Health Systems

State Institute of Health & Family Welfare, Jaipur

System ?

A set of interrelated and independent

parts designed to achieve a set of goals

Health System ?

Structure & functions of a Country's MoH having-

- ✓ Resources,
- ✓ Management,
- ✓ Organization,
- ✓ Economic support and
- ✓ Service delivery as it's main component

Health System Boundaries

The system includes all actors, institutions and resources that undertake health actions–where the primary intent is to improve health.

Health System Goals

- ✓ Improving the health of the population they serve;
- ✓ Responding to people's non-medical expectations;
- ✓ Providing financial protection against the costs of ill health

Health System: Components

Public Health

- What is public health?
- Why does it matter?
- How is the public health system structured?
- What does the public health system do for people?
- How is it done?

Core Functions of Public Health

- ✓ Monitoring health situation
- ✓ Disease surveillance
- ✓ Health promotion
- ✓ Regulations
- ✓ Partnerships
- ✓ Planning & Policies
- ✓ HRD
- ✓ Reducing impact of emergencies on health

Determinants of Health System

- **Economic-**
  - Affordability?
  - Availability?
- **Political**
  - Priorities
  - Appropriateness?
  - Accessibility
  - Equity
- **Cultural**
  - Acceptability
  - Utilization
  - Participation

Main Systems of Medicine

- ✓ Western allopathic
- ✓ Ayurveda
- ✓ Unani
- ✓ Siddha
- ✓ Homeopathy

Health Delivery Systems/ Models

- 200 countries, only 40 have established Systems
- 4 basic models of Health care delivery-
  - Beveridge Model- provided and financed by the Government through tax payments
  - Bismarck Model- based on insurance system- premium by company/ employee
  - National Health Insurance Model- private-sector providers, but payment comes from a government-run insurance program that every citizen pays
  - Out-of-Pocket Model- rich get medical care; the poor stay sick or die

Why study  Health Systems

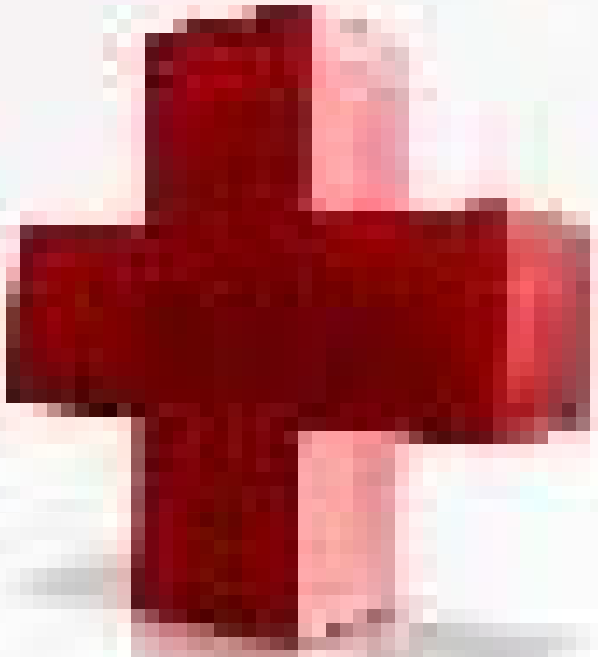
- ✓ Provides perspective to understand self
- ✓ Observe & examine strategies for achieving equity under different situations
- ✓ Draw generalizations-System's influence on health status

Problems:

- Indirectly related to health
  - Environment
  - Education
  - Empowerment

- Directly affecting Health
  - Diseases
    - Communicable
    - Non Communicable
    - New emerging
  - Fertility
    - Population
    - Growth rate
    - Total Fertility
  - Nutrition
    - Malnutrition
    - Obesity

Problems-Why



- ✓ Access
- ✓ Availability
- ✓ Utilization

Forces Asking for a Change in System

- ✓ New emerging diseases,
- ✓ Changing disease profile,
- ✓ Technical and diagnostic advances,
- ✓ Longevity of life,
- ✓ Expectations of people,
- ✓ Subsidies and cross-subsidies
- ✓ Increasing non-plan expenditure,
- ✓ Competing priorities and
- ✓ Improving awareness among people, and
- ✓ Rising Cost of health care delivery

Challenges

- ✓ Manpower- Number & Norms
- ✓ Rural / Urban differential
- ✓ Geographical divide across States
- ✓ S-E groups –accessibility/ reach
- ✓ Gaps between Policy & Action
- ✓ Health sector expenditure
- ✓ Newer Infections

National Health Systems

- **Issues :**
  - Generalizations of performance & trend
  - Political dimensions-Dynamism
  - Forces deciding character
  - Impact on Health
  - Relevance to human rights

Development of Health Systems

- ✓ Organization-changes in character with time
- ✓ Resource expansion
- ✓ Increase in utilization
- ✓ Increase in expenditure & Financing pattern
- ✓ Cost-control strategies & Increasing system's efficiency
- ✓ Technological advances-demand & application
- ✓ Prevention emphasized
- ✓ Quality assurance
- ✓ Public-Private interaction
- ✓ Pattern of service delivery
- ✓ Public participation in Policy decisions

Evolution of Health Systems

- Early Health Systems
  - Traditional practices and medicine (China, India)
  - Effect of industrial revolution
  - Politicization of workers in Germany
  - UK National Health System (1948)
  - Bhore Report (India) 1946

Evolution of Health Systems

- ✓Alma Ata Declaration, 1978
  - ✓Primary Health Care Themes
    - ✓Equity
    - ✓Social Justice
    - ✓Community participation
    - ✓Prevention/promotion
    - ✓Intersectoral collaboration
    - ✓Appropriate use of resources
    - ✓Sustainability

Evolution of Health Systems

- ✓ GOBI/FFF (UNICEF)
- ✓ Health economics brought in health care (1980-90)
  - ✓ Efficiency & effectiveness
  - ✓ Structural program adjustment-Health sector reform
  - ✓ Dominance of World Bank over WHO
- ✓ 1990-2000
  - ✓ "One size does not fit all"
  - ✓ Recognition of key elements-equity, empowerment & poverty reduction
  - ✓ Standardization & improving performance
  - ✓ HSR

Types

- Core capitalist-
  USA, Germany
- Core capitalist-social welfare
  Canada, UK, Japan
- Industrialized Socialist oriented
  USSR
- Capitalist dependencies
  India, Indonesia
- Socialist oriented
  China, Cuba

(Ray.H.Elling)

Health Systems

- Emergent
- Pluralistic
  USA, Switzerland
- Insurance/Social security
  Canada, Japan
- National Hlth.service
  Great Britain
- Socialized
  USSR

(Mark G.Field)

Types of Health Systems in Relation to Traditional Medicine

- ✓ Exclusive (tolerant) : UK, Germany
- ✓ Inclusive : India, Pakistan, Burma, Sri Lanka, Bangladesh, Thailand
- ✓ Integrated : China, Nepal

Types-Health Systems

Economic Level(GNP/ Capita)	Health System			
	Entrepreneurial & permissive	Welfare oriented	Universal & comprehensive	Socialist & centrally Planned
Affluent	USA	Germany	UK	USSR
Developing	Philippines	Malaysia	Israel	Cuba
Poor	Bangladesh	India	Sri Lanka	China
Resource Rich	-	Libya	Saudi Arabia	-

Health Care System in India: Public Sector

- Rural Health Scheme
  - ✓ Primary Health Centers
  - ✓ Sub- Centers
- Hospitals/Health Centers
  - ✓ CHC
  - ✓ District Hospitals
  - ✓ Teaching Hospitals
- Health Insurance Schemes
  - ✓ Employees State Insurance
  - ✓ Central Government Health Scheme
- Other Agencies
  - ✓ Defense
  - ✓ Railways

Health Care System in India: Private Sector

- ✓ Hospitals and Nursing Homes
- ✓ General Practitioners
- ✓ Medical Insurance

Health Systems in India (Inclusive)

- ✓ Official/ Allopathic
  - -Cost
  - -Coverage
  - -Coordination
  - -Culture
- ✓ Traditional (ethno/ alternative/ indigenous/un-official)
  - -Roots
  - -Respect
  - -Reach
  - -Rural
  - -Renaissance
  - -Role

Allopathic /Modern System

- ✓ Systematic
- ✓ Strong Data base
- ✓ Pharmacopoeia
- ✓ Diagnostic support
- ✓ Quick
- ✓ Interventional procedures
- ✓ Epid. developments

- ✓ Cost
- ✓ Isolated approach-Anatomical approach
- ✓ Dependence on technology
- ✓ Human touch missing
- ✓ Iatrogenic disease
- ✓ Voracious resource eater
- ✓ Drug use-irrational
- ✓ western

Traditional systems

- Ayurvedic
- Unani
- Homeopathy
- Naturopathy
- Siddha
- Chinese
- Tibetan
- Yoga & Meditation
- Hypnosis
- Divination & Exorcism
- Individual therapies like
  - Color
  - Flower
  - Diet
  - Hydrotherapy

Traditional–Ayurveda–the science of life

- Oldest
  - Ref. in upveda of Atherveda (114 hymns) & Rigveda
- Doctrine
  - Panchbhutas
    - Air, Water, Fire, Space & Earth
  - Tridosha
    - Vata, Pitta, Cough
  - Ashta dhatus
    - Rasa, Rakta, Mansa, Asthi, Mazza, Meda, Shukra, Maila

Ayurveda-

- School of Physicians (Atreya Sampradaya)
- School of Surgeons (Dhanvantari Sampradaya)
- Specialties
  - Kayachikitsa
  - Balchikitsa
  - Grahchikitas
  - Shalyachikitsa
  - Jarchikitsa
  - Vishaychikitsa

Indian Health System

Characteristics of Indian Health System

- ✓ Complex mixed health system
  - ✓ Publicly financed government health system
  - ✓ Fee-levying private health sector

How did Health System Evolve

Different Phases of Indian Health System Development

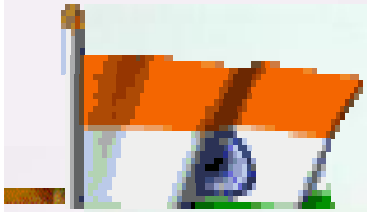
- ✓ Pre-independence phase
- ✓ Development centred phase
- ✓ Comprehensive Primary Health Care phase
- ✓ Neo-liberal economic and health sector reform phase
- ✓ Health systems phase

Before Independence

- ✓ Healthcare has been based on voluntary work
- ✓ Medicinal properties of plant and herbs was passed from one generation to another

1947

1950



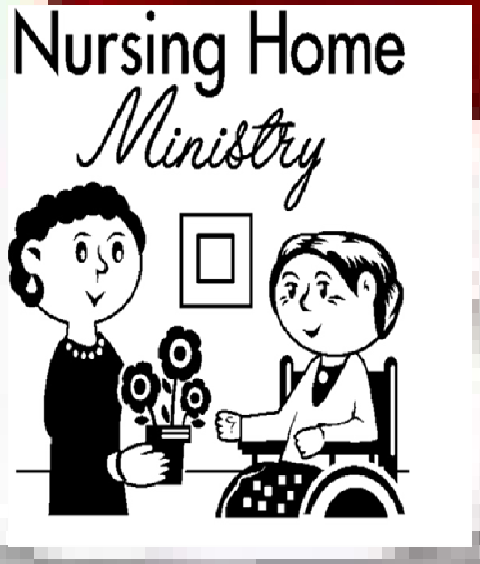
After Independence

- ✓ **Government of india laid down a stress on primary health care.**
- ✓ **Government initiative was not enough to meet the demand.**
- ✓ **Alternate sources of finance were critical for sustainability of the health sector.**

Entry of Private Sector

- ✓ Government on its own would not be able to provide more facilities for health care.
- ✓ Government allowed the entry of private sector to reduce the gap between the supply and demand for health care.

