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SUSTAINABLE HEALTH CARE SYSTEMS: AN INTERNATIONAL STUDY

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ABSTRACT. In many countries, the operation of the healthcare system is an important political issue and any changes to healthcare provision are often fiercely resisted by many stakeholders and can prove difficult to implement. Such changes to the organization and/or financing of healthcare may be necessitated by factors such as the continuing increase in service demands, the development of new medical science advances and the impact of financial and economic austerity across the globe. This paper considers how well the existing healthcare systems in eleven countries and across several continents are coping with various challenges, and looks at potential best practices. The general conclusion is that many such healthcare systems are unsustainable in the longer term and are in urgent need of reform.

Keywords: health; systems; sustainability; austerity; financing

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1. Introduction

In virtually every country in the world today there is some form of healthcare system that aims to provide at least basic healthcare services to the public. In many countries the existence of such a service is seen to be a cornerstone of a civilized nation and for the development of an aspiring one.

Healthcare systems themselves vary significantly from one country to another and can have regional variations within a single country (e.g. within the UK there are differences between England, Wales and Scotland). While the nature and configuration of these healthcare systems has been documented in many different sources (e.g. Lee and Goodman 2002) further analysis of their appropriateness in modern times is limited.

Healthcare systems around the world face a range of challenges, one of which is the existence of what is now termed economic and financial austerity consequent on the Great Recession of 2009. In many countries the operation of the healthcare system is an important political issue and any change to health care provision to meet emerging challenges is often fiercely resisted and consequently can prove difficult to implement.

This paper looks at the healthcare systems in a small but representative sample of countries across the globe to gauge how well these existing systems are coping with various challenges, but especially the challenges of austerity; how sustainable individual systems are in the longer term; and what sorts of changes are being proposed. The aim is not to provide a synopsis of what is happening in each of the countries investigated but more an attempt to identify cross-cutting themes where there is strong consensus or strong differentiation, between countries in the approach being adopted. The countries surveyed are listed in an annex to this paper.

2. The Nature of Healthcare Systems

While there can be many aspects to a healthcare system, this paper focuses on the:

- configuration of healthcare systems, and
- means by which they are financed.

Configuration of healthcare systems

There a number of different features to be considered including the:

- size and role of both the public and private sectors in healthcare systems
- balance between preventative services (designed to prevent people from falling ill in the first place), acute care and longer-term care services
- balance between primary care, secondary care and tertiary care
- relationship between health care and social care
- balance between different clinical specialties
- administrative structures and mechanisms for planning and managing healthcare services, including the degree of centralized and delegated service provision
- regulatory mechanisms existing in the healthcare system to maintain standards

• nature, number, size, roles and location of the various entities (e.g. hospitals) making up the healthcare system
• extent of specialization among the various entities
• degree of market competition between entities in the healthcare system etc.

Financing healthcare systems

While there are different approaches to funding health services, the World Health Organisation (WHO 2004) suggests there are generally five primary methods:
• general taxation
• social health insurance
• voluntary or private health insurance
• out-of-pocket payments, and
• charitable funding.

Healthcare systems rarely rely on just one funding mechanism and usually have a combination of mechanisms. This is illustrated by the UK National Health Service, as an example (Prowle 2010).

Figure 2.1 Configuration of healthcare systems in relation to financing

		Configuration	
		Public	**Private**
Financing	**Public**	**A**	**D**
	Private	**C**	**B**

Segment A: Services are provided by public sector agencies and financed through public funds (e.g. taxation). In the UK, the vast majority of hospital services provided through the NHS would fall into this category.
Segment B: Services are both provided and funded through private sector agencies. Financing is typically through private health insurance.
Segment C: Services are provided by public agencies but funded through private sources such as private health insurance. In the UK, some NHS hospitals operate private health units running alongside publicly financed services; patients in the former receive privately financed care in an NHS hospital.
Segment D: Services are provided by private sector agencies but are financed through public funds. In the UK, under existing treatment regimes, certain patients can opt to have their health care provided in a private hospital at the expense of the taxpayer.

This model of analysis can be applied to the healthcare systems of all countries but, clearly, the nature and size of the different segments will vary from country to country.

3. Challenges Facing Health Care Systems Internationally

Although the challenges faced by countries vary, a number of common themes exist.

Demography and ageing populations

The ageing population phenomenon taking place in many countries is generally caused by:

- significant decreases in later-life mortality leading to much longer lifespans for many more elderly people, and
- a reduction in the fertility of populations.

These two factors taken together result in a large increase in the proportion of a country's population deemed elderly (aged 60+ years old) or very elderly (aged 85+ years old). As a group they are likely to have greater health care needs and consume more healthcare resources than other parts of the population. This ageing population phenomenon is happening in a wide range of countries both developed and developing (Leeson and Harper 2007).

