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Online Ethics Course

Topic 11: Healthcare Organization and Questions of Justice

Intended learning outcomes

After completing the topic, learners should be able to:

1: Introduce and explain core health systems goals, functions, and typologies

2: Present and explore critical ethical considerations, such as questions of justice, to advancing health system goals in policy and practice

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Overview of Health Systems Organization

Defining a health system

"…comprises all organizations, institutions, and resources that produce actions whose primary purpose is to improve health"

(World Health Report 2000, WHO)

Health systems goals

- **Goal 1:** Improve health of population
- **Goal 2:** Enhance responsiveness to the expectations of the population
- **Goal 3:** Promote fairness in financing and financial contribution of households

(WHO 2000)

Goal 1

- Improve population health across life course
  - *Avert premature mortality*
  - *Avert non-fatal health outcomes*
- Increase average level of population health and promote equity in distribution of health within population
- Respond to public expectations for “health improving dimensions of their interaction” with the health system

(WHO 2000)

Goal 2

- Enhance health system responsiveness to “legitimate” expectations of population for “non-health improving dimensions of their interaction with the health system”
- Respond to population need in terms of two key sub-components:
  1. *Respect of persons*
  2. *Client orientation*

(WHO 2000)

Cont.

1. **Respect of persons**
   - Respect for dignity of person by protecting basic human rights, and promoting courtesy and sensitivity in patient-provider interactions
   - Respect of confidentiality and right to preserve privacy of personal health information
   - Respect for autonomy of individual in terms of making their own decisions and to have right of choice

(WHO 2000)

Cont.

2. Client orientation

- Prompt attention to health needs
- Basic amenities (i.e., hygiene of waiting room, sufficient beds, etc.)
- Access to social support networks for individuals receiving care
- Choice of provider, or freedom to elect institution and individual providing care

(WHO 2000)

Goal 3

- Advance fairness in financing and financial protection of households through:
  1. High degree of financial risk pooling to avert impoverishment of households
  2. Tiered payment by rich and poor (rich households make higher contribution than poor to reflect difference in income)

(WHO 2000)

Health systems functions

1. **Financing**
   - Revenue collection from various sources – primary (households and firms) and secondary (governments and donor agencies)
   - Fund pooling to accumulate revenue to share financial risk
   - Purchasing through allocation of pooled funds to institutional and individual providers

2. **Provision of health services**
   - Personal health services
   - Non-personal health services

   (WHO 2000)

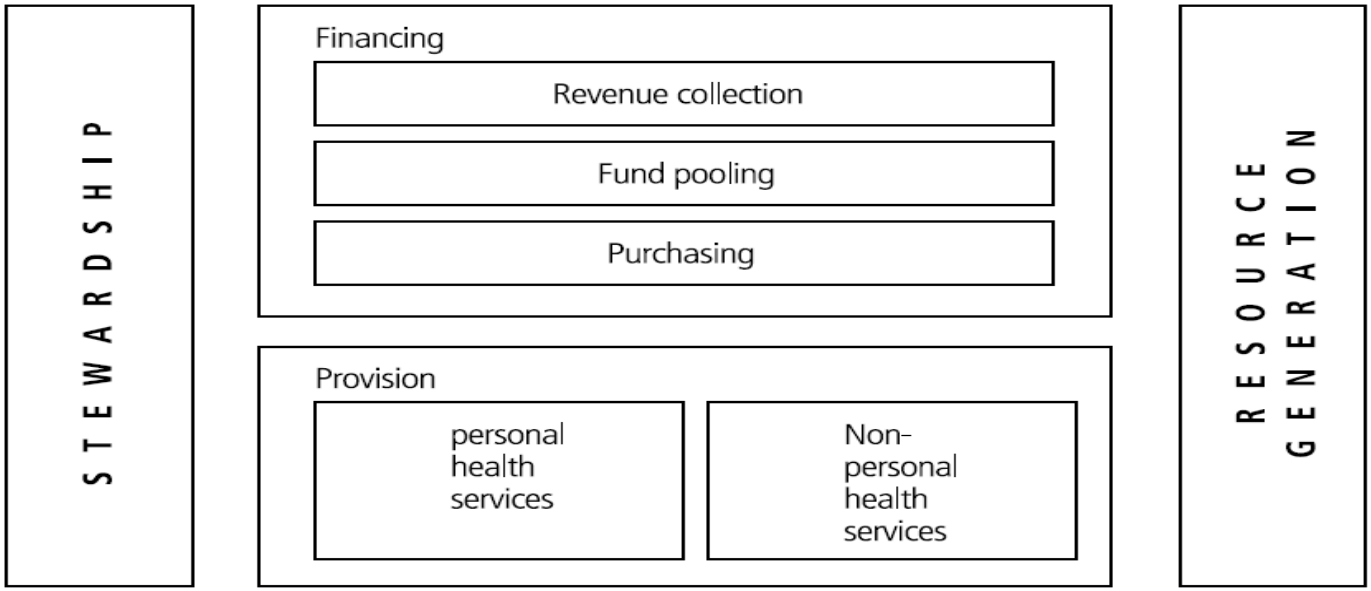
Cont.