Hospitals, Nursing Homes, Fitness centre. Ambulatory Services, pharmaceuticals



Cipla

WE'LL MAKE IT BETTER

VLCC

SLIMMING BEAUTY FITNESS

7 P's of Health Services

- ✓ Place
- ✓ Product
- ✓ Provisions
- ✓ Process
- ✓ People
- ✓ Price
- ✓ Performance

Committees & Commissions

Committees & Commissions

- ✓ 1946: Bhore Committee
- ✓ 1959-62 Mudaliar committee (Health Survey And Planning Committee): Health services restructuring
- ✓ 1963: Chaddah committee: TOR-Malaria
- ✓ 1964:Mukherjee committee: Family planning

- ✓ 1964-67:Junglewala committee: Integration Of Health Services
- ✓ 1972-73:Kartar Singh committee: MPW scheme
- ✓ 1974-75:Srivastav committee: Medical Education & Support Manpower

1959-62 Mudaliar Committee (Health Survey And Planning Committee)

- ✓ Consolidate gains
- ✓ Strengthen district hospitals
- ✓ Regionalization of health services
- ✓ PHC for 40000 population
- ✓ Integration of medical & health
- ✓ Creation of all India health services cadre

1963: Chaddah Committee

- **TOR-Malaria**
- **NMEP**
  - vigilance & maintenance by health services
  - Monthly home visits
  - 10000 population per worker
- **Basic health worker**
  - vital statistics &
  - family planning

1964:Mukherjee Committee

- ✓ TOR-Family planning
- ✓ Exclusive family planning staff (uni-purpose worker)

1964-67:Junglewala Committee (Integration Of Health Services)

- ✓ Unified cadre
- ✓ Common seniority
- ✓ Recognition of extra qualifications
- ✓ Equal pay
- ✓ Specialized pay
- ✓ No private practice

1972-73:Kartar Singh committee

- ✓ Conversion of ANM to MPHW (F)
- ✓ Uni-purpose to multi-purpose workers
- ✓ One PHC per 50000 population
  - ✓ 16 S/C per PHC
  - ✓ 3000-3500 population per S/C
  - ✓ One supervisor for 4 workers

1974-75:Srivastav committee (Medical Education & Support Man-Power Committee)

- ✓ Cadre of community health workers (CHW)
- ✓ Medical officer for maternal health at PHC
- ✓ Heath assistant to be a link between health worker and PHC

Bajaj Committee, 1986

- An "Expert Committee for Health Manpower Planning, Production and Management" was constituted in 1985 under Dr. J.S. Bajaj.
- Recommendations :
  - Formulation of National Medical & Health Education Policy.
  - Formulation of National Health Manpower Policy.

- ✓ Establishment of Educational Commission for Health Sciences (ECHS) on the lines of UGC.
- ✓ Establishment of Health Science Universities in various states and union territories.
- ✓ Establishment of health manpower cells at centre and in the states.

Health Services Development in India

Bhore Committee 1943-46
(Health Survey & Development Committee)

- ✓ Payment not to be a punctuation
- ✓ All facilities
- ✓ Prevention to be the priority
- ✓ Services close to people
- ✓ Participation
- ✓ Planning

-Long term-20000 (PHC), 60000 (CSC), 3 million (DH)

-Short term- 40000 (PHC), 1.5 million (CSC), 3 million (DH)

Training in preventive medicine

Milestones:

NRHM-2005

NHP-2002

NPP-2000

RCH-1996

UIP-1985

NHP-1983

Alma Ata-1978

Small pox eradicated-July 5, 1975

NFPP-1952

India Joins WHO-1948

HSDC-1946

Administrative Structure

1. Central Ministries of Health and Family Welfare –
   - Responsible for all health related programmes
   - Regulatory role for private sector
2. State Ministries of Health and Family Welfare
3. District Health Teams headed by Chief Medical and Health Officer

Health System's Organization- India

Central Govt.

Planning Commission → **MOHFW**

National Dev. Council
CCHFW

FW	**Medical & Public Health**	**ISM&H**
Secretary	Secretary	Secretary
Jt.Secy.(3)	Addl.Secy.	Jt.Secy.
Director	Jt.Secy.(9)	Director
	DGHS	
	Addl.DGHS	

National Developmental Council

Highest constitutional Policy making body to approve Policies and strategies for development

Composition:

Chairman-PM

Members- Central Ministers

Chief Ministers

Lt. Governors & Administrators of UTs, Dy.Chairman & members of Planning Commission

Planning Commission

March 15,1950

Composition: Chairman—PM
Dy.Chairman
Members 5-7(Full time)
2-3(Part time)

Functions :

- ✓ Assess & augment resources- material, capital & human
- ✓ Formulate Plan for utilization of resources
- ✓ Decision on priority based phased implementation
- ✓ Decide on nature of executing machinery
- ✓ Periodic progress review
- ✓ Make appropriate interim recommendations

Role of Central Govt. in Health Care

- ✓ Policy formulation
- ✓ Maintaining International health relations
- ✓ Administration of central health institutions
- ✓ Regulating Medical education through statutory bodies- MCI/DCI/Councils
- ✓ Medical & Public health research-funding
- ✓ Standards- laying & maintenance(Drugs/Education)
- ✓ Coordination-Other ministries/States/Statutory bodies
- ✓ Central Health Acts
- ✓ Negotiation with International agencies

Functions of FW

- ✓ Policy-Planning
- ✓ Information-Evaluation
- ✓ Contraceptive-Research /Supply
- ✓ Seeking International support
- ✓ EPI/UIP/CSSM/RCH/ ARI/ORT-trainings & area development
- ✓ IEC
- ✓ Rural Health
- ✓ Paraprofessional training
- ✓ NGO support
- ✓ Development of Sub-center

Functions of Medical & Public Health

- ✓ Health Policy
- ✓ National Health Programs
- ✓ Drug Control
- ✓ PFA enforcement
- ✓ Diseases-Communicable/Non-communicable
- ✓ Supplies& Disposal
- ✓ CGHS
- ✓ CME & Trainings
- ✓ Nursing
- ✓ Medical Education & Research
- ✓ Vital statistics & Health intelligence
- ✓ International support

Organization at State Level

State Govt.

MoH & FW

Secretary (Health/ Med. Education)

Principals(6)

Directors

FW **Public Health** **AIDS/HA** **IEC**

Addl.Directors

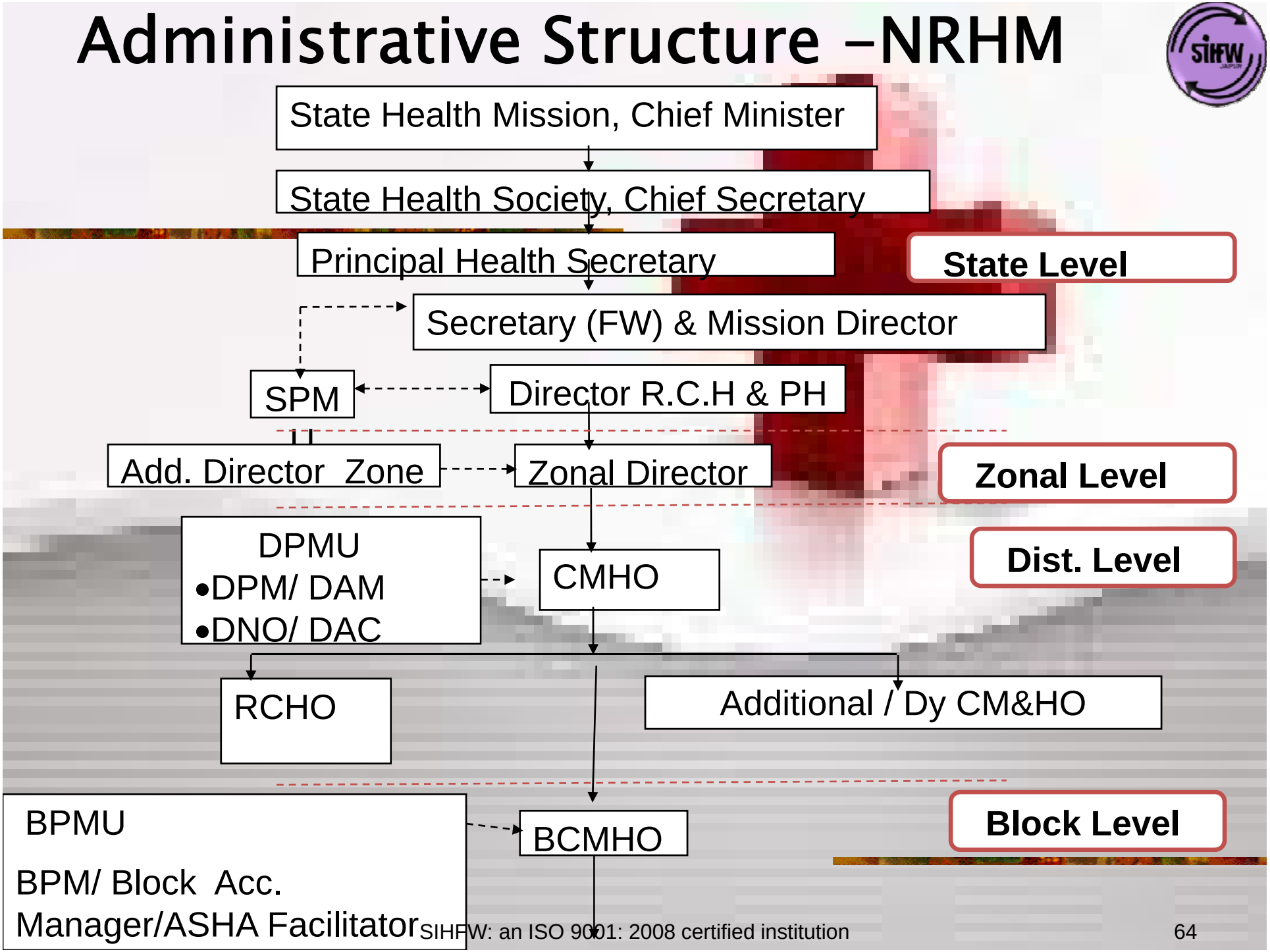
Jt.Directors

Dy.Directors

State Program Officers

Jonal Directors(6)

Administrative Structure –NRHM



District

- ✓ An Administrative unit
- ✓ Peripheral most Planning unit
- ✓ A self contained segment of National Health System

Defined Geographical boundary and Population(5M)

District Health Organization

CEO

DHS

CMHO (DPMU-DPM/DAC/DAM/DIEC/DNO)

Dy. CMHO RCHO

BCMO (BPMU-BPM, ASHA facilitator/ Accountant

CHC(100000)/ FRUs

Specialists(6)(IPHS)

Referral

PHC (20-30000)

Primary health

Medical Officer(2) (ASHA supervisor)

SC(3-5000)

HW-M/F

ASHA/AWW

PMO

Beds(100-300)

Functions of District Health System

- ✓ Liaison between Field units & Headquarter
  Tools- Field reports
  Monitoring
  Meetings
- ✓ Implementation of Policy/Programs
- ✓ District level planning-Action Plans
- ✓ Rationale use of Finances
- ✓ Communication- Plans/Schedules/Progress/Problems
- ✓ Coordination- effective resources use, avoid duplication
- ✓ Control & Monitoring

Problem Areas at District

- ✓ Quantity v/s Quality
- ✓ Cluttered Policy guidelines
- ✓ Decentralization on papers
- ✓ Roles/Responsibilities poorly defined
- ✓ Program integration ?
- ✓ HMIS-generation & use ?
- ✓ Managerial skills
- ✓ Donor initiative – “Societies”
- ✓ Resource restriction

4 Reasons Based on 4 Lesser Known Facts

- Reason 1:
  - Public doctors in India are among the most absent in the world
  - Absences are never below 30 percent!
- Reason 2:
  - When public doctors do show up for work, the exert very little effort
- Reason 3:
  - Public doctors in PHCs are not particularly competent to begin with
- Reason 4:
  - You still have to bribe public doctors to do their work

One Important Question…

Why don't the poor use public health facilities more?

