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care*. New York: The Commonwealth Fund.
- Department of Health (2004) *Improving Chronic Disease Management*. London: Department of Health.
- Gillies A (2003) *What Makes a Good Healthcare System?* Abingdon, UK: Radcliffe Medical Press.
- Glenngård A, Hjalte F, Svensson M, Anell A, and Bankauskaite V (2005) *Health Systems in Transition: Sweden*. Copenhagen, Denmark: WHO Regional Office for Europe on behalf of the European Observatory on Health.
- Goodwin N, Gruen R, and Iles V (2006) *Managing Health Services*. Maidenhead, UK: Open University Press.
- Maxwell R (1992) Dimensions of quality revisited: From thought to action. *Quality in Health Care* 1(3): 171–177.
- McPake B, Hanson K, and Mills A (1993) Community financing of health care in Africa: An evaluation of the Bamako Initiative. *Social Science and Medicine* 36(11): 1383–1395.
- Mossialos E, Dixon A, Figueras J, and Kutzin J (2002) *Funding Health Care: Options for Europe*. Buckingham, UK: Open University Press.
- Organisation for Economic Co-operation and Development (OECD) (2004) *Towards High Performing Health Systems: Summary Report*. Paris, France: OECD.
- Sandier S, Paris V, and Polton D (2004) *Health Care Systems in Transition: France*. Copenhagen, Denmark: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies.
- Starfield B (1998) *Primary Care: Balancing Health Needs, Services and Technology*. Oxford, UK: Oxford University Press.
- Wilkinson R and Marmot M (eds.) (2003) *Social Determinants of Health: The Solid Facts*, 2nd edn. Geneva, Switzerland: World Health Organization.

World Health Organization (2000) *The World Health Report 2000. Health Systems: Improving Performance*. Geneva, Switzerland: World Health Organization.

World Health Organization (2004) *The World Health Report 2004. Changing History*. Geneva, Switzerland: World Health Organization.

Further Reading

Hunte D (ed.) (2007) *Managing for Health*. London: Routledge.

Schrijvers G (ed.) (2005) *Disease Management in the Dutch Context*. Netherlands: ZuidamUithof Drukkerijen.

Smith J and Goodwin N (2006) *Towards Managed Primary Care: The Role and Experience of Primary Care Organizations*. Aldershot, UK: Ashgate.

Walshe K and Smith J (eds.) (2006) *Healthcare Management*. Maidenhead, UK: Open University Press.

Relevant Websites

<http://hospitalconnect.com/aha/about> – American Hospital Association.

<http://www.dh.gov.uk> – Department of Health, England.

<http://www.ehma.org> – European Health Management Association.
<http://www.euro.who.int/observatory> – European Observatory on Health Systems and Policies.

<http://www.epha.org> – European Public Health Alliance (EPHA).

<http://www.healthcarecommission.org.uk/homepage> – Healthcare Commission.

<http://www.dmalliance.org> – International Disease Management Alliance (IDMA).

<http://www.ijic.org> – International Journal of Integrated Care (IJIC).

<http://www.oecd.org> – Organisation for Economic Co-operation and Development (OECD).

<http://who.int> – World Health Organization (WHO).

Urban Health Systems: Overview

D C Ompad, Center for Urban Epidemiologic Studies, New York Academy of Medicine, New York, NY, USA

S Galea, University of Michigan School of Public Health, Ann Arbor, MI, USA

D Vlahov, Mailman School of Public Health, Columbia University, New York, NY, USA

© 2008 Elsevier Inc. All rights reserved.

Introduction

Demographic trends suggest that there is an urgent need to consider the health of urban populations. Cities are becoming the predominant mode of living for the world's population. According to the United Nations (UN), approximately 29% of the world's population lived in urban areas in 1950. By 2000, 47% lived in urban areas and the UN projects that approximately 61% of the world's population will live in cities by 2030. Overall, the world's urban population is expected to grow from 2.86 billion in 2000 to 4.94 billion in 2030. As the world's urban population grows, so does the number of urban centers. The number of cities with populations of 500 000 or greater grew from 447 in 1975 to 804 in 2000. In 1975 there were four megacities with populations of ten million or more worldwide; by 2000 there were 18, and 22 are projected by 2015. As illustrated by **Figure 1**, most cities are in middle- to low-income countries; in 2000 middle- to low-income countries contained 72% of the world's cities. During the second session of the World Urban Forum in 2004, world leaders and mayors warned that rapid urbanization is going to be one of the most important issues in this millennium.

