

Healthcare Delivery System in Developed, Developing and Underdeveloped Countries

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Abstract

The healthcare system refers to the way of treatment and policy which more than just medicine and doctors. In this regard, the developed nations rely on traditional medicine health care system model which engages doctors, nursing staff, pharmacists, and healthcare experts and professionals to deliver medicines and surgeries to provide individuals with health care services. Holistic medication or Naturopathic emphasizes the overall wellbeing and treatment of an individual. The developed countries invest a reasonable amount of their budget to their healthcare system. However, the developing and underdeveloped countries lack resources as compared to developing nations. As a result of inadequate resources, the developing and underdeveloped nations do not allocate required resources in their health sector which affects the overall health of the population at large scale regarding life expectancy, infant mortality rate, maternal mortality rate, prevention against diseases, and the crude death rate.

Introduction

Every country in the world has the healthcare system. In this regard, some of them have a more complex system as compared to other. Most developed countries such as U.S. Canada, Britain, Singapore, Germany, France, and Australia invest more in healthcare and try to address the basic health needs of their populations (Stoddart & Evans, 2017). On the other hand, the developing and underdeveloped nations struggle to provide their people with effective medical services. Further, the infrastructure of the countries also matters. This suggests that the overall environment, ideas, processes, basic structure, and the government's policy play a vital role in delivering health care services to patients (Marvin et al., 2015). In most of the developing and underdeveloped nations, the condition of the rural areas is not up to the mark, and people do not have access to fundamental rights. That is why in case of any medical emergency, they are unable to find appropriate services nearby, and by the time they reach any big hospital in the major city, it's sometimes too late for them.

During the last 15 years or so, there has been a lot of debate on the overall global health policy. The global health includes the organizations, institutions, and the total resources (financial and human) linked to provide health care services that cater the needs of the total population (Zhang et al., 2010). It is significant to focus on the low and middle-class countries because such countries need external funding for disease programs particularly for medicines and to develop the overall health infrastructure in these countries (Acharya et al., 2017). Therefore, *the fundamental difference regarding healthcare delivery system among developed nations, developing, and underdeveloped nations are of resources which include funding and basic infrastructure of health.* In this paper, the health systems of developed countries such as Britain, Canada, and the U.S, Singapore, France, Australia, and countries with medium and low income will be considered.

Healthcare systems in developed countries

Canada and Britain

Both the countries have adopted a single-payer system. However, there is a difference in the overall government's role and policies in terms of covering people. In Canada, the government funds health

insurance, and the private sector also provides a lot of care services (Gatrell & Elliott, 2014). Also, insurance is administered at the province level. In this regard, many Canadians have additional private insurance through their employment to pay for drugs, dentists alongside optometry. The government pays for almost 70% of the overall healthcare expenditure.

Britain has purely socialized medical services: Not only does the government fund care but also developed National Health Service (NHS). The overall coverage is wide, and most of the services are free of cost to the population. The government funds the system through taxes, although there is a private system which runs with the overall public system. In this regard, almost ten percent go for private insurance.

The government accounts for almost 80% of the total healthcare spending. In terms of healthcare, U.S. equivalents are Medicare which is similar to that of Canada and the Veterans Health Administration like Britain to a more significant extent. Canada and Britain have many similarities as far as spending is concerned. Both of the countries spend ten percent of their GDP on the healthcare system. The quality of healthcare is also up to the mark in both the countries. However, both the states are not on top in terms of international comparisons. Also, in Britain, people have easy access to health care services, often they do not have to wait long. The outcomes of the facilities are excellent. Also, in Canada, usually patients have to wait for extra, and some patients had to wait more than four months for elective surgery, and that is why it proves to be an inconvenience for them. Further, there has been a burden on National Health Services of Britain, but still, they ensure that patients do not have to wait longer.

United states

The healthcare system of United States comprises of different ideas which include private insurance via employment; single-payer Medicare primarily for the older population aged 65 or more; state-administered Medicaid for certain low-income people; private insurance launched by Affordable Care Act (Squires et al., 2015). Also, almost 28 million people are without insurance. Further, there are private hospitals.