Medical science and technological developments

People are accustomed to medical science and technology generating new health related treatments and procedures. In recent years the following have become commonplace:

- artificial joint replacements (since 1950s)
- organ transplants (since 1960s)
- drug and gene therapies (a long history of developments)
- radiological imaging, such as CT and MRI scans (since 1970s)
- developments in non-invasive/less invasive procedures (recent)
- genetic therapies (the future).

Before such scientific and technological breakthroughs were made, the demand for such services did not exist, but demand grows as they become more commonplace. This raises questions about whether future level of demand for certain treatments can continue to be met from limited public funds. If services are to be limited then difficult policy decisions arise around what should be provided and/or funded by the public sector, whether regional variations are acceptable, and how to manage demand and growing expectations.

Societal changes and behaviors
Particularly in the developed world a number of significant changes have occurred in the fabric of society, such as:
• adoption by some individuals of lifestyle choices with bad effects on health, including, for examples, sedentary lifestyles and over-consumption of alcohol
• high levels of family breakdown and many children living with a single parent
• a virtually complete loss of the extended family support that is available when three or more generations of a family live either together or in close proximity to one another
• an increase in the number of persons living alone, including both older and younger people.

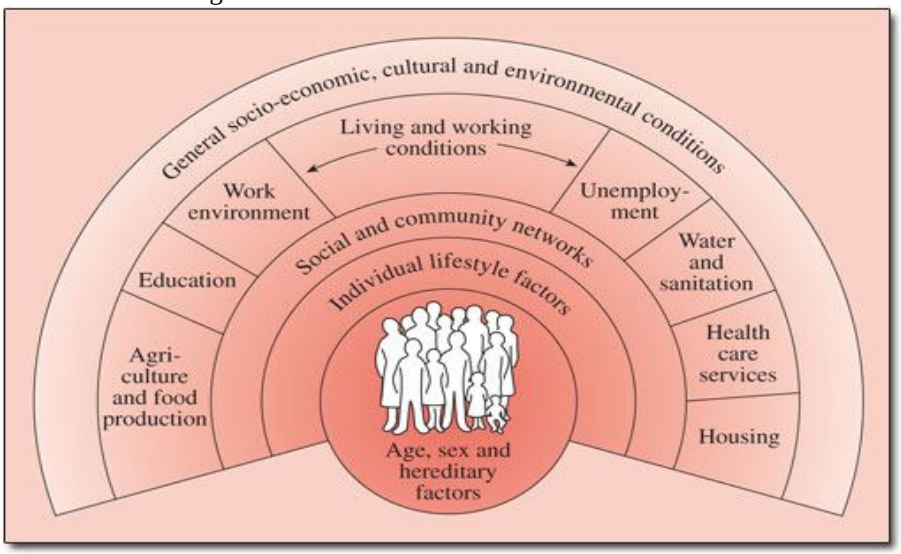
These factors have implications for the future demand of many public services, including healthcare services (Latham and Prowle 2012).

Achieving increased efficiency and productivity
One of the key themes in many countries, for several decades, has been government attempts to improve the efficiency and productivity of healthcare service provision. There are many ways of approaching this and different combinations of approaches have been implemented. Nonetheless, it is possible that the "easy options" for improving efficiency and productivity in healthcare systems have now been exhausted and new, more innovative approaches are needed. Thus a key challenge is identifying and implementing such approaches.

Increasing patient expectations and pressure for accountability
For a variety of reasons, in the aftermath of certain scandals, there has been increased dissatisfaction about healthcare services in some countries. Although there are many aspects and causes of this dissatisfaction, it is clear that two important issues are increased expectations by patients about what healthcare services can provide, and concerns about the way in which public healthcare resources have been used. This creates a challenge for public services in meeting raised expectations and providing assurance on the use of public funds.

Other non-health factors
In their influential work, Dahlgren and Whitehead (1991) argue that the health status of a country's population is affected by a wide range of factors, as illustrated in Figure 3.1 below.

Figure 3.1 Social, environmental and personal factors affecting the health of individuals



Leaving aside the age, sex and hereditary factors, which are uncontrollable, and lifestyle factors, which are controllable only by the individual, there remain a range of other important factors, including housing, education, and poverty. The challenges facing the health status of many countries today derive from what might be called non-health factors. Many countries suffer problems such as poor physical infrastructure, poor standards of literacy and high levels of poverty, all of which affect health status. Also, in many parts of the world, war and societal conflict lead to high levels of disruption and population movements, all of which contribute to poor health status.