A Brief History of Urban Health

Cities and their impact on health have been a concern for millennia. City architects as early as the fourth century

BCE designed cities to maximize exposure to the sun in winter, minimize solar exposure in the summer, and take advantage of mountain and sea breezes (Semenza, 2005). More familiar, recurrent plague epidemics in European cities between the fourteenth and sixteenth centuries, and pestilence within slums early in the Industrial Age became a major concern for urban dwellers such that authorities were required to develop and maintain knowledge for dealing with the epidemics.

For centuries, researchers and scholars have considered the study of how cities may shape health an important area of inquiry. Some of the early epidemiological studies and interventions were centered on urban populations. John Graunt, considered by many to be the first epidemiologist, published *Natural and Political Observations Mentioned in a Following Index, and Made upon the Bills of Mortality* in 1662. In it, he presented the first life tables, as well documenting increases in urban populations due to immigration. Almost two centuries later, John Snow, in what might be considered a prototypical urban health intervention, removed the Broad Street pump handle after observing differential attack rates for cholera in London.

Until relatively recently, in the academic literature, urban living and its related exposures were considered mainly in terms of their detrimental effects. This urban health 'penalty' perspective, described by Andrulis and others, focused attention on poor health outcomes in an inner-city environment and disparities in the burden of morbidity and mortality, as well as disparities in

- Harlem, New York, and Bayamon, Puerto Rico. *Journal of Acquired Immune Deficiency Syndrome* 27: 405–413.
- Deren S, Robles R, Andia J, Colon HM, Kang SY, and Perlis T (2001) Trends in HIV seroprevalence and needle sharing among Puerto Rican drug injectors in Puerto Rico and New York: 1992–1999. *Journal of Acquired Immune Deficiency Syndrome* 26: 164–169.
- Drucker E (2002) Population impact of mass incarceration under New York's Rockefeller drug laws: an analysis of years of life lost. *Journal of Urban Health* 79: 434–435.
- Friedman SR, Cooper HLF, Tempalski B, et al. (2006) Relationships of deterrence and law enforcement to drug-related harms among drug injectors in US metropolitan areas. *AIDS* 20: 93–99.
- Frye V, Latka MH, Koblin B, et al. (2006) The urban environment and sexual risk behavior among men who have sex with men. *Journal of Urban Health* 83: 308–324.
- Ruchirawat M, Navasumrit P, Settachan D, Tuntaviroon J, Buthbumrung N, and Sharma S (2005) Measurement of genotoxic air pollutant exposures in street vendors and school children in and near Bangkok. *Toxicology and Applied Pharmacology* 206: 207–214.
- Sampson RJ, Raudenbush SW, and Earls F (1997) Neighborhoods and violent crime: A multilevel study of collective efficacy. *Science* 277: 918–924.
- Semenza JC (2005) Building healthy cities: A focus on interventions. In: Galea S and Vlahov D (eds.) *Handbook of Urban Health: Populations, Methods and Practice*, pp. 459–478. New York: Springer.
- Stack C (1977) *All Our Kin: Strategies for Survival in a Black Community*. New York: Harper and Row.
- Subramanian SV, Delgado I, Jadue L, Vega J, and Kawachi I (2003) Income inequality and health: Multilevel analysis of Chilean communities. *Journal of Epidemiology and Community Health* 57: 844–848.
- Takano T, Nakamura K, and Watanabe M (2002) Urban residential environments and senior citizens' longevity in megacity areas: The importance of walkable green spaces. *Journal of Epidemiology and Community Health* 56: 913–918.
- Vermeiren R, Schwab-Stone M, Deboutte D, Leckman PE, and Ruchkin V (2003) Violence exposure and substance use in adolescents: Findings from three countries. *Pediatrics* 111: 535–540.
- Weich S, Burton E, Blanchard M, Prince M, Sproston K, and Erens B (2001) Measuring the built environment: Validity of a site survey instrument for use in urban settings. *Health and Place* 7: 283–292.
- Whyte WF (1943) *Street Corner Society: The Social Structure of an Italian Slum*. Chicago, IL: University of Chicago Press.
- Philadelphia, PA: American College of Physicians. <http://www.acponline.org/hpp/pospaper/andrulis.htm>.
- Bureau of the Census (2002) Qualifying urban areas for Census 2000. Department of Commerce. Federal Register, vol 67, No. 84. May 1, 2002: 21962.
- Diez Roux AV (2001) Investigating neighborhood and area effects on health. *American Journal of Public Health* 91: 1783–1789.
- Freudenberg N, Silver D, Carmona JM, Kass D, Lancaster B, and Speers M (2000) Health promotion in the city: A structured review of the literature on interventions to prevent heart disease, substance abuse, violence and HIV infection in US metropolitan areas, 1980–1995. *Journal of Urban Health* 77: 443–457.
- Freudenberg N, Vlahov D, and Galea S (2005) Beyond urban penalty and urban sprawl: Back to living conditions as the focus of urban health. *Journal of Community Health* 30(1): 1–11.
- Galea S and Vlahov D (eds.) (2005) *Handbook of Urban Health: Populations, Methods and Practice*. New York: Springer.
- Harpham T and Tanner M (1995) *Urban Health in Developing Countries*. London: Earthscan.
- Kawachi I and Berkman LF (eds.) (2003) *Neighborhoods and Health*. New York: Oxford University Press.
- Leviton LC, Snell E, and McGinnis M (2000) Urban issues in health promotion strategies. *American Journal of Public Health* 90: 863–866.
- Luke DA (2004) *Multilevel Modeling*. Thousand Oaks, CA: Sage.
- Patton MQ (2001) *Qualitative Research and Evaluation Methods*. Newbury Park, CA: Sage.
- Raudenbush SW and Bryk AS (2002) *Hierarchical Linear Models*, 2nd edn. Thousand Oaks, CA: Sage.
- Vlahov D and Galea S (2002) Urbanization, urbanicity, and health. *Journal of Urban Health* 79(supplement 1): S1–S12.
- Vlahov D, Galea S, and Freudenberg N (2005) The urban health "advantage." *Journal of Urban Health* 82: 1–4.