Singapore

The healthcare system of Singapore is based on a unique approach. The primary care in the wards of the state-run hospital is affordable, and sometimes free of cost, with more care in private rooms which are available for those paying additional amount. Besides, the working class of Singapore contributes to about 37 percent of their income to mandatory saving accounts which are spent primarily on healthcare, education, and other welfare projects. The government helps in controlling costs. Also, the government makes decisions about investing in new technology. Further, through bulk purchasing strategy, the government spends less on drugs, manages the total number of medical students alongside doctors in the country, and they regulate their pay. The overall system of Singapore is economical (Bai et al.). Generally, it is believed that in terms of small amount spending, Singapore provides quite good care to their citizens while others believe that quality is not the same at all level as there are differences in providing services for rich and those not so affluent (Khoo et al.).

France

The country provides extensive services in comparison with much other healthcare delivery systems. In this regard, it is mandatory for everyone to buy health insurance in France which is sold by small non-profit organizations, they are normally financed through tax. In this regard, seventy to eighty percent of costs are covered by Public insurance. The remaining cost can be covered by Voluntary health insurance, and in this way, the out of pocket payment is considerably low. In France, almost 95% of the population is covered by voluntary coverage. The Ministry of Health allocates budgets and funds. Through these budgets and funds, the number of hospital beds is funded, and the purchasing of equipment is decided. Also, the medical students are trained as a result of those funding. The ministry determines prices for procedures and the medicines. Overall the French System is relatively expensive with 11.8 percent of G.D.P. However, if anything is not covered, then patients need to pay that out of their pocket. Many doctors are self-employed,

work in different groups. Most of the hospitals are public. Also, 85% of the outpatient services are paid by the government.

Australia

Inpatient care is provided free of cost in Australia in public hospitals which includes accessing medical services and prescription medicines. The voluntary private health insurance system is also in place which provides people with access to private hospitals, and some services that are not covered by public system (Duckett, & Willcox. 2015). In this regard, almost 85 percent of the outpatient services are paid by the government.

Switzerland

The country has a universal healthcare system. It is mandatory for everyone to buy insurance. To a larger extent, the plan is similar to that of United States under the Care Act which is offered by private insurance companies with prices changing by things like such as facility of consulting a specialist (Wilson et al., 2016). The subsidies are offered to almost 30% of the people. These plans are offered on a non-profit basis.

Germany

The vast majority of Germans which are 86% of the total population receive their coverage through the national public health system while others choose voluntary private health insurance. In this regard, most premiums for the public system are obtained by income paid for employees and employers. For the amount, subsidies are available, but there is a cap on the income of \$65,000 (Mossialos et al., 2016). The patients have plenty of options as far as doctors and hospitals are concerned, and the overall cost sharing is not high either. The cap is for low-income people, which is minimized for those with a serious disease and chronic conditions. Also, there is no subsidy for private health insurance; however, the premiums are regulated by the government which can be high for people with prior conditions. Many physicians do the job in a fee-for-service environment which is based on variable rates. In this regard, there are certain limits as to what they can be paid annually.

Health care situation in developing and underdeveloped countries and comparison with developed nations

During the past 15 years, there has been a lot of discussion regarding global health services. The discussion highlights the significance of health care systems, which comprises the institutions, resources, and organizations. In this regard, the recent analysis draws public attention to the shortcomings in health-care system in low- and middle-class income countries such as in the 75 countries that record for in excess of 95% of child and maternal deaths, the average percentage of births attended by professional health worker is just 62% (10%-100%) (Van Der Wees et al., 2014). In this regard, women without funds or coverage for such service have fewer chances to obtain it as compared to the women who have resources to pay for that.

Further, inadequate financial protection for healthcare costs indicates that almost 100 million are living below the poverty line every year through payments for health care, and many more will not get care because they do not have enough funds. In reaction to such shortcomings in the overall health care system, the countries and their allies in development have been employing new strategies for financing and delivering healthcare systems. There are some structural level deficiencies in the system in middle and low-income countries. Some responses have led to a controversy which includes the question that should one pay for health care through general taxation or contribution funds for the betterment of financial protection regarding particular sections of the citizens? Should financial incentives be given to improve healthcare and quality or to empower the private sector to maximize the access of the overall healthcare approach? In this regard, there is considerable literature on the overall flaws in healthcare systems and on the database of the health system.