Some Facts About Public Health Care in India

- Fact #1:
  - Most spending is private; the fraction on genuine public goods is tiny
- Fact #2:
  - The poor use private care as much as the rich
- Fact #3:
  - More public money on health goes to the rich than the poor (because hospital use is regressive)

A summary of Why Poor People may not be Using the PHC System

- ✓ The doctors are low on competence
- ✓ They don't show up for work
- ✓ When they do show up, they don't work to the level of their knowledge
- ✓ And patients have to pay bribes anyway

- ✓ And we still ponder over Health system
- ✓ A system
  - ✓ not well understood
  - ✓ large enough in content & context
- ✓ A system
  - ✓ which needs inputs, and
  - ✓ aim to bring out
  - ✓ outputs and Outcomes

Global Health Systems

USA


WASHINGTON
OREGON
CALIFORNIA
IDAHO
NEVADA
MONTANA
WYOMING
UTAH
ARIZONA
COLORADO
NEW MEXICO
NORTH DAKOTA
SOUTH DAKOTA
NEBRASKA
KANSAS
OKLAHOMA
TEXAS
MINNESOTA
IOWA
MISSOURI
ARKANSAS
LOUISIANA
WISCONSIN
ILLINOIS
MICHIGAN
OHIO
KENTUCKY
TENNESSEE
MISSISSIPPI
ALABAMA
GEORGIA
FLORIDA
SOUTH CAROLINA
NORTH CAROLINA
VIRGINIA
WEST VIRGINIA
PENNSYLVANIA
NEW YORK
MAINE
VT
NH
MASS.
RI
CONN.
NEW JERSEY
DELAWARE
MARYLAND
ALASKA
HAWAII

US Health System

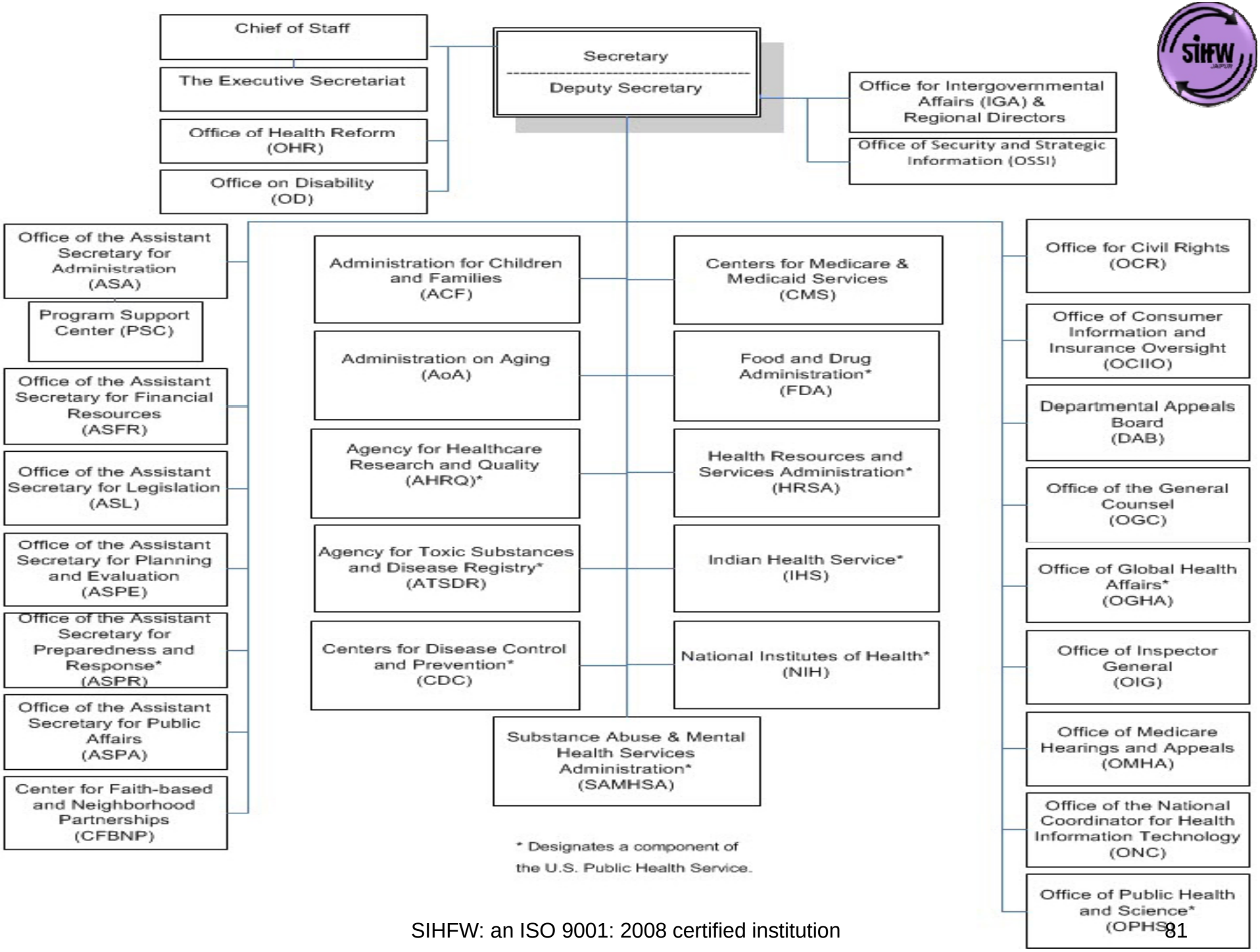
Major Features:

- ✓ Dominant private sector
- ✓ Resources in abundance
- ✓ Highly Decentralized
- ✓ Free Market Economy
- ✓ Dynamic

US Health System- 5 Drivers

- ✓ Payments- Money based decisions
- ✓ Physician- Choices
- ✓ Products- Good care but good value
- ✓ Purchases- By business houses for employee
- ✓ Prospects- sustainability threatened

Organization of US Health System


Chief of Staff
The Executive Secretariat
Office of Health Reform (OHR)
Office on Disability (OD)
Secretary
Deputy Secretary
Office for Intergovernmental Affairs (IGA) & Regional Directors
Office of Security and Strategic Information (OSSI)
Office of the Assistant Secretary for Administration (ASA)
Program Support Center (PSC)
Office of the Assistant Secretary for Financial Resources (ASFR)
Office of the Assistant Secretary for Legislation (ASL)
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
Office of the Assistant Secretary for Preparedness and Response* (ASPR)
Office of the Assistant Secretary for Public Affairs (ASPA)
Center for Faith-based and Neighborhood Partnerships (CFBNP)
Administration for Children and Families (ACF)
Administration on Aging (AoA)
Agency for Healthcare Research and Quality (AHRQ)*
Agency for Toxic Substances and Disease Registry* (ATSDR)
Centers for Disease Control and Prevention* (CDC)
Substance Abuse & Mental Health Services Administration* (SAMHSA)
Centers for Medicare & Medicaid Services (CMS)
Food and Drug Administration* (FDA)
Health Resources and Services Administration* (HRSA)
Indian Health Service* (IHS)
National Institutes of Health* (NIH)
Office for Civil Rights (OCR)
Office of Consumer Information and Insurance Oversight (OCIIO)
Departmental Appeals Board (DAB)
Office of the General Counsel (OGC)
Office of Global Health Affairs* (OGHA)
Office of Inspector General (OIG)
Office of Medicare Hearings and Appeals (OMHA)
Office of the National Coordinator for Health Information Technology (ONC)
Office of Public Health and Science* (OPHS)
* Designates a component of the U.S. Public Health Service.

Components of US Health System

- MoH
- Other ministries
  - Labor, Mines, Agriculture, Justice, Social welfare
  - Industry, Education, Local bodies, Planning, Public works
- Vol. bodies
- Professional bodies
- Private market

Mgt. of US Health System

- ✓ Local responsibility
- ✓ Private sponsorship
- ✓ Minimum Govt. role
- ✓ Comprehensive health Planning
- ✓ Decentralization & Voluntarism
- ✓ Strict regulation-avoid misuse & negligence

Service Delivery in US Health System

Primary-

- ✓ Private physician/ poly-clinics
- ✓ Payment-insurance, out of pocket
- ✓ Preventive NO
- ✓ Sec./Ter. Care-
- ✓ Govt. hospitals

Increasing cost

- ✓ HMOs (pre-paid)
- ✓ PPO (groups, competitive cost)

Health Manpower in US Health System

Health manpower
Medical schools 50:50 Pvt.:Public
24.2/10000 –Physicians(2010) ; 98.2/10000-Nurses
Source: WHO, World Health Statistics,2012

Health commodities
Patents-valid for 17 yrs.
Regulation-on prescription/OTC drugs
Drug formulary with hospitals

Health knowledge
Extensive and varied research
Research grants from Govt.

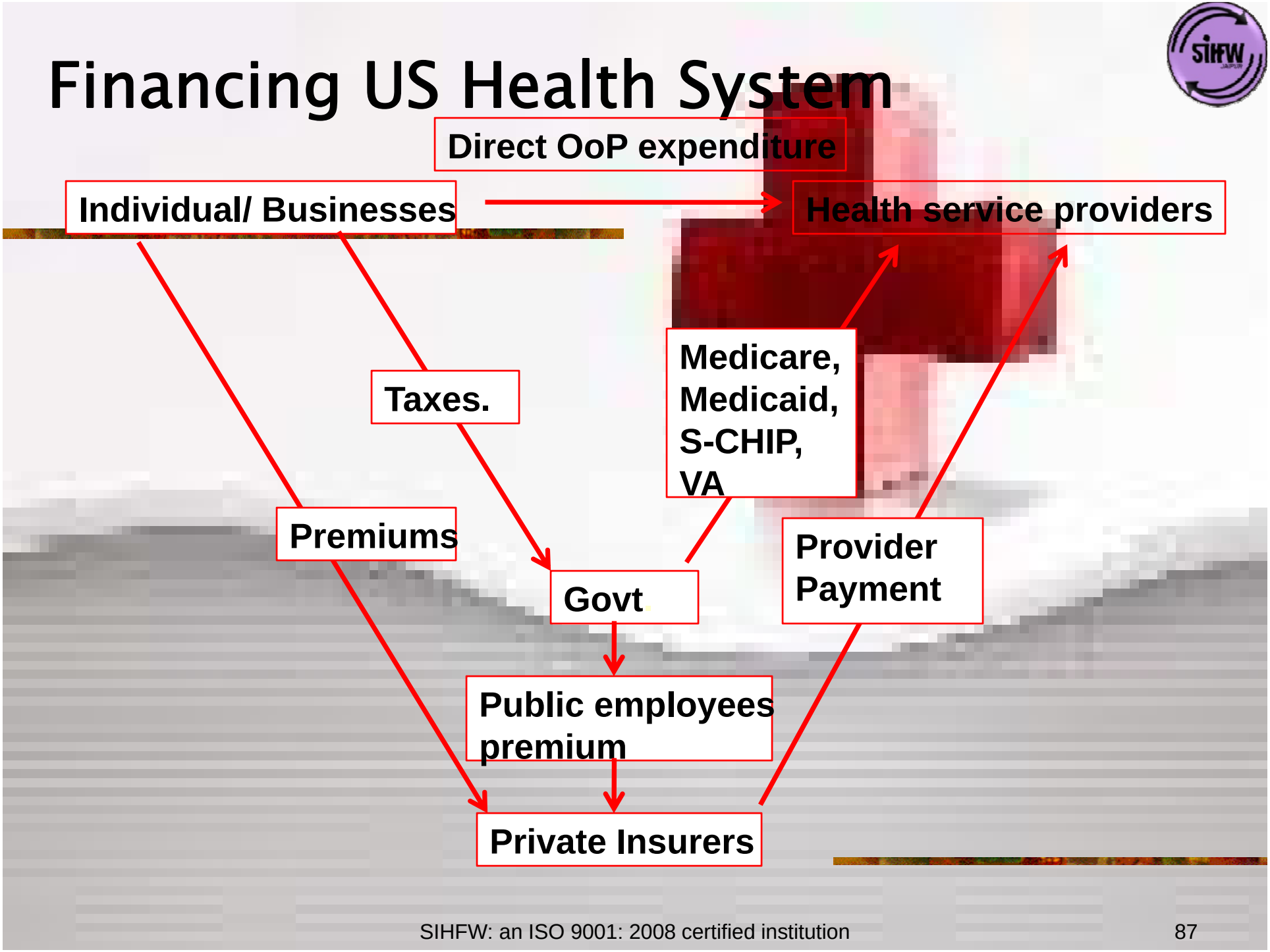
Health facilities
30bed/10000(2010)
Govt. hospitals-free
OPD-only for poor
Health centers-Preventive care

Source: WHO World Health Statistics,2012

Financing US Health System

- Funding
  - Total expenditure on health as % of GDP :17.6%(2009)
  - Per capita total exp. On health (PPPint.$):7960(2009)
  - General Govt. exp.on health as % of Total exp. On health :47.7% (2009) Source: WHO, World Health Statistics,2012
  - Individuals (47 million U.S. residents 8 M –Children) have no health insurance)
  - Federal Govt.
  - State Govt.
  - Employers
    - Larger houses(500+ employees) with declining trend