Relevant Websites

- www.isuh.edu – International Society of Urban Health.
- <http://www.un.org/esa/desa> – United Nations Department of Economic and Social Affairs.
- <http://www.unhabitat.org> – United Nations Human Settlements Program.
- http://www.who.int/social_determinants/knowledge_networks/settlements – Commission on Social Determinants of Health, Knowledge Network on Urban Settings.
- <http://www.who.or.jp> – WHO Center for Health Development, Kobe, Japan.

Further Reading

- Andrulis DP (1997) The urban health penalty: New dimensions and directions in inner-city health care. *Inner City Health Care*.

Comparative Health Systems

H Wang, Yale University School of Public Health, New Haven, CT, USA

© 2008 Elsevier Inc. All rights reserved.

Introduction

A good health system is one of the most important elements in ensuring the health of a population in any modern society. Although all nations share the same goal of improving the health of a population in a cost-effective and equitable manner, health systems vary greatly from

country to country. However, a perfect health system does not exist. In fact, nearly every nation is continuously undergoing certain health system reforms and system improvements. Governments are constantly striving for a high-quality, cost-effective, and universal health-care system.

Comparative health-care systems is a rapidly growing field that is being called on more and more frequently in

health policy and health service research communities. This is particularly true in the current trend of globalization, wherein alternative ways to solve inherent problems in health systems and to improve the performance of health systems are being analyzed.

Experience from previous decades shows that the development of a health system is facilitated with international comparisons of other nations' health systems. First, the comparative nature of the analysis allows for a greater number of policy options to be identified, which will likely assist policy makers in the implementation of health strategies. Second, the comparative analysis of a health system can help people realize the consequences of various policy decisions: the successes that they might consider adopting and the failures that they should avoid. Finally, comparative analyses can act as benchmarks for in-depth evaluations of the performance of a health system.

Concept of Health System

Health systems have been conceptualized in various ways. Roemer (1991) defines a health system as "the combination of resources, organization, financing and management that culminate in the delivery of health services to the population." This definition emphasizes the input requirements of a health system. The World Health Organization's (2000) definition includes "all the activities whose primary purpose is to promote, restore or maintain health." Rather than emphasizing inputs such as resources, this definition focuses primarily on the outcome aspects of a health system. Irrespective of the definition, a health system should include the following two major components: The first component is the goal of a health system, that is, to address health and illness in society, and the second component is a set of mechanisms that transform health-related resources into health services in order to achieve the goal of a health system.

Although health systems vary across countries, all include similar structural components (see **Figure 1**): health-care providers, consumers of health-care services, health financing agencies, resources suppliers, and government/regulatory entities. Each component is directly linked to the other four components. For example, health providers provide health-care services to the consumers, receive payments from a financing agency to recover the cost of health services, obey the regulations imposed by the regulatory entity, and receive resources from resource suppliers.