Also, the poor quality and sluggish coverage of evidence to improving the overall healthcare systems refer to shortcomings of individual counties strongly impact decisions regarding which strategies can be relevant and their overall outcome. Therefore, any generalization made through health system research in specific countries must be closely analyzed. It cannot be the case to have a single blueprint for the best healthcare system model or some remedy that could improve all the weaknesses in the system ("Health Care Systems in Low- and Middle-Income Countries | NEJM," 2018). The improvement in healthcare systems in low and middle-class income counties must be considered a long-term development process.

Averagely, about half of the healthcare financing in low-income countries is obtained from the pocket of the people in comparison with 30% in the countries with medium-income, and 14% high-income nations. The following figure shows the trend of spending in developed, underdeveloped and developing countries.

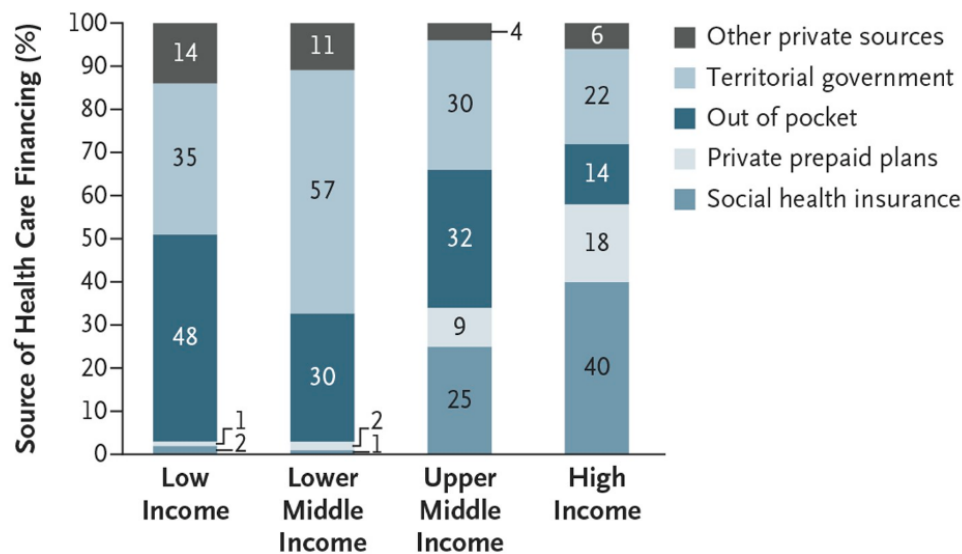


Figure 1. Health Care Systems in Low- and Middle-Income Countries | NEJM," 2018

When finances from government expenditure, social insurance, and pre-paid private insurance are pooled, just 38% of healthcare funds in countries with low-income is gathered in all the funding, which yields the risks of healthcare costs to be divided among population groups in comparison with almost 60% in middle-income nations and 80% in countries with high-income. Therefore, the major financing problem for countries with middle and low-income is how they provide financial assistance for families. The section of the population in employment, in which governments can levy taxes, may be included in social insurance arrangement.

Healthcare situation in philippine, vietnam, rwanda, ghana, latin america, and india (discussion)

It is widely acknowledged that the poorest people need a full subsidy for health care costs from taxation; also, the households with low earnings require at least part subsidy. The main question is those who are not among the poorest, should they be covered through funds raised by taxation policy or should they be motivated to register in insurance programs. The issue has gained a lot of attention regarding the financing of universal coverage in Southeast and South Asia. In this perspective, The Philippines and Vietnam, have looked to broaden financial assistance by motivating voluntary registration in social health insurance plan, while the countries like Thailand have utilized funds out of the general taxation that is channelized to Ministry of health or local health administrations (Primeau, 2016). Further, the report from the Group of Universal Health Coverage by Indian Commission to design a plan for implementing universal health

coverage throughout India until 2020, suggested channelizing significantly more funds through tax revenue policy to broadly public providers with the help of public purchasers at the national level (Akay & Tamura, 2015). The report is perfect for dismissal of contributory insurance arrangement.