Economic performance

The Great Recession of 2009 resulted in a situation whereby many countries entered economic recession (involving a contraction in domestic economic output) or suffered a reduction in previous high levels of economic growth. As a result of recession, many countries have found it difficult to finance their public expenditure programs from current tax revenues and have had to resort to high levels of borrowing, which are unsustainable in the longer term. Subsequently, this has led many countries to implement austerity policies involving increases in taxation and lower levels of growth or even reductions in public spending. These policies have had implications for the healthcare budgets of those countries.

In recent years the economic conditions in these countries have improved and the extent and the levels of government borrowing, while still high, are

lower than in previous years. However, the economic situation is uncertain and there may be difficulties in returning to, and sustaining, pre-recession levels of economic growth. This has implications for future levels of public spending and consequently the health budgets of many countries may continue to be constrained for many years to come. This, of course, is happening at the same time as an increase in demand for services and the other challenges referred to above are taking place.

4. Findings of the Study

Existing healthcare system configurations

This study looked at the configuration of healthcare systems in relation to:

- healthcare service provision:
  - hospital care – secondary and tertiary
  - primary care, and
  - other healthcare services.
- commissioning and planning of healthcare services.

In most countries the government is the dominant provider of hospital care. While there is usually a private hospital sector running alongside the public hospital sector, the size of the former is never very large and varies considerably between countries. An exception to this position is the US, where publicly owned hospitals are but a small proportion of the total and are also closing at a much faster rate than hospitals overall and so the situation is constantly changing.

In general, the private healthcare sector in most countries tends to be a mix of not-for-profit and for-profit organizations, with the proportions of each varying between countries. Here the history of the nation is important, particularly the influence of religious orders that originally provided, and in some cases continue to provide, services. In some countries (e.g. UAE), there seems to be considerable growth in the private hospital sector, mostly to provide care to the large "ex-patriot" population in the country. Also, in some countries, there are examples of what might be termed an "informal" private healthcare sector whereby government healthcare sector employees provide some care for payment (possibly using government facilities and resources) in a manner that raises questions of legality and ethics.

Private hospitals can perform two main roles, they:

- provide healthcare services to private patients who pay via health insurance or self-payment.
- provide healthcare services, paid for by government, to non-private patients.

There are various models of this approach.

The first role is the traditional role of the private hospital sector but the second role is also important. In the US, large volumes of healthcare services are provided by private hospitals but paid for from government funds through Medicare and Medicaid. In other countries (e.g. England, Australia) there are often models whereby patients can have treatment paid for by government but provided by private organizations, although not in the majority of cases where public provision is available. In certain countries such approaches are not favored and seem unlikely to grow.

A different picture emerges with primary care. In some countries, all primary care staff are employees of the government while in others primary care is provided by private sector organizations, although the care is ultimately financed by the government. Different models were seen to operate in the study. For example, in the UK, private primary care practice is paid for by the government on the basis of a national contract for service (i.e. the patient does not pay) while in Australia the patient has to make a payment for service to the private primary care practice but then claims reimbursement of that amount from the government. A third situation is where the patient chooses to go to a private primary care practitioner and pays out of personal resources. A further interesting feature is the role of primary care practitioners, be they public or private. In some countries, they act as a "gatekeeper" to the hospital sector and patients must first be seen by a primary care practitioner before any referral to a hospital. In other countries, a patient has in effect a choice of going to see a primary care practitioner or going straight to a hospital-based practitioner.

Many study interviewees placed great emphasis on the importance of preventative measures as a means of reducing the incidence and prevalence of avoidable diseases. Nonetheless, it was difficult to find evidence of a significant investment in, or alternatively a successful major outcome from, such an approach.

In the English healthcare system, a clear distinction is drawn between organizations that plan and commission healthcare services (Clinical Commissioning Groups) and those that provide such services (National Health Service Trusts and others). While it is unusual, in most countries, to find such a formal divide between commissioning and provision of healthcare services it appears that many of the functions of healthcare planning and commissioning are carried out, to some extent, by government itself. In countries where there are two tiers of government (e.g. State and Federal) it is usually the lower tier that has responsibility for planning and commissioning of health care while the upper tier is more concerned with national priorities and the provision of funding for health care. Where there is a single tier of government then these roles fall to the relevant government health department.