The variations arise from the individuals that comprise the components, the manner in which the individuals function collectively, the importance of each component in the system, and the relationships among the components of a specific health system. For example, all health systems have health-care financing agencies. However, these agencies vary, from governments to private health insurance to

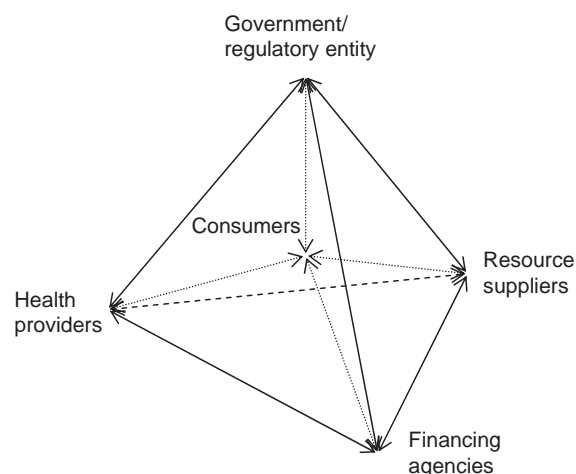


Figure 1 The common structure of health systems.

individual consumers themselves. In some health systems, governments are the major agencies for health financing; in other cases, out-of-pocket payments are the main sources of health financing; that is, the individual health-care consumer acts as the health financing agency. The relationships between health financing agencies and health-care providers are based on the contract arrangements of capitation or fee-for-services payments.

Methods in Comparative Health Systems

Methods to compare health systems have evolved into three types (Rodwin, 1995). The first type can be summarized as random observations in the early stage of comparative analysis. That is, "travelogues . . . written by physicians from overseas tours" to express the variations of health systems without specific policy purposes. The second type can be summarized as purposeful learning of comparative analysis, which focuses primarily on the practical issues of improving the performance of a health system through health system reform. The third type can be summarized as a social science comparison of health systems. Comparative health system analysis involves a multidisciplinary approach and incorporates disciplines such as anthropology, sociology, political science, and economics. Furthermore, rigorous study design with elaborate hypotheses and sophisticated analytic methods are applied in comparative analysis.

In terms of study design, the majority of comparative analyses of health systems have been cross-sectional. In order to make the health systems as comparable as possible, countries with similar socioeconomic environments (serving as the control variable) are often selected for comparative analysis. Since an experimental study design is rarely feasible, quasi-experimental study designs have been used instead. However, this type of study is very expensive and is able to test multiple sites only within the same country.

Comparative analyses of health systems can be performed by a ‘snapshot’ approach to examine the overall performance of a health system or by an ‘anatomical’ approach to examine the effects of specific components on the outcomes or overall function of a health system. The snapshot approach commonly uses the following measures to compare health systems: total health-care expenditure, life expectancy or healthy life expectancy, or health system outcomes. These are then used to judge the overall performance of a health system. Although this approach is intuitive and easy to understand, it does not provide significant details for the policy learning purpose. The second approach incorporates a more in-depth analysis of each component of the health system in order to gain a greater understanding of how a specific system works. Certainly, these two approaches are not mutually exclusive. A snapshot approach is usually the first step of a more elaborate comparative analysis of a health system.

The framework of “structure, process, and outcome” (Aday, 1998) is often implicitly or explicitly applied in comparative health system analyses. Structure refers to the investment of health resources – including resources for the delivery of health services, as well as resources for the organizational structure of health services – and the health status of a population in a specific society. Process encompasses the delivery of health services, as well as the utilization of health services. Outcome can be dissected into two groups: intermediate outcomes and ultimate outcomes. Intermediate outcomes refer to the immediate outputs of health system performance such as quality, efficiency, and access to health services. Although these outputs are the consequences of health system performance, they are not necessarily the final goals from a societal perspective. The ultimate outcomes refer to health status, customer satisfaction, and financial risk protection (Roberts *et al.*, 2004). According to a World Health Organization report, the goal of customer satisfaction is replaced by “increasing responsiveness to the legitimate demands of the population” (World Health Organization, 2000). In addition to the overall level of these indicators, the distribution of these indicators among various factors, such as socioeconomic status, race, ethnicity, and gender, is also of particular interest in health policy. Health equity with respect to health-care financing and health-care utilization has become an increasingly important goal in modern society. Commonly used indicators to measure ultimate and intermediate goals are listed in Table 1.

Variation of Health Systems and Their Performance

There are a variety of health systems. Field (1973) observed five types of health systems based on the evolutionary progress of industrialized nations: the private

health system, the pluralistic health system, the national health insurance system, national health services, and socialized health services. Bambra (2005) grouped the health systems of OECD countries into three categories, liberal, conservative, and social democratic, on the basis of the degree of health-care decommodification. Lassey (1997) classified health systems into “most advanced,” “somewhat advanced,” and “less advanced” on the basis of technology use, resource availability, and health service accessibility.