Also, in Africa, Rwanda is mostly considered as a country that has gained considerably high voluntary insurance coverage. However, the total services are very limited, and still, there is inadequate financial assistance for the poorest class. In this regard, Ghana, a West African country quoted for its efforts to extend healthcare services/coverage, launched a health insurance program in which registration is mandatory for the sector and optional for unofficial sector, and that coverage is free of cost for the poorest members of the country's population (Kieny et al., 2014). Also, issues in considering premiums affordable and in the making voluntary registration prompted ruling party to suggest one-time payment instead of annual charges from those out of the formal sector. Further, the general taxation that includes value-added tax is the major funding source for the national health insurance of Ghana, but the launching of a one-off payment system would indicate a decline in the significance linked with the contributory insurance system.

The tax net in developing and underdeveloped countries and the inability of people to make payment for healthcare either directly or via contributory insurance, the development to better financial protection would be slow. In this regard, the countries should utilize all the sources, but their main focus should be to examine as to which financing arrangement according to their specific economic, political and social structure will be suitable for the vulnerable population, and should ensure that coverage includes adequate services. Another main issue in efforts to improve health structure has been whether to use financial incentive by mean of motivating people to utilize service and motivating service providers to provide patients with good quality (Busse et al., 2015). These strategies form part of the broad strategy called results-based financing or aid based on the outcome that is aimed to resolve the issues regarding inadequate demand for intervention and weak responses and encouragement at provider's end. Incentives can be aimed at recipients.

Furthermore, the incentives could be directed to the recipients of healthcare with the help of vouchers and cash payments depending on the utilization of service or healthcare facilities. In this regard, the analysis of systemic approach of the utility of such financial incentives indicates some positivity in short-term for incentive aiming at healthcare recipients and healthcare professionals which are looking to get and obtain distinct goals regarding the provision and utility of relatively simple services.

In the countries of Latin America, conditional transfers have been linked with the more use of preventive service (Vázquez et al., 2015). Whereas, in Rwanda, performance-based primary care increased the deliveries of babies in hospitals or other facilities. However, insufficient evidence base gives little guidance as to how well these programs would work. In this regard, there is a concern as to whether the programs can be complicated to apply in countries with inadequate resources where the governments are short of staff, required skills, and the comprehensive system to administer and monitor services and performance. This happened with a maternity incentive compensation in Nepal as not so poor got advantage more as compared to the poor. Further, there are concerns that if changes will be sustained over time or if they are helpful for more diverse services.

Also, the financial incentives signify one way of improving healthcare level utilization and the overall quality of services. Financial incentives are strong. For example, a study of the world's biggest demand-side incentive plan projecting hospital births of Janani Suraksha Yojanas suggested that cash incentives improved women's access to these facilities, it was also linked with increased fertility. There is increased private participation in the overall healthcare system of developing and underdeveloped country particularly in the delivery of service. The private sector has a range from a limited formal non-profit and profit providers to many unofficial providers which include traveling drug sellers (Olivier et al., 2015). The number of private providers has increased in recent times which was the outcome of the failed public service plans to fulfill the overall demand.

Conclusion

The major difference between Developed, developing and underdeveloped nations is the resources. In developed nations, a large population is covered by the government. The countries like Britain, Canada, the U.S., Australia, France, Germany, and others have better health services. Overall households have to spend less as they are mostly covered. In developed countries, one of the major sources of spending is the tax as they have large tax net. However, in developing and underdeveloped countries on average almost 30% and 50% of financing is obtained from the pocket of households, whereas, in developed nations, the average is almost 14%. The reason why people have to spend more in developing and underdeveloped countries is because the overall tax net is not big and as a result of poor financial situations, the households show reluctance to pay taxes to the government.

Also, countries like Rwanda and Ghana realize the significance of primary health care. As a result of the failure of the public health system, the private providers are also providing people with service which may be slightly better than that of Government's, but of course, they charge high and poorest are unable to afford it. Although there have been a lot of talks about a universal health care system but deficiencies in fundamental structures are the hurdle in its implementation alongside lack of political will and socio-economic conditions.

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