A controversial topic among those questioned in the present study was the extent to which market competition exists within healthcare systems. Such competition can be among hospital providers, primary care providers or even commissioners. While price competition did appear to exist in some areas, in others the competition was primarily based around the quality of services, which understandably is of more interest to service users, especially if they do not have to fund treatment directly. Another monopolistic concern was situations where patients requiring specialist treatment may be faced with a single provider in their country. It is often thought that the large private healthcare sector in the US must lead to strong price competition but this does not seem to be the case. Some skepticism was expressed about the degree of real competition in US hospitals – this point has been reinforced by an article in *The Economist*, which states: "At the core of America's problems with health care is a great delusion: it likes to think it has a vibrant private marketplace. In fact the country has long had a subsidy-laden system that is the most expensive and complicated in the world, with much of the government cash going to the rich, millions of people left out and little individual responsibility" (*The Economist* 2014).

Existing healthcare system financing methods

As mentioned in Chapter 2, most healthcare systems are funded by one or more sources of finance:

- the proceeds of taxation
- charges to service users
- social health insurance
- private health insurance
- charitable funding.

The study shows that the funding of healthcare services is normally dominated by government. In most countries, the primary source of healthcare finance is from the proceeds of taxation levied by government and this funding may be used to finance publicly provided health care and/or, in some cases, privately provided health care. In the UK around 90% of the cost of the National Health Service is directly met by government from the proceeds of taxation. In some other countries, even though the services are financed through some form of health insurance scheme, some or all of the insurance cover is provided by a government-managed health insurance scheme. Examples of this arrangement include Ghana and UAE.

In some cases the health insurance scheme appears to have many of the attributes of a tax, with the premiums being based on income levels and not health risk which is the basic principle of insurance. In Germany the compulsory element of the scheme is based on a percentage (currently 7.3% to

15.5%) of salaried income and is paid for by the employer rather than the employee. Even in the US (which is often thought of as purely a private healthcare system) the government, at both Federal and State levels, is a major contributor to the financing of healthcare through the Medicare and Medicaid programs, which represent some 62% of total aggregate inpatient hospital costs in the US.

In some countries, such as the UK and Canada, the only health insurance schemes are private schemes used largely to finance private health care but in other countries a range of insurance schemes exist. Such schemes may combine a compulsory and a discretionary element and may be government-based or private.

While charging for services is the significant source of income for the private health sector, public healthcare organizations also receive income by levying charges on indirect services, such as charges for drug prescriptions and use of car parks. The levying of charges for direct healthcare services is, however, a controversial issue in some countries.

In developing countries such as Malawi the aid funding obtained from donor countries is often critical to the continued operation of the healthcare system.

Challenges facing healthcare systems

The study assessed these challenges by examining the answers provided to a questionnaire issued to interviewees following their interview (see Appendix).

(i) Financial and economic austerity

Question: Has the climate of financial and economic austerity over the last few years had an impact on the provision of healthcare services in your country?

Major consequences	Considerable impact	Moderate impact	Little impact	Total
18%	46%	27%	9%	100%

This suggests that almost two-thirds of respondents identified the impact of austerity as having major consequences for, or a considerable impact on, the provision of healthcare services in their country. Discussions with interviewees revealed that financial and economic austerity had affected such services in their countries in different ways.

• In some countries, as already noted, the impact of the economic recession led to a need to borrow large amounts of money to finance public budget deficits. This situation was untenable and countries were forced to make large scale reductions in public spending to reduce deficits and borrowing

levels. This "austerity" affected countries in different ways, depending on the degree of protection given to health care by the relevant governments/ funders.
• In some cases, the economic slowdown that had led to the onset of financial and economic austerity in public services also resulted in other factors such as rising unemployment, reduced incomes, higher levels of taxes, etc. In turn this had implications for the demand for health care and the ability of people to pay for that care in cases where some form of payment was necessary.
• In developing countries, it is often the case that healthcare services rely significantly on overseas financial aid to support operating budgets. In some cases, austerity in donor countries led to reduced levels of financial aid, with consequent impact on the healthcare system of the country.

(ii) Other challenges
Question: What do you think is the relative importance of the following possible challenges facing the healthcare system in your country in the foreseeable future?

	Very important	Important	Unimportant	Very unimportant	Total
• Limited growth in financial resources	63%	37%	–	–	100%
• Ageing populations	63%	18%	19%	–	100%
• High levels of preventable illnesses	63%	37%	–	–	100%
• Inability to recruit staff	37%	63%	–	–	100%

This suggests that a continuation of limited growth in funding is seen as a key issue in all the countries surveyed. Given the nature of financial austerity and the fact that, in all probability, it will continue for many years to come, this should not come as a surprise.

The prevalence of high levels of preventable illnesses is also seen as an important issue. One interviewee commented: "There is a lot of movement to increase quality, to try to prevent disease from occurring and a lot of criticism that we don't treat disease early enough, we wait until it hits an acute care stage and then we try to treat it when it's too late."