Rather than classifying different types of health systems, this article uses the anatomic approach to examine the method by which each component of a health system functions and to assess the potential outcome indicators of a particular health system. This approach is likely to facilitate the translation of comparative results into policy recommendations.

Epidemiological Profiles of Populations or Patients

The centerpiece of a health system is its beneficiaries – that is, the population or patients. The health of a population varies greatly from country to country. Disparities in population health are often used to compare the performance of health systems. In addition, the health status of a population, determined by epidemiological profiles, is an important factor that influences the development of a health system in a specific society. For example, in a society with a high prevalence of communicable diseases, tax-based financing for disease prevention at population level, as well as emergency services for disease treatment, will be required. However, in a society characterized by chronic disease, community-based disease prevention and disease management are essential components of the health system. Therefore, health system development requires the population or patients to be the centerpiece. Health systems should reflect the health demands and needs of a specific society. Health systems should also evolve as the populations or the patients’ health status changes.

Financing of Health Services

Financing is one of the most important components and functions of a health system. Health system financing varies depending on how resources are generated, pooled, and used. Health services can be financed in a variety of ways: from an individual who is self-insured, through an insurance agency, or through a government agency that provides health insurance to a specific group or the entire population.

There are three basic issues that policy makers must address in terms of health financing. The first is the amount of resources that a financing system can mobilize

Table 1 Ultimate and intermediate goal indicators of a health system

<i>Categories</i>	<i>Key indicators Levels</i>	<i>Distribution</i>
Ultimate goals of health system		
1. Health status	Life expectancy at birth Infant mortality Maternal mortality Life expectancy at 65 Disability-adjusted life year (DALY) Quality-adjusted life year (QALY)	Indicators of equity, which refers to the difference of the outcomes among different groups of the population. The most commonly used indicators for assessing a health system include health equity, financial equity, and access equity
2. Financial risk protection or the share of financial burden	Health insurance coverage Percentage of out-of-pocket payment of total health expenditure Percentage of poverty due to illness	
3. Customer satisfaction or responsiveness to people's nonmedical expectations	Consumer-satisfaction survey indicators	
Intermediate goals of health system		
1. Efficiency	Cost per unit of outcome (health improvement)	
2. Quality	Appropriateness (overused, underused, or misused)	
3. Access	Utilization rates of health services Physician/hospital beds per 1000 population	
4. Cost	Total health expenditure Percentage of health expenditure in gross domestic product	

This table is based on information from Roberts MJ, Hsiao W, Berman P, and Reich MR (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press and World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: WHO.

and then allocate to health services. The combination of multiple sources of financing is the total health expenditure in a specific society. The second issue is the type and amount of services that can be purchased. This refers to the benefit package design in response to the demand and/or needs for health services and resource constraints. The third issue involves the purchase of health services through the use of incentives in order to achieve the desired outcomes of a health system.

The level of health expenditures varies greatly from country to country. **Table 2** summarizes total health expenditure per capita, the health expenditure as a percentage of Gross Domestic Product, and sources of health financing in selected countries. There is no consensus on the appropriate amount that should be allocated to health financing. In many of the poorest countries, the level of spending is still insufficient to ensure equitable access to basic and essential health services and interventions. Thus, a major health policy issue in poor countries is ensuring adequate and equitable resource mobilization

for health. On the other hand, in many of the richest countries, the level of spending is considered too high, and the concomitant benefits from these investments do not generate a reasonable return in terms of health gain. Consequently, a major policy issue in the wealthiest nations is controlling the cost of health services and ensuring their maximum efficiency.

Although there is ongoing debate over the appropriate amount of health-care spending per country, there is fairly common agreement on how health expenditures should be financed. For example, if out-of-pocket payments for health-care financing are too high, the financial risk protection of a health system will be low in a given society. **Table 3** summarizes financial risk protection and other selective effects of various health financing mechanisms.

Provider Payment Methods

Provider payment methods are a set of contracts made between health-care providers and financing agencies