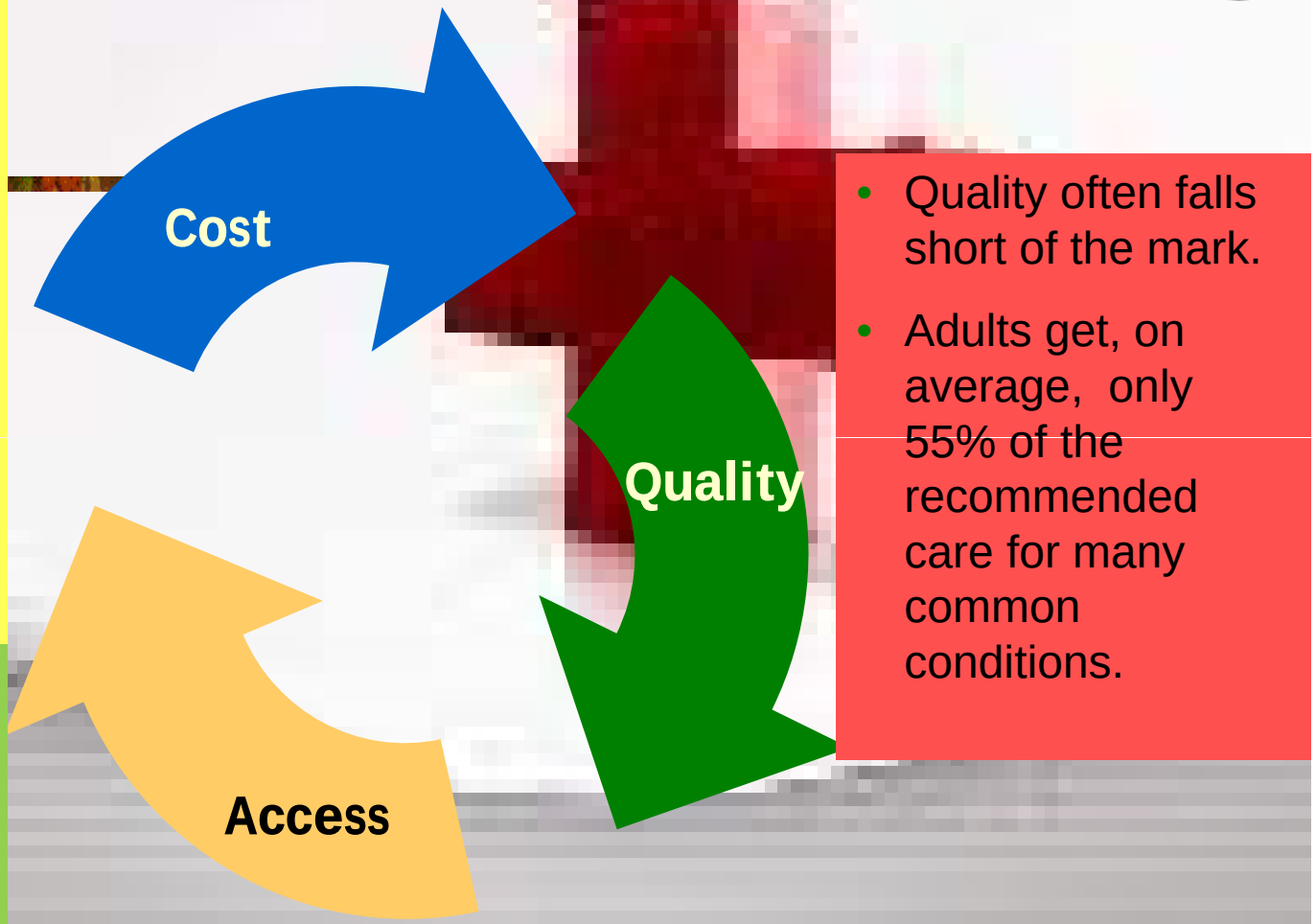
Financing US Health System



Financial implications

- In 1960, spent a nickel out of every dollar earned, on health; today spend 15 cents out of every $1 on health.
- The U. S. spent $6,400 per person in 2004; By 2014, this amount is expected to be $11,000.

- Almost 46 million are uninsured.
- Many uninsured are from working families.
- The uninsured are 8 times more likely to skip medical care because they can't afford it.



- Quality often falls short of the mark.
- Adults get, on average, only 55% of the recommended care for many common conditions.

Economics of US Health System

In 2003-

- ✓ Private Employer sponsored insurance- 62% of non elderly
- ✓ 15% in public insurance programs like Medicaid
- ✓ 18% were uninsured
- ✓ 5% purchased insurance on the private non group (individual) market

Components of US Health system

- Large private market
  - Ambulatory care
  - Dental
  - Prosthetic
  - Surgical
  - Optical
- Emergence of poly clinics (complimentary role)

Public Health Insurance

- **Medicare**
  - Beneficiary: 65+ and disabled
  - Single payer(Govt.) program
  - 3 parts-
    - Part-A- Hospital Services
    - Part-B- Physician's services
    - Part-C – pharmacy
  - No coverage for skilled Nursing care, dental, hearing, vision, preventive care

Public Health Insurance

- **Medicaid**
  - Financed jointly by the states and federal government through taxes
  - Very poor pregnant women, children, elderly, disabled, and parents

Public Health Insurance

- **S-CHIP**: The State Children's Health Insurance Program (S-CHIP) (1997)

- **VA-**
  - Federally administered program for veterans of the military
  - Funded by taxpayer dollars

Private Health Insurance

- Private non-group (individual market)
  - private insurance companies
  - Individuals pay an insurance premium out-of-pocket for coverage
- Employer-sponsored insurance
  - financed both through employers (who usually pay the majority of the premium) and employees

UK


ENGLAND
ATLANTIC OCEAN
SCOTLAND
0 100 km
0 60 miles
Northumberland
Newcastle-upon-tyne
Durham
Carlisle
NORTHERN IRELAND
Lake District NP
Isle of Man
Irish Sea
Blackpool
York
Leeds
Liverpool
Manchester
IRELAND
NORTH SEA
Nottingham
Birmingham
Shropshire
Northampton
Ipswich
WALES
The Cotswolds
Oxford
London
Bristol
Bath
Canterbury
Stonehenge
Celtic Sea
BELGIUM
Bude
New Forest
Exmouth
Isle of Wight
The Channel
Newquay
Isles of Scilly
Channel Islands
FRANCE

UK Health System (NHS: 1948)

- **Major features**:
- Publicly-funded healthcare system
- Biggest and oldest single-payer healthcare system
- Comprehensive nature of services
- Universal reach-primary care, in-patient care, long-term healthcare, ophthalmology and dentistry.
- Socialized medicine(social entitlement)
  - Funded through the general taxation system
  - "Free at the point of use"
- Initiated as worker's insurance
- National Health Service 1948- (NHS Act 1946,2006)

- ✓ It meet the needs of everyone
- ✓ Free at the point of delivery
- ✓ Based on clinical need, not ability to pay
- ✓ Since 2000 July
  - ✓ Provide a comprehensive range of services
  - ✓ needs and preferences of individual patients, their families
  - ✓ needs of different populations
  - ✓ improve the quality of services and to minimize errors
  - ✓ Use public funds for healthcare devoted solely to NHS patients
  - ✓ Work with others to ensure a seamless service for patients
  - ✓ work to reduce health inequalities
  - ✓ confidentiality of patients ,access to information about services, treatment and performance

Service Delivery

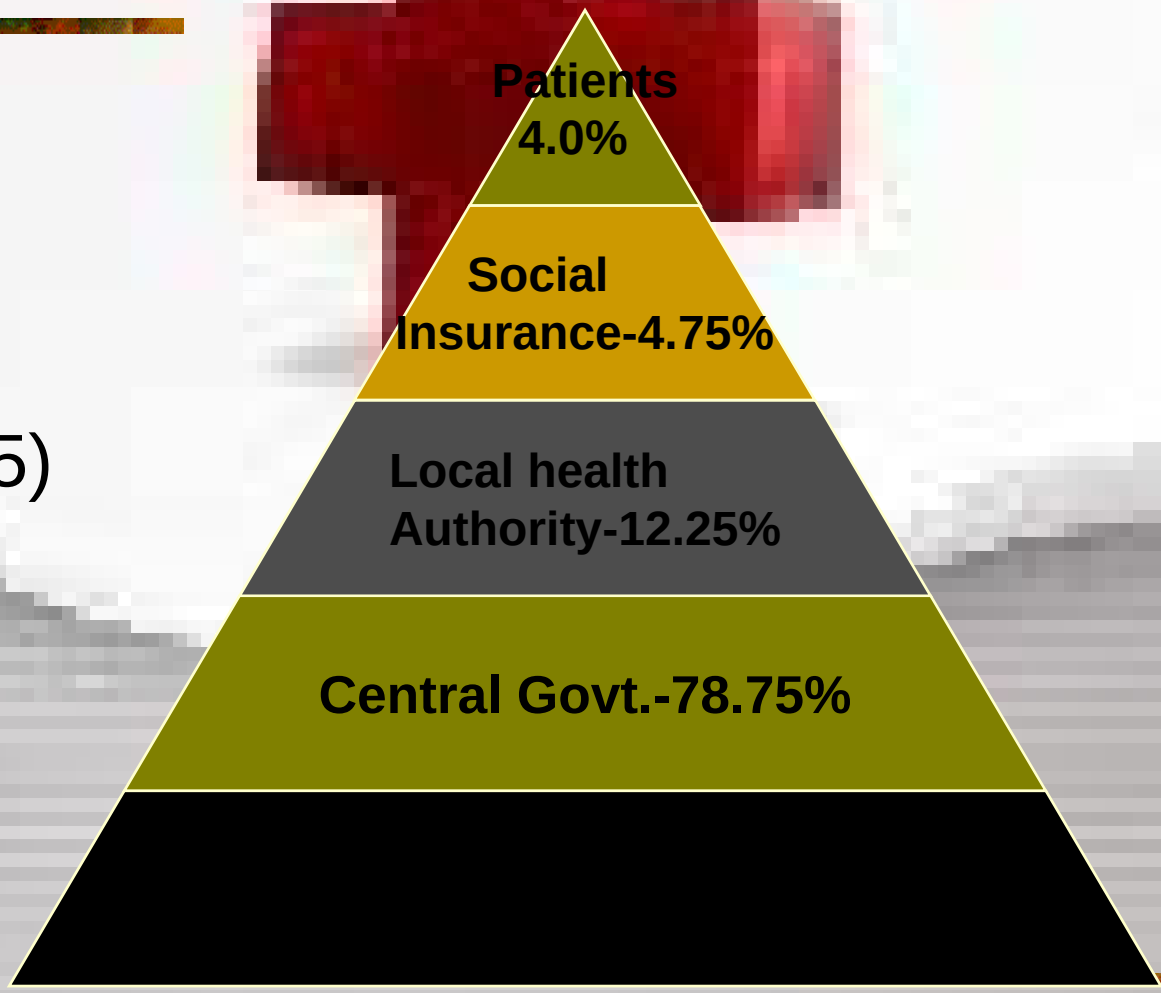
- ✓ Community Hospitals, GPs, Teaching Hospitals and Public Health Authority
- ✓ Primary health care services by general practitioners, dentists, pharmacists and ophthalmic practitioners who were independent contractors
- ✓ Preventive services were provided by local Govt.
- ✓ Hospital services by regional hospital boards

The Initiatives of the Current NHS Reforms

- ✓ Providing incentives for people to take out private health insurance;
- ✓ Introducing new charges for health care services;
- ✓ Converting the tax-based financing system into a social health insurance system; and
- ✓ Limiting the provision of health care services to the core services.

Economic support to NHS

- ✓ 6.1% of GNP(1985)



Service Trends

- National health insurance act (1911)
- Manpower supply increase-gradual & slow
- 27.4 physicians/10000population, 2010
- 101.3 Nurses/10000 population, 2010
- 33 Bed/10000 population,2010 Source: WHO, World Health Statistics,2012
- Increase in hospitals expenditures
- Grouping of physicians-poly clinics
- Correction of geographic overloads
- NHS reorganization(1974) - Area health authority
- - Health districts
- Predominance of private sector-payment by govt.

Financing UK Health System

In 2009

- ✓ Total expenditure on health as % of GDP: 9.8
- ✓ General Govt. Expenditure on health as %of Total expenditure on Health: 84.1
- ✓ Per capita Expenditure on health (PPPint.$):3438
- ✓ Out of pocket expenditure as % of private exp.on health: 62

Source: WHO, World Health Statistics,2012

USSR: Health System

Socialist Health System – USSR

- Major features:
  - Health services-a social entitlement
  - Health –Govt. responsibility
  - Integration of Preventive & Curative
  - Resources/services-Centralized planning
  - Single authority-MoH with sub-divisions
  - Prioritize services-workers & children first
  - Regulate private practice
  - Application/practice only based on scientific principles

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Organization

Central govt.
(Central council of Ministers)
MoH
setting standard
supervision
Republics

Province(1-5 M population)
Districts
Sectors

- **Manpower**
- ✓ Medical education under MoH
- ✓ Strength-430/lac (1986),M:F 50:50
- ✓ Middle medical workers
- ✓ CME
- ✓ Secondary medical schools
- ✓ Stations
- ✓ **Commodities**
- ✓ State owned enterprises
- ✓ Cost/competition-delays

- **Health facilities**
- ✓ Govt. owned, small no. in private
- ✓ Sector hospitals-35-50 beds,pop.-4000
- ✓ District-100-300 beds,40-150 thousand
- ✓ Provincial –600-1200 beds,1-5 M pop.
- ✓ Rural-Mid-wife post
- ✓ Emergency medical services
- ✓ Sanitary.-Epidemiology.