Nonetheless, the same commentator echoed the view that the key problem with preventative health care is its lack of proven effectiveness in all settings. He said that effort is required to: "come up with new financing mechanisms

to reward people for catching these diseases earlier and preventing the acute phase, etc. None of that has proven to be very successful yet. There's a lot of experimentation going on but I would tell you that there are physicians in hospitals who are very skeptical of the ability of our government to do that. And while everybody is making efforts to do it, there is a high degree of skepticism as to whether or not that's going to work out as it's supposed to work."

An ageing population was also seen as a big challenge by interviewees in the majority of countries surveyed, although in developing countries it is not such a problem because of the much shorter life span of people, coupled with high fertility rates. One interviewee described the challenge of ageing populations thus: "I think the main problem is when the population is ageing, people are living longer, and it's putting more and more pressure on the system to deliver. And in fact we know that there's no way that we can deliver in the same way until we radically change our approach. I think the answer is not ask your next generation to look after you, it's [for] our generation [to] look after ourselves, look after each other. And I think with the ageing population that's the only solution."

Inability to recruit staff to work in healthcare services was also seen as important. There could be a number of reasons for this, including competition between hospitals to recruit scarce staff (leading to wage inflation) and a loss of specialist staff to other countries.

In addition to the above challenges, certain interviewees voluntarily suggested certain other challenges that they believed were important within their own country. These included:

- inflexible labor markets, affecting healthcare provision
- inadequate governance arrangements in the healthcare sector
- lack of IT investment in health care
- the need for cultural respect in providing health care
- large inequalities in health care provision
- high dependency on overseas aid
- high fertility rates driving up costs of health care
- misalignment of care provision with need, and
- poor access to care by some communities.

As these challenges were volunteered by individual interviewees, it is not clear how generally applicable they are among countries generally. Even so, from the content of the interviews it would appear that some of these challenges occur in several of the countries surveyed, especially the misalignment of care provision, poor access to care, widespread inequalities and inadequate governance arrangements (including those for fraud prevention).

(iii) Possible changes to the configuration of healthcare systems

At the outset, respondents were asked how appropriate they thought the configuration of their healthcare system was to the challenges raised.

Question: How would you assess the appropriateness of the current configuration of health services in your country in dealing with those challenges?

Very appropriate	Appropriate	Inappropriate	Very inappropriate	Total
–	45%	37%	18%	100%

Over half the respondents indicated that the current configuration of their healthcare system was inappropriate (or very inappropriate) and therefore, in need of change. The questionnaire also asked respondents to consider the likelihood that different kinds of change would be made to the current configuration.

Question: What do you see as the likelihood of the following changes being made to the configuration of the health system in your country?

	Very likely	Likely	Unlikely	Very unlikely	Total
• Some form of administrative restructuring and or re-organization of the healthcare system	63%	28%	9%	–	100%
• Greater decentralization of the healthcare system by government	9%	37%	45%	9%	100%
• Increased market competition for funds among healthcare service providers	9%	63%	28%	–	100%
• Expansion of the private healthcare sector	28%	36%	28%	8%	100%
• Involvement of the private sector in the provision of public health care	55%	18%	18%	9%	100%

Over 90% of the respondents indicated that they anticipated that some form of administrative reduction and/or reorganization of the healthcare system would be likely (or very likely) to be undertaken in their country. Commentators on healthcare systems might view this situation with a degree of skepticism on the grounds that it is not addressing the root causes of imbalances within the healthcare system. A majority of respondents further stated they did not anticipate that such a change would involve greater decentralization of decision making to lower tiers within the healthcare system.

Another proposed change was the increased use of market competition in the healthcare sector, given that some respondents believe their healthcare

systems are often driven by provider interests rather than patient interests. The survey suggests that developments in this area are likely and in certain countries are already taking place (e.g. Australia, Canada and England). An important and related feature is the separation of the commissioner function from the provider function and the development of activity-based funding whereby health providers are funded according to the volume (and perhaps quality) of work they undertake.

Overall there appears to be a strong view, among interviewees that there is an enhanced role to be played by the private sector in providing health care to private patients but also, and perhaps more controversially, in providing health care to non-private patients within the publicly funded healthcare system. This could take many forms, as seen in England with the use of Public Private Partnerships (PPPs). Some countries appear to be undertaking such developments enthusiastically while others are much more cautious and are taking things slowly. An example of the former is represented by the following comment: "The emerging trend is to have private operators of public hospitals. So we will own the real estate as it were and then we will contract with the private sector to deliver services. And we've just run a tender for another new hospital, a 700-bed teaching hospital, and we actually ran a tender for the private sector to run the whole show."

