Health Systems

Health and society in times of change
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Social equity and justice should not only guide health care systems towards health promotion and preventive medicine, but also, through the application of human values, help to obtain high quality and efficiency in health care delivery.

Recent changes in Europe – collapse of socialism in eastern Europe, German reunification, and growth of the western European Union – have raised fundamental questions about health care systems and their adaptation to national or regional situations, and particularly concerning a renewal of the relation between health/medicine and society. The current situation may tempt politicians to go for an “optimal” health system – one that is universal, practical, and affordable and has been tested under a variety of situations – if such a model exists.

Issues for consideration

• First there can be no universally acceptable system. Health systems are rooted in the culture and history of a society, and their transformation requires more than mere technological changes to structures, which cannot simply be imported or exported. “Optimal” means the best or what is right for a particular country, region or situation. Dissatisfaction with one system (e.g. among people who travel and see other systems) may be unavoidable, each person having his or her special interests, likes and dislikes. No single design is perfect.

• As the costs of health systems everywhere are increasing at a pace often exceeding that of GNP growth, they are seen as “too expensive”. The myth of the “cost explosion” casts health care as the villain – a burden to economic development. Efforts to treat social and medical care like “commodities” or consumer products have only made matters worse and may even destroy the idea of health as an economic asset to be protected. In these circumstances, naturally, it has become hard to gain additional resources for health by redistribution.

• The third point is that the most expensive health systems are not necessarily the best. The USA, for example, has the highest expenditure for health per capita and as a proportion of GNP, medical technology there is very advanced but the health indicators do not reflect its benefits. Meanwhile the spread of “social poverty” increases the inequalities in health care delivery. Elsewhere, with increasing industrialization, health systems have become part of the social security or welfare system, in
many ways dependent on or influenced by it; but with their own dynamics and reactions since, as stated, they reflect local cultural and historical factors more than an overall framework for social security.

Nevertheless, the analysis of different systems is worthwhile. New insight may be gained which helps focus on the problems of a certain system and generates ideas for developmental strategies. It would therefore be wrong to consider only “optimal” and “final” solutions, since it is not the apparently positive aspects of a given system that are necessarily the most rewarding in the analysis, but rather the real practical problems and deficiencies. Frequently more is learned from mistakes and contradictions than from an uncritical acceptance of success stories. Likewise, a model should not be a seductive presentation of the positive aspects, but an aid to recognition of what is not required and what may go wrong.

**Social and economic interests**

A realistic approach must also consider change applied to health systems as likely to be an expression of political power and social interests rather than a purely administrative act resulting directly from scientific research and social studies. In other words, it has to be planned and fought for by people with a clear idea of others’ motives, aims and interests – who is “for” and who “against”, and why. In Europe, certainly, such reforms have tended to occur at times of social crisis and transformation, becoming established only slowly and needing repeated adaptation to the actual situation. In this sense also, no health system can be called “final”; it is always in a state of flux, more like a running river than a still pond.

State systems are not necessarily incompatible with those of the private economic sector.

Their continuation has a long history in western Europe, and should not be dismissed out-of-hand. In all developed countries (and increasingly in the less developed) the State may intervene in the regulation of health care delivery, albeit for different reasons. It may be said that only the State can guarantee social justice and social peace, and may control and regulate costs better than “market forces”. However, it can also use its power to favour particular interests unless other democratic checks are applied to health politics and the organization and operation of the system to protect the interests of each and every citizen.

A country’s social wealth – that is, the material wealth whose distribution may be determined according to social criteria, is the basis for the design of its health system. This does not mean that rich countries will have no difficulties, as we have already seen, but the material deficiencies can be compensated for more readily. Expenditure on health and the distribution of the care and its cost will depend on the ability of social forces to determine and articulate such expenditure for the delivery of care.

Thus a health system always shows the effect of social power, but it also conditions that power. Since it influences the capacity to work – an economic quality if not a marketable “product” – it may be used for political oppression or economic stability, to secure social privileges or remove social inequalities. So historically there is a strong ethical element.
Finally, the main criteria for a health care system should be social equity and justice, orientation to health promotion and preventive medicine, attachment to human values and high quality and efficiency in health care delivery, and priority for those who are most seriously ill or at risk.

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**Conditions for development**

Health conditionality is wider in scope and more fundamental in character than remedial or project responses. It implies that the essential health objectives of protection and improvement of health status and quality of life should be defined at the very outset along with the macro-economic objectives, and that the processes of adjustment should achieve both sets of objectives simultaneously. ... In setting general conditions for development any society needs to identify the areas of vulnerability in that society and their acute manifestations in highly vulnerable groups.