Medical facilities:

- ✓ Bed: 97/10000 population

Man power:

- ✓ Physician: 43.1/10000
- ✓ Nurses: 85.2/10000

Source: WHO, World Health Statistics,2012

Financing: USSR Health System

- ✓ General taxation to the state, county or municipality
- ✓ Social health insurance
- ✓ Voluntary or private health insurance
- ✓ Out-of-pocket payments
- ✓ Donations

In 2009

- ✓ Total expenditure on health as % of GDP: 5.6
- ✓ General Govt. Expenditure on health as %of Total expenditure on Health: 63.4
- ✓ Per capita Expenditure on health (PPPint.$): 1043
- ✓ Out of pocket expenditure as % of private exp. on health: 82.1

Source: WHO, World Health Statistics,2012

China


Heilongjiang
Jilin
Liaoning
BEIJING
Tianjin
Hebei
Inner Mongolia
Xinjiang
Gansu
Ningxia
Qinghai
Shanxi
Shandong
Henan
Jiangsu
Shaanxi
Shanghai
Tibet
Sichuan
Hubei
Anhui
Zhejiang
Chongqing
Jiangxi
Hunan
Guizhou
Fujian
Yunnan
Guangxi
Taiwan
Guangdong
Hong Kong
Hainan
Islands of South China Sea
Islands of South China Sea

China

- Population: 1,313,900,000 (2006)
  - Some 900,000,000 in rural areas
- Life Expectancy: 70.9 male/ 74.5 female
- Infant Mortality: 23.1 per 1000 (2006)
  - Urban:11 per 1000
  - Rural: 37 per 1000 (1999)
- Population >65: 7.7%

Health system classified in relation to traditional medicine-

- ✓ **Exclusive (tolerant)** :UK, Germany
- ✓ **Inclusive** :India, Pakistan, Burma, Srilanka, Bangladesh, Thailand
- ✓ **Integrated** :China, Nepal

China: Geographical Units

Country-National

Province (State), 21

Counties (Districts), 2300

Communes (Townships vs. Tehsils)

Production Brigades (Villages or Village clusters)

Production teams (Hamlets)

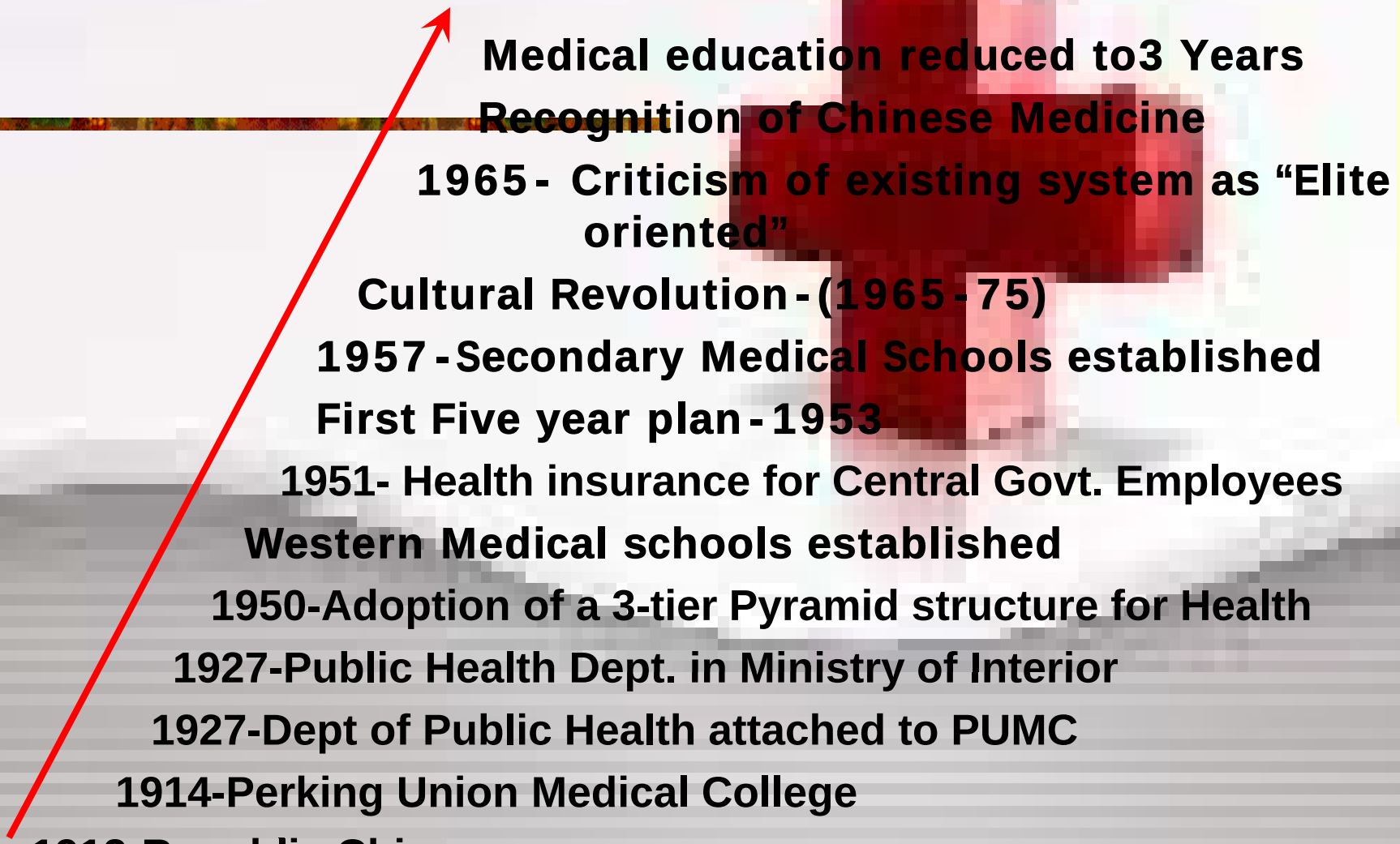
Exemplary Health Reforms(1985)

4% GDP on Health
MMR 44/100000
CPR-74% (1985)
CBR-20/ 1000
IMR-33/ 1000
Life Expectancy-70 (1987)

"Sick Man Of Asia"(1911)

(Malaria, Plague, TB, Small Pox, Trachoma, Leprosy, Chorea, Syphilis, Typhoid…)

Health system evolution : China



Medical education reduced to3 Years

Recognition of Chinese Medicine

1965- Criticism of existing system as “Elite oriented”

Cultural Revolution-(1965-75)

1957-Secondary Medical Schools established

First Five year plan-1953

1951- Health insurance for Central Govt. Employees

Western Medical schools established

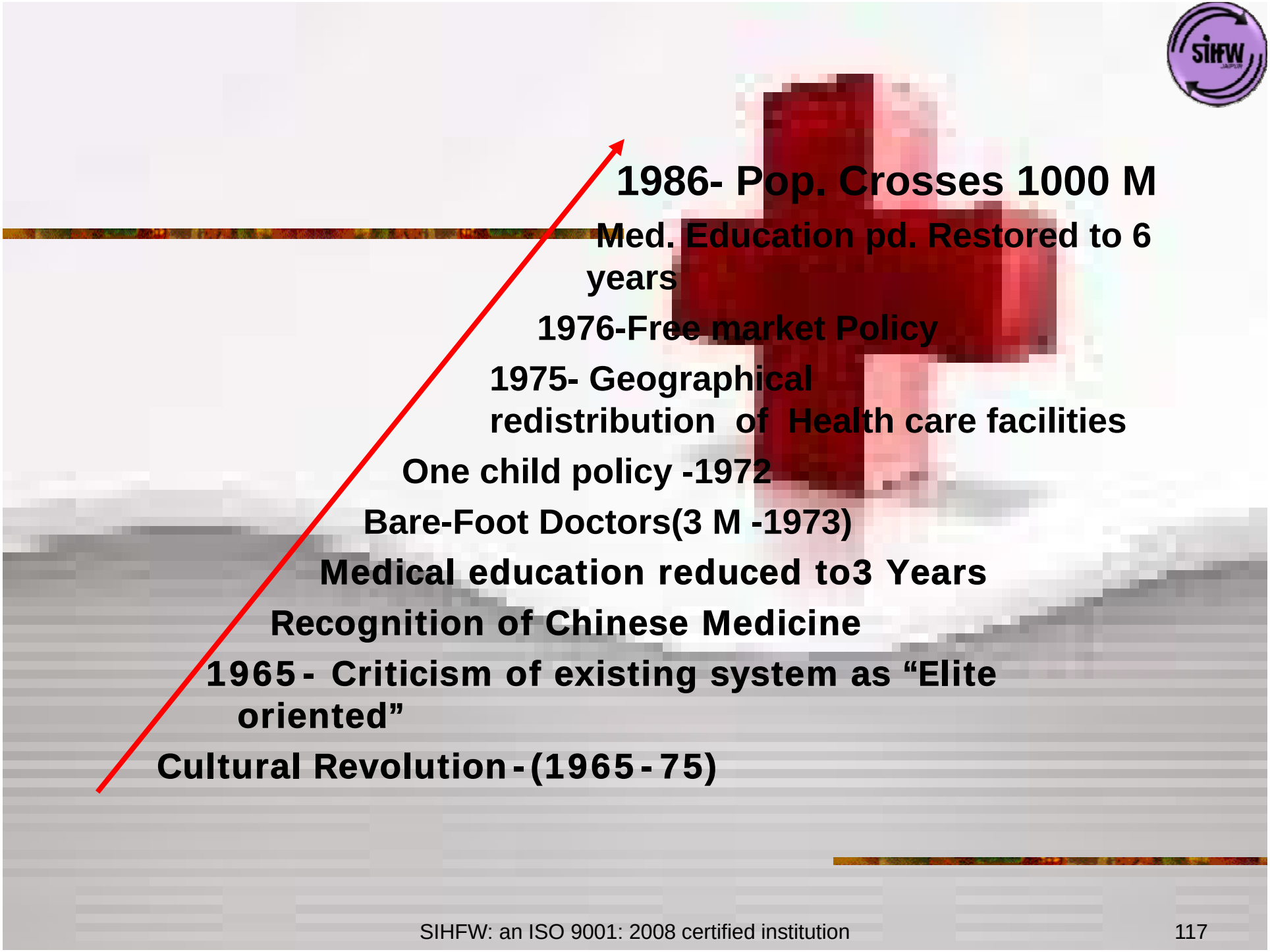
1950-Adoption of a 3-tier Pyramid structure for Health

1927-Public Health Dept. in Ministry of Interior

1927-Dept of Public Health attached to PUMC

1914-Perking Union Medical College

1912-Republic China


1986- Pop. Crosses 1000 M
Med. Education pd. Restored to 6 years
1976-Free market Policy
1975- Geographical redistribution of Health care facilities
One child policy -1972
Bare-Foot Doctors(3 M -1973)
Medical education reduced to3 Years
Recognition of Chinese Medicine
1965 - Criticism of existing system as “Elite oriented”
Cultural Revolution - (1965 - 75)

Health System-China

Major features

- ✓ Comprehensive-Universal
- ✓ Little regulation
- ✓ Wide variations in implementation
- ✓ Payment for services-reimbursed subsequently
- ✓ Large presence of Traditional healers
- ✓ Bare-foot & asset. Doctors trained in Sec.med.schools

- Universal reach of primary care-
  - Innovative trg,
  - Bare foot doctor
  - Asstt. doctor
- 3-Tier system-County
  - Commune
  - Village hlth.station
- Family welfare-social approach
- Unintended negligence –no action
- Health Insurance
- All services to be paid for

Health Resources-

Manpower:

- Practitioners of Traditional Chinese Medicine (31.9 /100000, 1986) Curriculum- Traditional: Western 70:30
- Physician 14.2/ 10000 Source: WHO, World Health statistics,2012
- Nurses 13.8/ 10000Source: WHO, World Health statistics,2012
- Assistant Doctors (Products of Secondary Medical Schools, 3-4 yrs of Training) 45/ 100000
- Bare Foot Doctors
  - Rural Doctors
  - Orderlies

Health Facilities-

- ✓ 42 Beds/ 10000 Source: WHO, World Health statistics,2012
- ✓ 1414 Hospitals (12% Traditional Medicine)
- ✓ All Govt controlled
- ✓ Encouraging Entrepreneurs under PPP
- ✓ Specialty Hospitals
- ✓ Epidemiological units(3410 by 1985)
- ✓ Health centers (48100 by 1986, 1/22000)
- ✓ Pharmaceutical Industry for Western & Traditional herbal drugs- Private sector by 1976

Organizational Structure-

National Level-

Ministry Of Public Health

(Centre for Policy leadership)

- Health & Epi. Prevention
- Med. Administration
- Science & Education
- MCH
- Pharmaceutical. Administration
- Traditional Medicine
- Planning & Finance
- Retail drug distribution
- Academies
  - Medical sciences
  - Traditional medicine
  - Preventive Medicine

Province level-

Bureau of Public health

Provinces to finance up to 90%

Services to be area specific

County Level-

Bureau of Public health

Hospitals

Epidemics

Health campaigns

Drugs

Secondary Medical Schools

Supervision of township

- Township level-

  Health centers (CHCs)

  No public health admn. Office

- Village level-

  Village Health Stations (PHCs)

Other Govt. Agencies-

- Petroleum & Chemicals
  (Drug Production)
- Commerce
  (Drug Distribution)
- Light Industry
  (Medical Equipments)
- Labor + MoPH
  (Safety standards)
- Education
  (Medical education Standards)
- Finance + Labor
  (Health Insurance)