Only one interviewee volunteered the view that a possible change to the configuration of the healthcare system was a major re-design of health care delivery systems. The study indicated that there was little support for fundamental change in the way in which healthcare services are provided, which was especially surprising in the light of austerity and other challenges. This does not mean, of course, that such changes are not being considered but they did not appear to be at the forefront of thinking of most of those questioned.

(iv) Possible changes to the financing of healthcare systems

The questionnaire asked whether the methods of financing healthcare systems were appropriate for tackling the challenges raised.

Question: Do you think the existing approach to financing healthcare services in your country is financially sustainable in the longer term?

Definitely	Possible	Unlikely	Impossible	Total
9%	27%	55%	9%	100%

Only 9% of respondents indicated that the existing approach to financing health services in their country was definitely sustainable in the longer term, while 64% stated that it is unlikely or impossible. This is quite a strong finding which brings into doubt the viability of most financing systems across the globe.

When the questionnaire asked what the respondents saw as likely changes to the methods of financing healthcare systems in their countries, the following picture was observed.

Question: What do you see as the likelihood of the following changes being made to the financing of the health system in your country?

	Very likely	Likely	Unlikely	Very Unlikely	Total
• More revenues from government	–	36%	55%	9%	100%
• Introduction/extension of health insurance	27%	27%	46%	–	100%
• Introduction/extension of charges to service users	9%	55%	27%	9%	100%
• A drive for efficiency improvements	82%	18%	–	–	100%

Not surprisingly, given the impact of financial and economic austerity referred to earlier, a large majority of the respondents do not see additional government revenues as a solution. Many countries already fund their healthcare systems through some form of health insurance but there are huge variations in the types of insurance scheme involved. Some schemes are voluntary while others are compulsory and still others have a minimum compulsory level of insurance with a voluntary top-up to cover a variety of items. Health insurance schemes may be provided by the government or by the private sector or a combination of both. When health insurance funding models are mentioned, many members of the general public (including many Americans) point to the US health system as a reason that health insurance schemes are not a good approach given the tens of millions of people who are uninsured. This study suggests, however, that health insurance schemes work satisfactorily in many countries. Nonetheless, some of these schemes are not true health insurance schemes (with the cost of cover being linked to the risk) and are instead a form of taxation where the proceeds of the tax are earmarked for the funding of health care.

Those questioned held a strong view that the extension of charges to service users was a likely change to the financing methods of healthcare systems. While a large variety of charges are already levied on services users (e.g. charges for car parking and drug prescriptions) the levying of co-charges for the receipt of direct healthcare services is a more controversial issue. In many healthcare systems there are already co-charges levied for both primary and secondary hospital care but in other systems such a development would be new and controversial. Clearly, there are many concerns about the intro-

duction/extension of charging for health care, not least the impact on poor people and the administrative tasks of collecting the revenue.

There was an identified consensus among interviewees from all countries surveyed that a key issue for governments would be initiatives to improve performance in their healthcare systems. Whether this should be centrally driven or achieved through devolved decision making was unclear, as were the prospects for success. It was argued that, too often, efficiency improvement initiatives seem to be the last resort for politicians. Some commentators suggested that such improvements will come only from transforming healthcare systems through a process of disruptive innovation, but such processes may be unpalatable to politicians and the public.

Interviewees identified other changes to their healthcare systems that they stated were likely, but these changes seemed largely concerned with the internal allocation of funds within the healthcare system itself. Such changes included:

- a greater focus on quality measures when allocating funds
- changes to models used to allocate funds in devolved administrations, and
- realignment of care patterns through changes in internal financing mechanisms.

Effecting the changes needed

This chapter has outlined the need for changes to be made to the configuration and financing of healthcare systems as a consequence of financial and economic austerity and other challenges. Identifying desirable changes is important but implementing and effecting those changes in a healthcare system is often a very difficult task.

A former UK Chancellor of the Exchequer (finance minister), Nigel Lawson, once commented that the National Health Service is the nearest thing the British have to a national religion. One commentator on this stated that: "It is a helpful phrase because it explains why politicians must always approach NHS reform with fear and trembling. If the public come to think of them as blasphemers against the faith, they are, to use a non-theological term, toast" (Moore 2011).

The suggestion being made is that the British are simply too heavily invested emotionally in the National Health Service to change it too much, too quickly. While this might be an extreme example, it does seem that outside non-democratic or authoritarian democratic countries, there is always likely to be much resistance from many quarters to any changes to a centrally provided healthcare system. One interviewee illustrated this with the following comments: "I think health is a very politically sensitive issue for any country. It's just [that] health is something that everyone is concerned about and so this is the nature of the sector. So I think we can't get away

from all these bad headlines. What we hopefully will get away from is politicians making changes to the health sector without necessarily helping the sector."