Table 2 Total health expenditure and financing mechanisms

Country	Total expenditure per capita (international dollar)	Total expenditure on health as % of GDP	Source of financing, % of total health expenditure			
			Government expenditure	Private prepaid plans	Out-of-pocket	Other
Algeria	186	4.1	80.8	0.8	18.3	0.1
Argentina	1067	8.9	48.6	19.6	28.6	3.2
Australia	2874	9.5	67.5	7.8	22.0	2.7
Brazil	597	7.6	45.3	19.6	35.1	0.0
Canada	2989	9.9	69.9	12.7	14.9	2.4
China	278	5.6	36.2	3.7	55.9	4.2
Czech Republic	1302	7.5	90.0	0.3	8.4	1.4
Germany	3001	11.1	78.2	8.8	10.4	2.6
Japan	2244	7.9	81.0	0.3	17.1	1.6
Kenya	65	4.3	38.7	3.7	50.6	7.0
Mexico	582	15.2	44.6	36.5	13.5	5.4
Mozambique	45	4.7	61.7	0.2	14.9	23.2
Namibia	359	6.7	70.0	22.8	5.8	1.4
Republic of Korea	1074	5.6	49.4	2.1	41.9	6.6
Russia	551	5.6	59.0	2.7	29.2	9.1
Singapore	1156	4.5	36.1	0.0	62.0	1.9
Spain	1853	7.7	71.3	4.3	23.5	0.9
Sweden	2704	9.4	85.2	0.3	13.6	0.8
Switzerland	3776	11.5	58.5	9.0	31.5	1.0
United Kingdom	2389	8.0	85.7	3.3	11.0	0.0
United States	5711	15.2	44.6	36.5	13.5	5.4
Zimbabwe	132	7.9	35.9	13.5	36.3	14.3

Source: World Health Organization (2006) *The World Health Report*. Geneva: WHO.

Table 3 Source of health-care financing

Types	Financing mechanisms	Efficiency	Equity	Financial sustainability	Financial risk sharing	Service utilization
Out-of-pocket	Individuals	Low	Low	Low	Low	Low
Medical saving account	Individuals	Medium	Low	Medium	Low/medium	Low
Community financing	Premium contribution	Medium	Low	Medium	Medium	Medium
Private health insurance	Premium contribution	Medium	Low	Medium	High	High
Social insurance	Payroll and tax deduction	High	Medium	High	High	High
National health insurance	General tax	High	High	High	High	High

This table is created mainly based on World Bank (1999) *Teaching materials of the Flagship Program on Health Sector Reform and Sustainable Financing*. Washington DC: World Bank; Roberts MJ, Hsiao W, Berman P, and Reich MR (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press; and World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: WHO.

with respect to compensation for provider health service delivery. Since different payment arrangements alter the financial risk-bearing status of providers, they impose differing financial incentives for providers and thus influence the performance of a health system. **Table 4** lists seven of the most commonly used provider payment methods, as well as their incentives for providers in terms of quantity, quality, and cost control. In practice, however, there are payment methods that combine different payment mechanisms into one payment arrangement.

For example, salary plus bonus payments combine both fee-for-services and salary into one payment method in order to balance the incentives for quantity, quality, and cost of services.

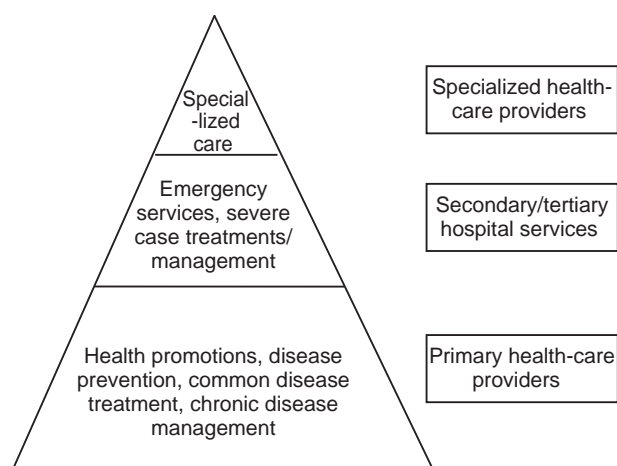
Delivery of Health-Care Services

The delivery of health-care services can be divided into two components: the types of services delivered and by whom, that is, its ownership. The types of services vary

Table 4 Provider payment mechanisms

Payment methods	Unit of payment	Financial risk-bearing of providers	Financial incentives for providers		
			Quantity	Quality	Cost control
Fee-for-service	Per service item	No	High	High	Low
Salary	Monthly payment	No	Medium	Medium	High
Capitation	Per contracted patient/person	Yes	Low	Low/High	High
Daily payment	Per patient day	Partial	Low/High	Low/High	Medium
Case payment	Per case of different diagnosis	Partial	Low/High	Low/High	Medium
Line item budget	Budget line	No	Low	Low	Medium
Global budget	All services	Yes	Low	Low/High	High

This table is created mainly based on World Bank (1999) *Teaching materials of the Flagship Program on Health Sector Reform and Sustainable Financing*. Washington DC: World Bank; Roberts MJ, Hsiao W, Berman P, and Reich MR (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press; and World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: WHO.