Non-Governmental Agencies-

- No significant presence
- Professional Bodies like-
  - Chinese Medical Association
  - Anti-Tuberculosis Association
  - Mental Health
  - Leprosy
  - Anti-Cancer
  - Anti Smoking
  - Family Planning Association
- Chinese Red Cross Society
- Chinese Communist Party-
  - Privatization
  - Decentralized authority
  - Local self reliance
- Private Market

Economic Support-

- On payment services

- Price regulated by Govt. and kept at its min.
- Urban Oriented
- Not Obligatory for Govt. to finance
- Health –Personal responsibility rather than collective action(1983)
- Covers cost of care to central employees
- Govt. Insurance (Health), not for Dependents
- Labor Insurance – Workers & Dependents, Freedom to choose, Reimbursement
- Health care cooperatives at Village levels with Annual Membership fee (Participation)
- Health Expenditure-4.0 % of GDP (1987)
  - 95.3% Recurrent Expenditure
  - 4.7% Capital construction

Economic Support–

Sources of Health funds (%)

	1980	→	1987
Insurance	48	→	50
Govt.	35	→	18
Individuals	17	→	32

Health Care Delivery

- Primary Health Care
  - **Universal coverage**
  - **Innovative training**
  - **Bare foot Doctors**
  - **Assistant Doctors**
- 3 Tier structure below province levels
- Largely preventive, though to be paid for
- Traditional Chinese system
- Say of lowest cadre of workers respected
- Unintentional mistake not punished
- Uninsured rarely hospitalized(High cost)
- 40 % pop. Covered by some insurance

Family Planning services in China-

- ✓ Regular policy changes

- ✓ Birth planning committees at each level
- ✓ Easy access to delivery of contraceptive services
- ✓ Deliveries assisted by SBA(97%)
- ✓ Strong IEC
- ✓ 1968-National policy
  - ✓ Late marriages, (23 & 20 yrs.)
  - ✓ Incentives on single child
  - ✓ IEC for FP
  - ✓ Abortions legalized

Summary Highlights-

- ✓ Decentralized Administration, Centralized planning leading to regional disparities
- ✓ Dominant role of CCP
- ✓ Strong Soviet influence
- ✓ Local Self Reliance
- ✓ Area specific planning & Service Delivery
- ✓ Resources public but services on payment
- ✓ Health facilities need to be self supporting
- ✓ Even preventive services are to be paid for
- ✓ Community participation- Communes
- ✓ Bare-foot Doctors

Summary Highlights-

- ✓ 4% of GDP
- ✓ Incremental Govt. Health spending
- ✓ Traditional System not neglected
- ✓ Gradual decline in Rural Health Cooperatives
- ✓ Health Insurance to cover rising costs
- ✓ Separate funds for different socio-economic groups
- ✓ Pooled contributions to meet Pooled risks
- ✓ Communicable diseases not in first 5 leading causes of Death
- ✓ General Anesthesia by Acupuncture

China: Health Indicators

(http://www.who.int/gho/countries/chn.pdf)

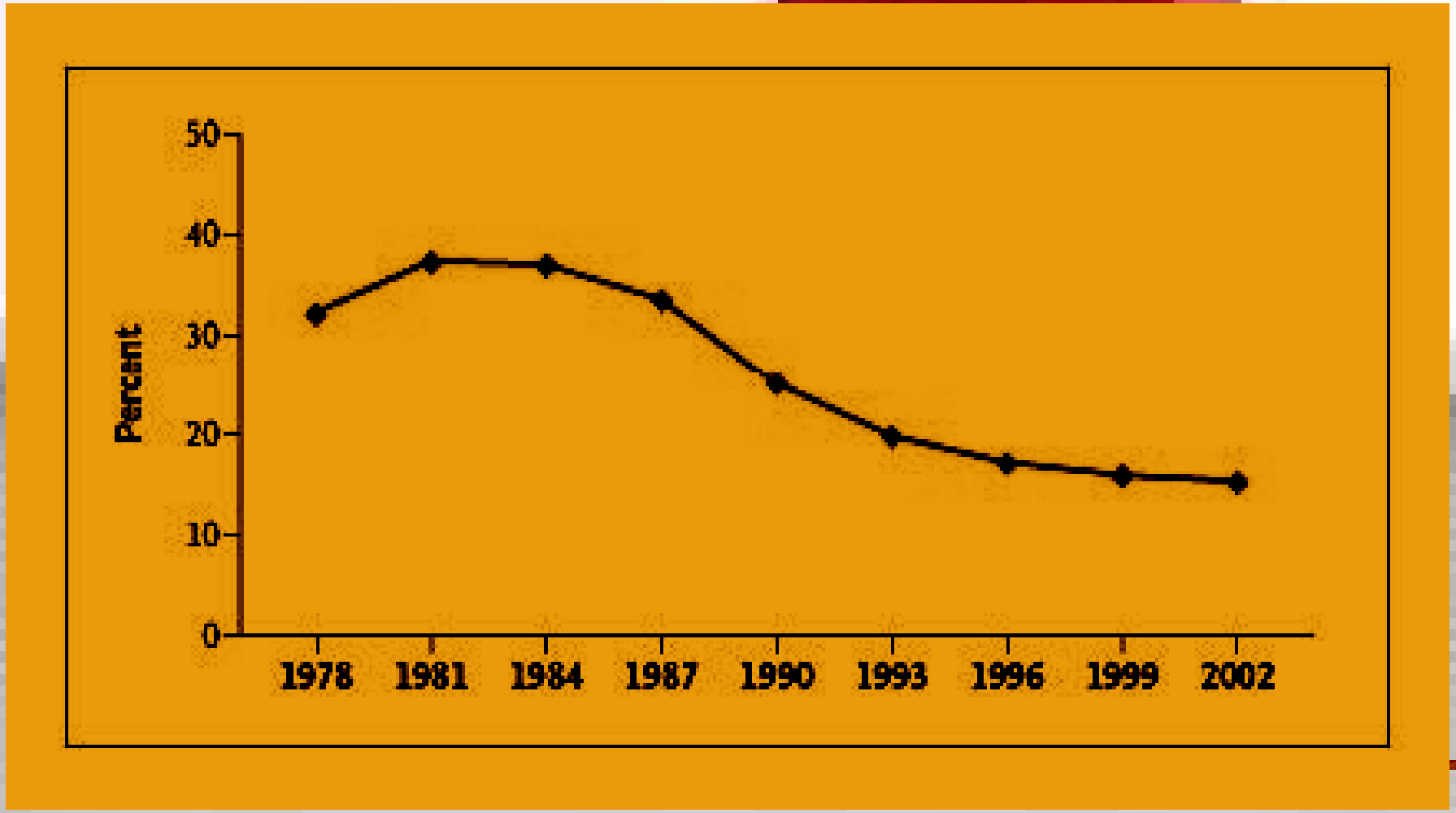
(2009 data)		Country	Regional average	Global Average
Total population (thousands)		1353311	-	-
Population living in urban areas (%)		44	48	50
Gross national income per capita		6890	9497	10599
Life expectancy at birth	Male	72	72	66
	Female	76	77	71
	both	74	75	68
Maternal mortality ratio		38	51	260

4 Historical and Economic Steps to a Decline in Population Health Outcomes

- ✓ 1st: 1978 to 1999, reduced federal funding of healthcare from 32 to 15%--in favor of provincial/local gov'ts having more "control" (result: disparities & privatization)

- ✓ 2nd: Govt. imposed Perverse Price Regulations: hospitals and physicians that generated more income got bonuses; promoted use of new, expensive pharmaceutical products and high-technology services

Chinese Federal Health Expenditure as % of Total Health Expenditures



- Dismantling of Cooperative Medical System,
  - 900 million rural Chinese became uninsured overnight,
  - barefoot doctors became unqualified peddlers of high cost pharmaceuticals, loss of preventative emphasis

- Reduced govt. funding for public health efforts
  - local agencies switched to revenue generating focus (restaurant/food inspection) vs. MCH, epidemic control & health ed.

Blumenthal D, Hsaio W *Privatization and Its Discontents — The Evolving Chinese Health Care System.* NEJM. Volume 353:1165-1170 (11)

- ✓ Health expenditure as % of GDP: 5.1 (2009)
- ✓ Per capita total health expenditures: $ 347 US (2009)
- ✓ General Government expenditure on health as % of total expenditure on health: 52.5(2009)
- ✓ Private expenditures out of pocket: 78.9%(2009)
- ✓ External resources for health as a % of total expenditures on health: 0.2%(2008)

50-70% of ALL healthcare spending is on pharmaceuticals—many of which are counterfeit

Source: WHO, World Health Statistics,2012

- **Privatization**
  - Hospitals: 15% cooperative ownership, 15% private, for-profit
  - Rural area clinics and hospitals allowed to privatize

Rural Healthcare

- Rural residents pay for 90% of their own healthcare (out-of-pocket)
- Public Health Campaigns: Government and NGOs/INGOs frequently sponsor immunization or other healthcare campaigns
- No opportunity for rural residents to purchase health insurance (no competitive market place for insurers)
- In 2002, officials launched several experiment inpatient care insurance plan as a rural health safety net. The government provides $2.50 a year, rural residents must match this with an annual $1.25.

Urban Healthcare

- Public hospitals: 70%, state mandated charges
- Two tier “National” insurance system: based on employer and employee contributions—started in 1998
  - 1st Tier: Personal medical account
  - 2nd Tier: Universal fund available when the personal account is exhausted
  - A “young” program, not all employers participate, time will tell the impact

Canada


Yukon
Whitehorse
Northwest Territories
Yellowknife
Nunavut
Iqaluit
British Columbia
Victoria
Alberta
Edmonton
Saskatchewan
Regina
Manitoba
Winnipeg
Ontario
Toronto
Ottawa
Quebec
Québec
Newfoundland and Labrador
St. John's
Prince Edward Island
Charlottetown
Fredericton
Halifax
New Brunswick
Nova Scotia
CANADA – Political
International boundary
Provincial/territorial boundary
Alberta Province/territory
Ottawa National capital
Regina Provincial/territorial capital
Scale
0 250 500 750 1 000 km

Health System- Canada

- **Major features:**
  - Welfare oriented
  - Resource rich
  - Health-Provincial responsibility
  - *National Health Insurance*

Organization-

- ✓ Deptt. Of National Health & Welfare
- ✓ Provincial Health bodies
- ✓ Federal agencies
- ✓ Deptt. Of Veterans affairs- Military hospital
- ✓ Other agencies-Justice, Defense, Agriculture
- ✓ Workmen's compensation board
- ✓ Voluntary agencies

- ✓ Private clinics-fee for service
- ✓ Insurance payment-strict reg.
- ✓ Low malpractice rate-Quality
- ✓ Hosp.Insurance-strong Govt. Surveillance
- ✓ Med.faculty- NO pvt. practice
- ✓ Weak chain of CHCs
- ✓ Legislative action against harmful health practices