Another interviewee from a different country commented: "I think we have problems of pulling resources, integration, decentralization, so those are the things that the government is already working on. So I don't see any complete change in the healthcare policies, at least in the near future."

A third interviewee stated: "One of the most unattractive positions, of course, is to be the Minister of Health, where they try to implement all sorts of reforms and they always fail."

As part of the study, the questionnaire asked respondents to indicate what level of resistance to change in the healthcare system was posed by a variety of factors.

Question: What do you see as the level of resistance posed by the following factors in relation to changes in the organization or financing of healthcare services in your country?

	Very high	High	Low	Very low	Total
• Public opinion	55%	27%	9%	9%	100%
• Medical and nursing staff	9%	64%	18%	9%	100%
• Employees	19%	36%	36%	9%	100%
• Media opinion	18%	55%	18%	9%	100%
• Lack of financial resources	55%	27%	9%	9%	100%

Apart from the lack of financial resources it is clear that, in line with earlier comments, public opinion was seen as one of the most significant factors posing resistance to change, supported by resistance from health professionals and the media, which influence public opinion. Strong resistance was also caused by the lack of financial resources, which suggests that it would have been better to have tried to implement the necessary changes to healthcare systems before the onset of austerity.

Other factors identified in the interviews as resistors to change in healthcare systems were:

- a lack of consensus among politicians about the nature of changes required
- the influence of private economic interests in the country, and
- bureaucratic interests in maintaining the status quo ante.

Overcoming these resistances to change is a formidable task with no simple solutions. Two factors seem to present themselves – one technical and one political. The technical factor concerns the organization of the change process within healthcare systems – it is not always done well. One interviewee commented: "…and that's one of the biggest problems in my country, that

there is no central body…or mandate…for directing changes or reformation or whatever."

Similar comments were made by other interviewees.

The lack of political consensus over healthcare reform is also a major barrier. There is a strongly held view that, because of the high priority given to healthcare policy by electorates, politicians use "health" as a political football for scoring points against their political opponents, rather than focusing on what needs to be done. Several calls have been made by politicians and academics for a better degree of consensus about healthcare reform (Prowle 2012).

5. Discussion of Study Outcomes

This section looks at cross-cutting themes that had resonance in several countries.

The role of preventative health care

In many countries there are concerns about the high levels of morbidity and mortality that would be easily preventable through changes in the lifestyles of individuals. This is recognized by politicians, and policymakers who often talk about the need to transfer resources from caring and curative services towards prevention services. In practice, progress in this area usually seems limited and there are probably a number of reasons for this.

The first is an inability to persuade individuals to change their lifestyles in order to improve their health (e.g. stop smoking, reduce alcohol consumption, reduce weight). Various approaches have been tried but with mixed degrees of success. Perhaps the key issue to consider here is the balance to be struck between providing incentives to individuals to change their lifestyles (as the UK government is considering through the provision of healthy food shopping vouchers for those who lose weight) and the imposition of sanctions on people who do not make such changes. The second reason concerns funding mechanisms, given that preventative services often require up-front funding to initiate them, although there will be the expectation of downstream savings.

The role of the private healthcare sector

In virtually every country, there is some form of private healthcare sector that provides healthcare services to private individuals in return for payment, either directly or through a private health insurance scheme. Inevitably there will always be political discussion on the appropriate size of the private healthcare sector, but of more interest to policymakers is the role of the private healthcare sector in providing health care to non-private patients.

In theory there are advantages in using the private healthcare sector for this purpose, including the use of spare capacity in the private sector at lower cost and the exposure of public health care providers to market competition. There may also be disadvantages, however, not least problems that arise when profit motives conflict with public service equity considerations. In some countries, such as England, there is a significant involvement of the private healthcare sector in publicly financed health care, and other countries are experimenting with this idea. In some countries such an approach is strongly resisted, possibly on political grounds. It is important that the approach to be adopted is considered on its merits and not on the basis of an ideological position.

Finding additional resources for health care

Public demands for more healthcare resources are usually incompatible with the requirement to save money in a period of austerity. It must be recognized that existing health care funding mechanisms were often developed a long time ago and are no longer appropriate in the modern world. Thus there needs to be a greater degree of open-mindedness and debate about alternative mechanisms for funding healthcare, and countries facing this situation should consider the lessons learned by those countries that have already tried new methods.

Inappropriate healthcare delivery systems

As with funding mechanisms, it is often the case that existing healthcare delivery systems were developed many decades ago and are no longer appropriate. Thus open-minded consideration is again needed when re-designing such arrangements.