**Figure 2** The structure of health services delivery.

from community-based health services for the majority of the population to hospital-based services for a select group of patients with severe health problems, to specialized health services for those patients who require specialized care (see **Figure 2**). In some health systems, providers are organized into a three-tier hierarchical system. Primary health-care providers often serve as gatekeepers of the health system; a referral system is often in place in order for patients to receive higher-level hospital and/or specialized care. In other systems, these three tiers may not be present. For example, a lack of resources may force informal health-care providers, such as traditional healers, birth attendants, and community health workers, to act as the primary health-care providers although they are not considered part of the formal health system. Another example is the direct entry of patients into tertiary and specialized health services. The referral system is bypassed in order to increase a patient's freedom of choice among health providers. These structural differences in the delivery of health services may have great impact on access, quality, and efficiency of health services.

The second component of health service delivery is ownership. Health-care providers may be part of a publicly owned or a privately owned system. Recently, a trend has been growing toward converting publicly owned delivery systems to public-private partnerships. Public-private partnerships are viewed as a 'win-win' arrangement, with various motivations and philosophies working together – albeit with different incentives – to contribute to the improvement of the health status of a population. **Table 5** lists the major characteristics of publicly and privately owned delivery systems, as well as the predicted outcomes of the performance of the delivery systems. In the public-private partnership, the public system can take advantage of the higher levels of efficiency and quality of a private system, while at the same time maintaining its equity and cost-control goals.

Regulation of a Health System

Regulations are rules or orders mandated by a government in order to improve the outcomes of a system through behavior change. Health regulation functions to (1) ensure the fairness of market exchange in a health system, (2) correct the market failure of a health system, and (3) ensure the equity of financing and delivery of health-care services.

Regulatory policy is incorporated into almost every aspect of a health system. From a functional perspective, regulations have the following four objectives: financial risk sharing; quality and safety; equity of health services; and cost-effectiveness, or value for money (**Table 6**).

Criticism of Comparative Analysis of Health Systems

Comparative health systems is a rapidly growing field that is being used more and more frequently in health policy and health service research communities. However,

Table 5 Health-care providers by ownership

<i>Variables</i>	<i>Public</i>	<i>Private</i>	<i>Public-private partnership</i>
Characteristics			
Incentives	Low	High	Medium
Financial risks	Low	High	Shared
Decision space	Centralized	Decentralized	Shared
Profit	No	Varies	Controlled
Performance			
Efficiency	Low	High	Medium
Quality	Medium	High	Cost-effective
Equity	High	Low	Medium
Responsiveness	Low	High	Medium
Cost control	High	Low	Medium

This table is created mainly based on World Bank (1999) *Teaching materials of the Flagship Program on Health Sector Reform and Sustainable Financing*. Washington DC: World Bank; and World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. Geneva: WHO.

Table 6 The objectives and options for regulation in health system

<i>Objectives</i>	<i>Regulations</i>
Financial risk sharing	Mandating enrollment for health insurance Setting community rate Providing open enrollment Ensuring minimum benefit package
Medical safety	Market entry license, including doctor's practice license, hospital licenses, drug manufacture license, etc. Practice guidelines and procedures Drug quality
Equity	Medical safety net Medical resource reallocation
Cost-effectiveness	Services prices control Profit/surplus regulation Capital investment

there are many criticisms, including questions about the usefulness of international comparisons, the simplicity of methods used in the analysis, and the value of international experiences as a means of health system improvement.

Although many comparative analyses attempt to conduct objective comparative analyses using similar frameworks and statistical indicators, the results of the comparison remain debatable. Often, the information is not reported in the same format, and statistics are calculated differently and use dissimilar definitions. This issue raises concern about the use of simple statistical comparisons as a method of comparative analysis. Comparative analyses should be made for countries with similar characteristics – serving as control factors – and with elaborate and careful interpretation.

Many health system comparative analyses attempt to establish a causal relationship between a health system and its outcomes. However, the majority of these analyses

are based on cross-sectional data. Furthermore, the outcomes of a health system, particularly the health of a population, are influenced by many factors that exceed the boundaries of the health system. These factors are difficult to control in comparative analyses. Therefore, the results derived from comparative analyses must be interpreted with caution as they may not be valid or reliable results.

Health systems are deeply rooted in their country's historical, cultural, ethical, political, social, and economic development. The successes of one health system may not apply to another health system in a different society. For example, a community health financing scheme may work well in a society with a high degree of trust, reciprocity, and social networking but may not work well in a society with low social capital. Therefore, the transfer of knowledge should be done cautiously when adapting successful strategies.