Health Manpower in Canada Health System

Health manpower

- ✓ 19.8/10000 Physician
- ✓ 104.3/10000 Nurses

Health Facilities

- ✓ 32/10000 Bed

Source: WHO, World Health Statistics,2012

Financing in Canada Health System

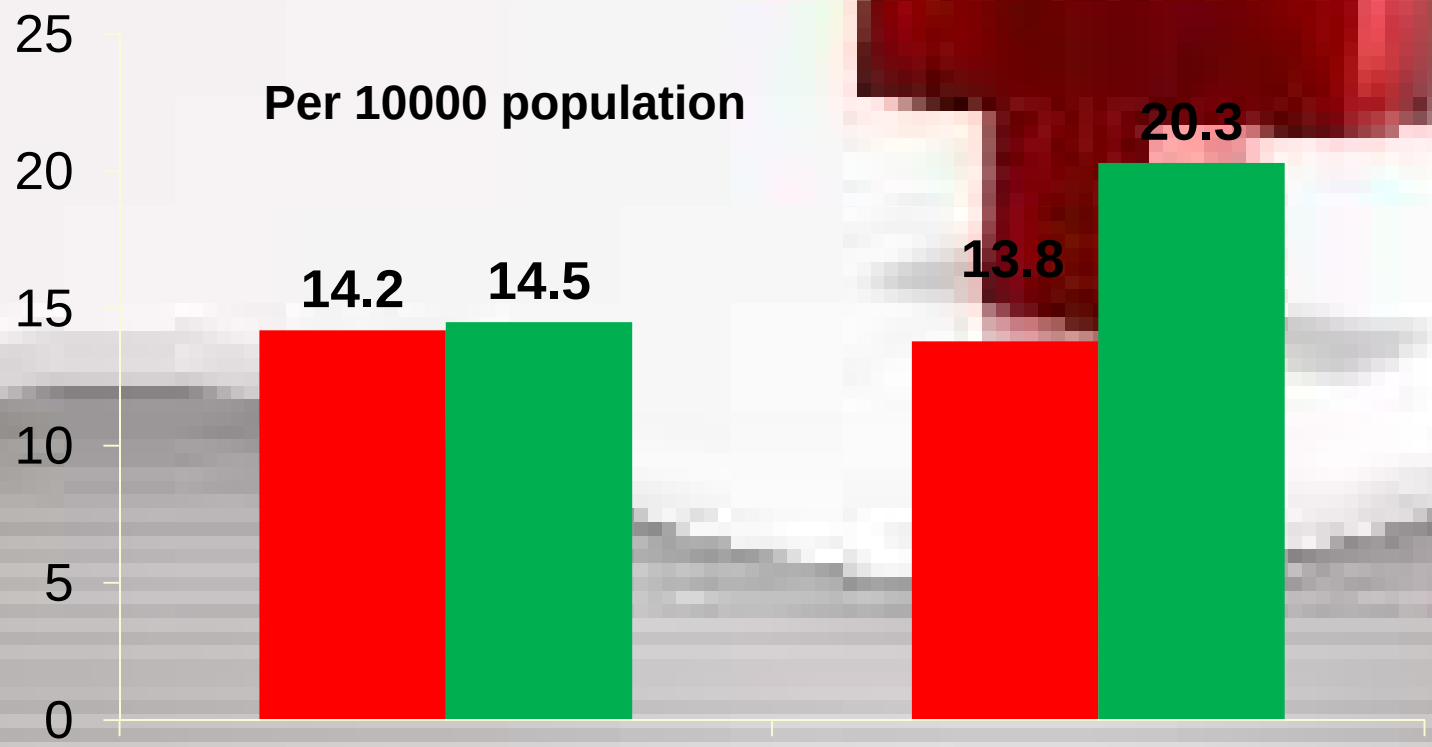
- ✓ Total expenditure on health as % of GDP- 11.4
- ✓ General Govt. expenditure on health % of Total expenditure on health- 70.6
- ✓ Per capita expenditure (PPPint.$)- 4314

Source: WHO, World Health Statistics,2012

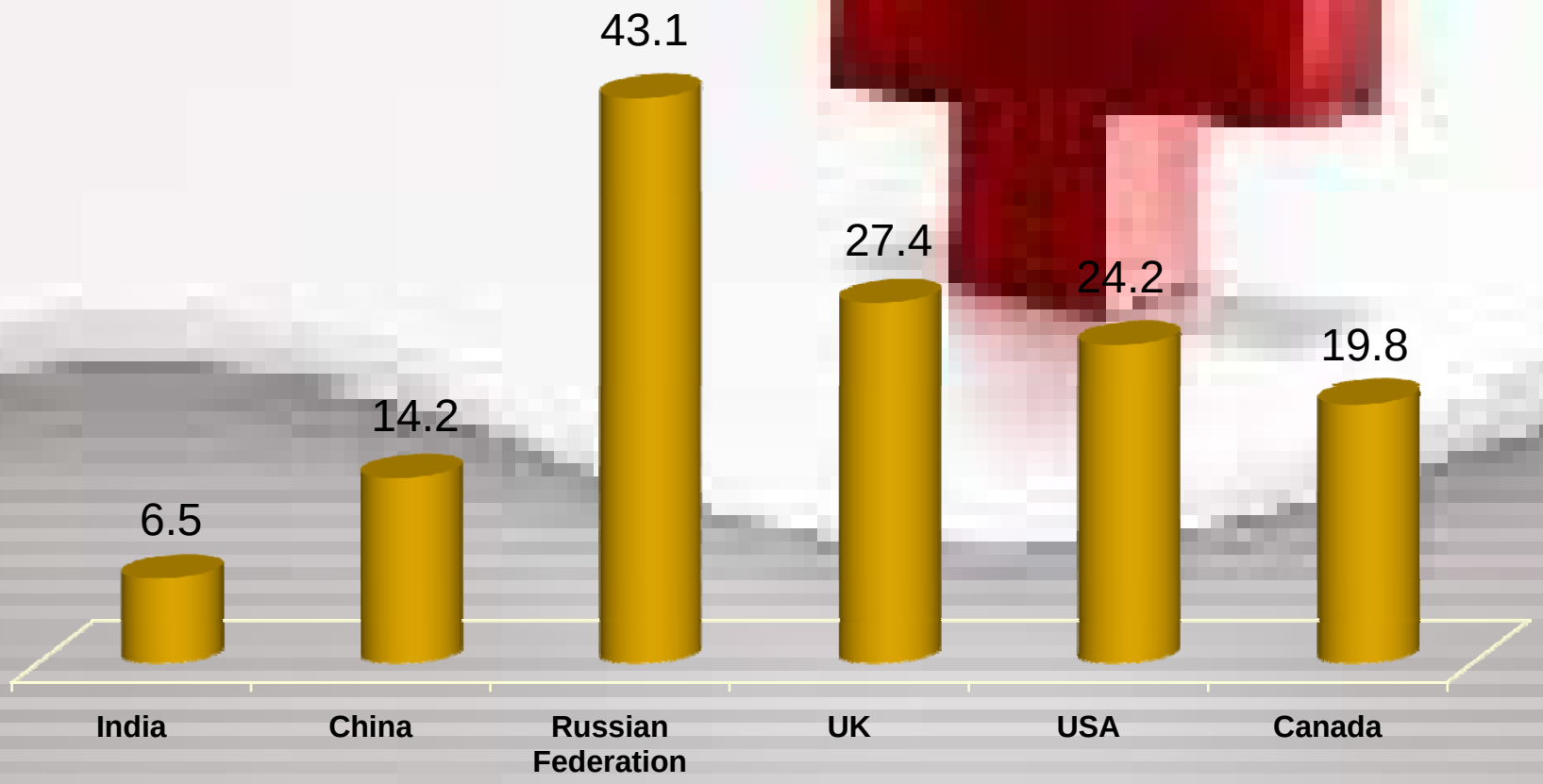
Some Indicators Across the Countries

Health Indicators

(http://www.who.int/gho/countries/chn.pdf) (2009 data)

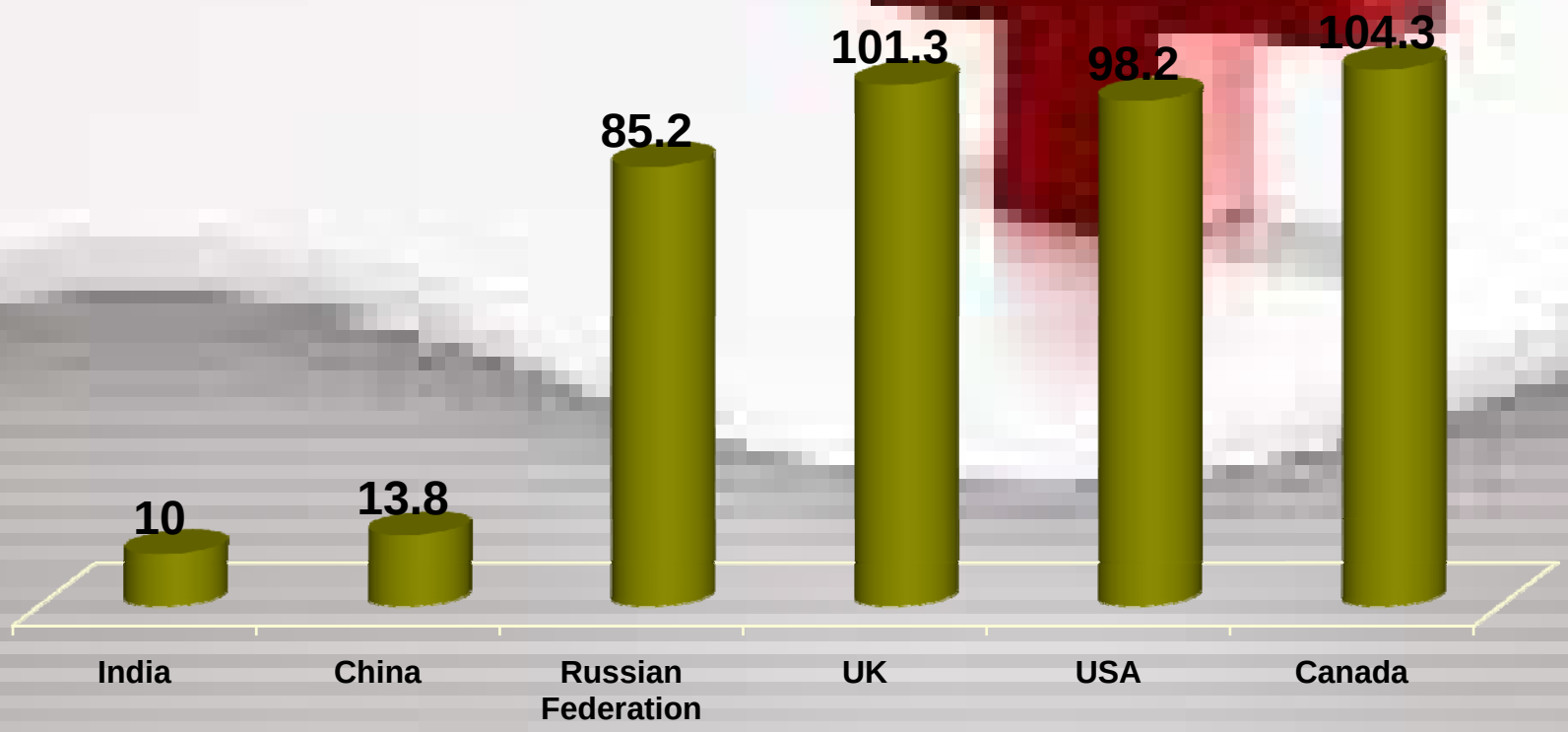


Physicians per 10000 population



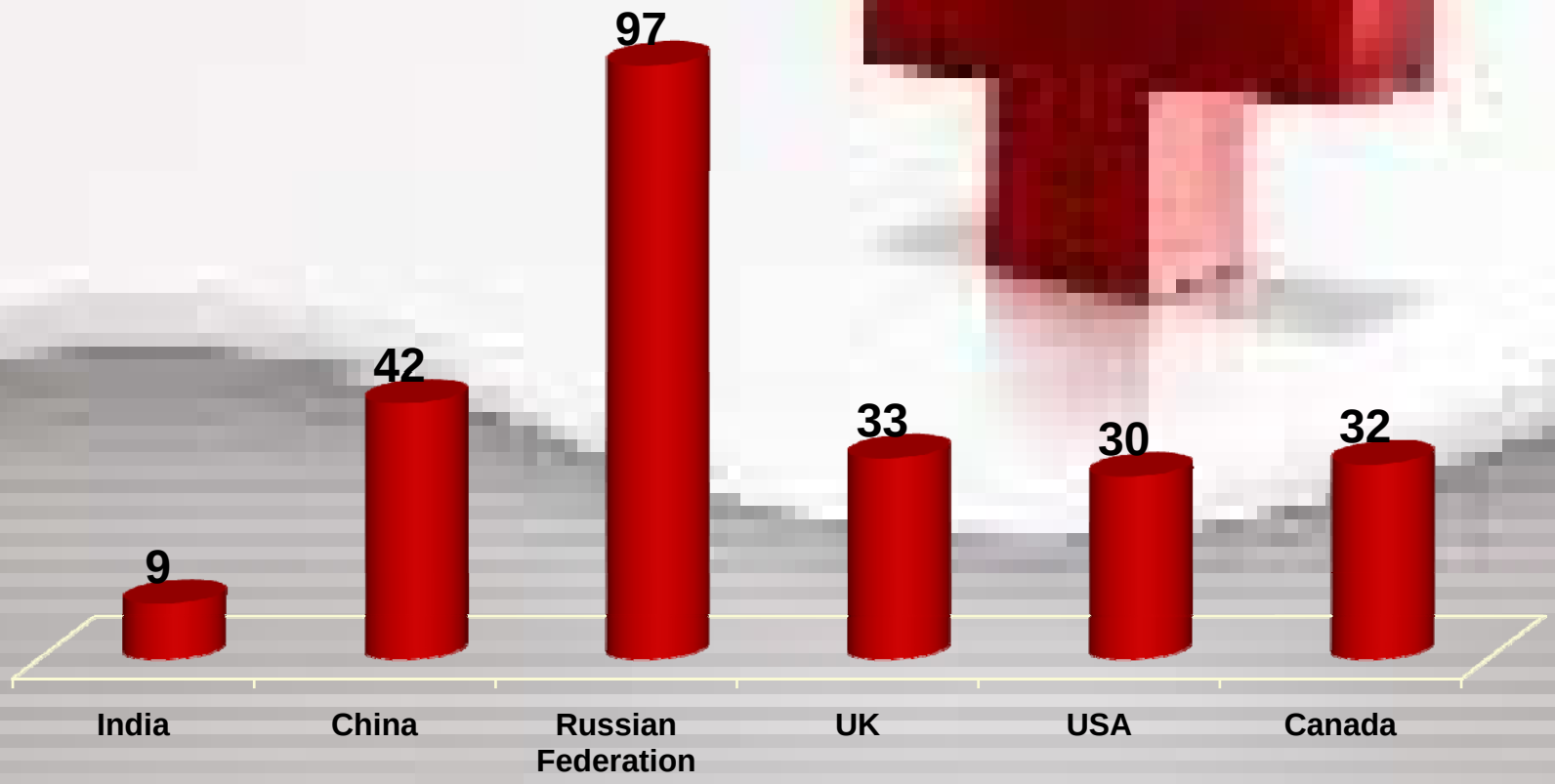
Source: WHO, World Health Statistics, 2012