The need for better political consensus on health care

The study further highlighted the need for better political consensus on healthcare policy, across political parties. This would have the added value of replacing short-termism with a longer planning timespan. The themes highlighted above all require substantial changes to be made to existing healthcare systems and this is difficult to achieve in the short term. The task will be made far worse if healthcare policy continues to be a political football (as it is in many countries) and opposition political parties block desirable changes in return for short-term political advantage.

6. Conclusions Reached

The merits of a particular healthcare system can be judged by a number of criteria, namely:

- quality
- efficiency
- acceptability, and
- equity.

Looking at the healthcare systems reviewed above, there are examples of systems that might be regarded as unbalanced in relation to these criteria. For example, the US healthcare system scores very highly in relation to quality, but many commentators argue that it scores badly in relation to equity and efficiency. On the other hand, the healthcare system in a developing country such as Malawi might have limitations in relation to care quality and equity between different parts of the population, but probably does quite well on efficiency given the limited resources available. In yet other healthcare systems there seems to be a better balance between these four criteria. Given the different requirements and structures of different countries it is not surprising that a single "one-system-fits-all" approach is not tenable.

This research has identified that in the countries reviewed the impact of financial and economic austerity has been significant. Moreover, in spite of the variety of healthcare systems to be found in those countries the impact of austerity over the last few years, linked with an increasing demand for healthcare services, suggests that existing systems are unlikely to remain sustainable in the longer term.

Possible ways of dealing with the impact of these external drivers would, by and large, have significant implications for existing healthcare systems. The problem is that in non-authoritarian democratic countries there is likely to be much resistance to any such changes. Thus perhaps the key message is for politicians and healthcare managers and professionals in those countries to devise ways of communicating the essential need for such changes and the means by which they should be implemented.

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Annex

Research approach

Research methods

The research methods adopted for this project are set out below.

(i) Review of relevant documentation

An initial review was undertaken of available documentation describing the healthcare systems of various countries. This has involved, for instance, government documents, reports from international bodies and academic commentaries.

(ii) Structured interviews

Using a video conferencing system, structured interviews were conducted with informed persons from various countries. Usually the person involved was either a finance professional working in the healthcare sector of a particular country or an academic commentator working in the healthcare field. Each interview lasted about 60–80 minutes and broadly followed the format shown below.

- The role and background of interviewee were obtained.
- There was discussion about how the healthcare system of the country was configured.
- There was discussion on the methods financing the healthcare system.
- Interviewees were asked what they saw as the strengths/weaknesses of the current healthcare financing system in the country.
- Interviewees were asked about any recent or planned major changes to the configuration or financing of the healthcare system.
- Interviewees were asked about current challenges to the healthcare system and how they are being addressed.
- The impact of financial austerity or economic slowdown on healthcare and other public services in the country was examined and the possible implications for healthcare financing were raised with interviewees.
- Interviews included discussion about public attitudes towards change in the country's healthcare system.
- Lessons to be learned from the country's experiences were identified.

The interviews were dynamic in nature and interviewees were asked supplementary questions and asked for clarification on certain issues. The recorded interviews were transcribed and analyzed systematically. In most cases both researchers took part in the interviews to enable triangulation of interpretation and assist the reflection process.

Before the interviews took place, the interviewees were also asked if they could supply some additional background information about their healthcare systems so that this would inform the interviews.

(iii) Issue and analysis of questionnaires

Following the interviews, each interviewee was also asked to complete a short questionnaire about the issues raised. The tables reproduced in Chapter 4 are based on the format adopted for the questionnaire. The aim was to clearly establish, in a more quantitative manner, their opinions on certain issues. The questionnaires were returned and subsequently analyzed.

(iv) Choice of countries

The choice of countries incorporated into this research was, to some degree, determined by the availability and willingness of particular individuals to be interviewed as part of the research. Nevertheless, an attempt was made to obtain a cross section of different countries, as shown below.

	Country	**Continent**	**Type**
1	England	Europe	Developed
2	France	Europe	Developed
3	Germany	Europe	Developed
4	US	North America	Developed
5	Canada	North America	Developed
6	Australia	Oceania	Developed
7	New Zealand	Oceania	Developed
8	Ghana	Africa	Developing
9	Malawi	Africa	Developing
10	Abu Dhabi	Asia	Middle income
11	India	Asia	Middle income

The research study has covered eleven countries from most continents on the globe (the exception being South America where the lack of Anglophone interviewees and willingness to participate were a problem) and also countries at different stages of economic development. It is not intended that this limited number of countries can give an accurate picture of the global situation of healthcare systems but those involved do give interesting perspectives on a range of cross-cutting issues, which were prominent and formed clear themes.