In summary, there is great variation in terms of health systems and their levels of performance. Health systems are dynamic and evolve in response to changes in the epidemiological profiles of the population, improvements in medical technology, and people's knowledge of the health system. Although there is criticism regarding the methodology and results of comparative health system analyses, the field is growing rapidly and is being used more and more frequently in health policy and health service research communities. Comparative health system analyses are still considered useful learning tools for health system improvement, particularly in the current environment of globalization.

See also: Global Health Initiatives and Public Health Policy; Health Policy: Overview; Human Rights, Approach to Public Health Policy; Politics, and Public Health Policy Reform; Resource Allocation: International Perspectives on Resource Allocation; The State in Public Health, The Role of.

Citations

- Aday LA, Begley CE, Lairson DR, and Slater CH (1998) *Evaluating the Healthcare System: Effectiveness, Efficiency, and Equity*. Chicago, IL: Health Administration Press.
- Bambra C (2005) Worlds of welfare and the health-care discrepancy. *Social Policy & Society* 4: 31–41.
- Field M (1973) The concept of health system at the macrosociological level. *Social Science and Medicine* 7: 763–785.
- Lassey ML, Lassey WR, and Jinks MJ (1997) *Health Care Systems around the World*. Upper Saddle River, NJ: Prentice Hall.
- Roberts MJ, Hsiao W, Berman P, and Reich MR (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*. New York: Oxford University Press.
- Rodwin VG (1995) Comparative health systems: A policy perspective. In: Kovner AR (ed.) *Jonas's Health Care Delivery in the United States*. New York: Springer.
- Roemer M (1993) *National Health Systems of the World*. New York: Oxford University Press.
- World Health Organization (2000) *The World Health Report 2000: Health Systems: Improving Performance*. Geneva, Switzerland: WHO.
- Block MAG (1997) Comparative research and analysis methods for shared learning from health system reforms. *Health Policy* 42: 187–209.
- Lee RP (1982) Comparative studies of health-care system. *Social Science and Medicine* 16: 629–642.
- Liman TJ and Robins L (1971) Comparative analysis of health-care systems: Socio-political approach. *Social Science and Medicine* 5: 573–581.
- Mills AJ and Ranson MK (2001) The design of health systems. In: Merson M, Black R, and Mills AJ (eds.) *International Public Health: Diseases, Programs, Systems, and Policies*. Gaithersburg, MD: Aspen.
- Raffel MW (1985) *Comparative Health Systems: Descriptive Analysis of Fourteen National Health Systems*. University Park, PA: Pennsylvania State University Press.
- Seedhouse D (1995) *Reforming Health Care: The Philosophy and Practice of International Health Reform*. West Sussex, UK: Wiley.
- World Bank (1993) *World Development Report 1993: Investing in Health: World Development Indicators*. New York: Oxford University Press.
- Thai KV, Wimberley ET, and McManus SM (2002) *Handbook of International Health Care Systems*. New York: Marcel Dekker.
- Twaddle AC (1996) Health system reforms: Toward a framework for international comparisons. *Social Science and Medicine* 43(5): 637–653.
- World Bank (1993) *World Development Report 1993: Investing in Health*. New York: Oxford University Press.

Further Reading

- Asian Development Bank (1999) *Health Sector Reform in Asia and the Pacific: Options for Developing Countries*. Manila, Philippines: Asian Development Bank.

The Health Care of Indigenous Peoples/Nations

G Bodeker, University of Oxford, Oxford, UK; Columbia University, New York, NY, USA

© 2008 Elsevier Inc. All rights reserved.

Background

Indigenous peoples have suffered from historic injustices as a result of, *inter alia*, their colonization and dispossession of their lands, territories and resources, thus preventing them from exercising, in particular, their right to development in accordance with their own needs and interests.

Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

(Draft UN Declaration on the Rights of Indigenous Peoples, 2007)

The term ‘indigenous peoples’ is widely used to characterize a reported 300–350 million people worldwide (WHO, 2007) – from the Arctic to the South Pacific, from the Kalahari Desert in southern Africa to Tierra Del Fuego at the southernmost tip of the Americas. With ancient roots in their local areas, these peoples are among the world’s most marginalized populations – politically, economically and territorially – and suffer the highest burden of health challenges.

In 1990, the United Nations proclaimed the International Decade of the World’s Indigenous People, starting on 10 December 1994 (resolution 48/163). By the end of the Decade, the health of indigenous peoples was widely seen as of global concern and, in one instance – Australia – of proportions of a national emergency.

Who Are Indigenous Peoples?

Asia, according to the International Work Group for Indigenous Affairs (IGWIA), is home to the vast majority (70%)