Nursing/ Midwifery Personnel Density/10000 population



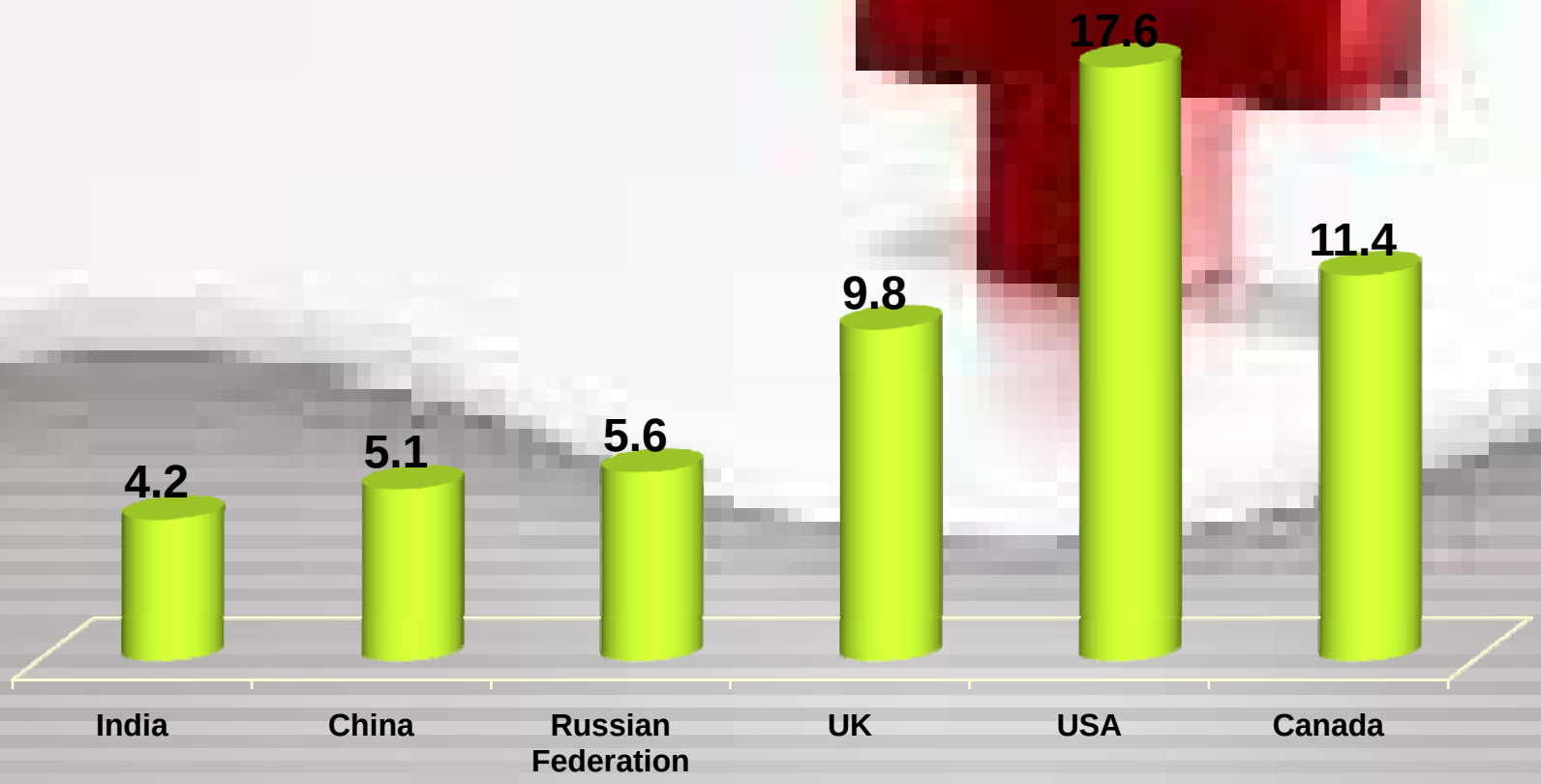
Source: WHO, World Health Statistics, 2012

Hospital Bed/10000 Population



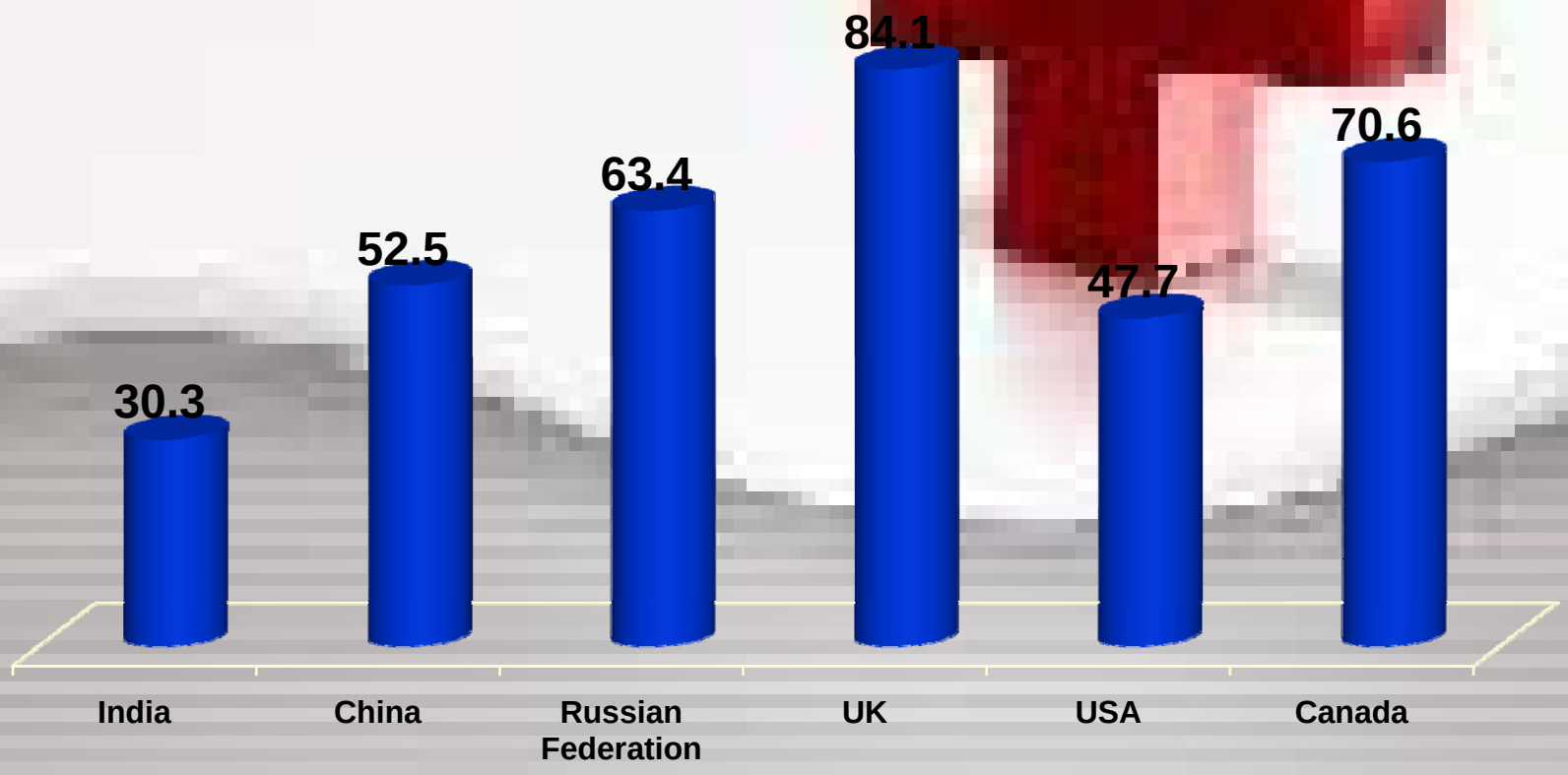
Source: WHO, World Health Statistics, 2012

Health Expenditure Ratio
Total Expenditure on Health as % of GDP



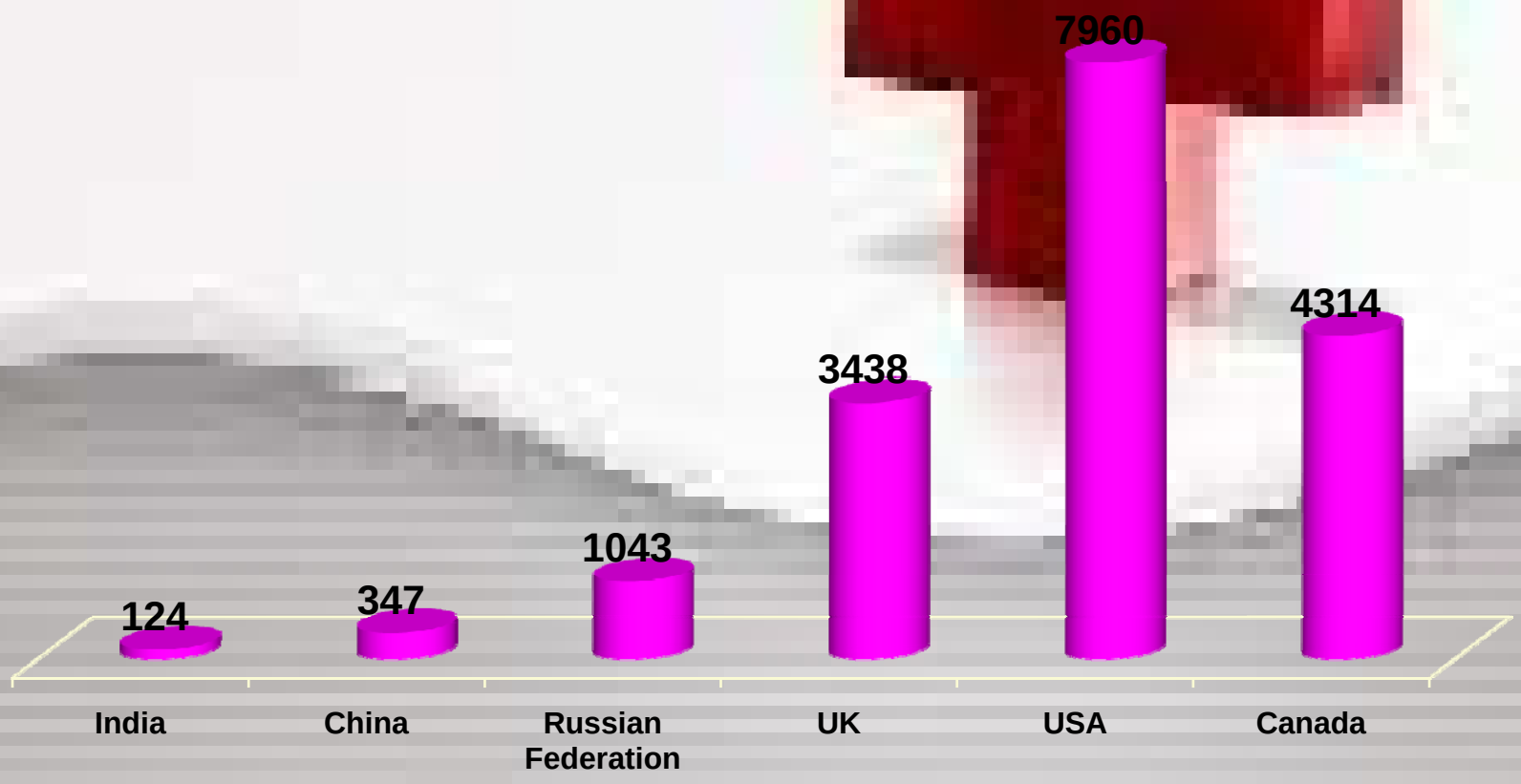
Source: WHO, World Health Statistics, 2012

General Govt. Expenditure on Health as % of Total Expenditure on Health



Source: WHO, World Health Statistics, 2012

Per Capita Total Expenditure on Health (PPP int$)



Source: WHO, World Health Statistics, 2012

Thank You

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Or

log on to: www.sihfwrajasthan.com