3. **Resource generation**
   - Production of inputs to service provision by diverse set of organizations – human resources, physical resources (i.e. facilities and equipment), and knowledge

4. **Stewardship**
   - "Careful and responsible management" of the health system
     - Priority setting, strategic direction for overall health system, regulation of actors within the health system

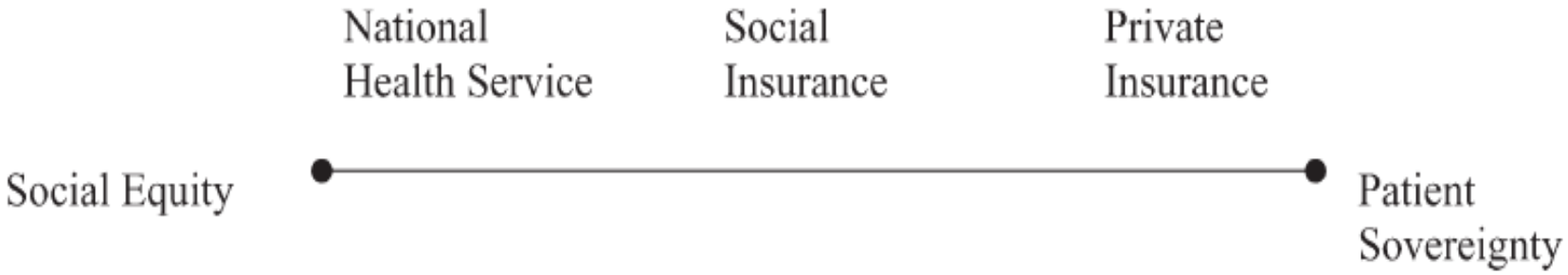
(WHO 2000)

Cont.



Source: Murray & Frenk 2000

The trajectory of health system typologies



(Burau & Blank 2006)

Health systems typologies

Table 2.1 Types of national health systems, as classified by Field

	General definition	*Position of physician*	*Role of professional associations*	*Ownership of facilities*	*Economic transfers*	*Prototypes*
Type 1 Private	Health care as item of personal consumption	Solo entrepreneur	Powerful	Private	Direct	USA, Western Europe
Type 2 Pluralistic	Health care as consumer good or service	and member of variety of groups/ organizations	Very strong	Private and public	Direct and indirect	USA in twentieth century
Type 3 National health insurance	Health care as an insured/guaranteed consumer good or service	and member of medical organizations	Strong	Private and public	Mostly indirect	Sweden, France, Canada
Type 4 National health service	Health care as a state-supported consumer good or service	and member of medical organizations	Fairly strong	Mostly public	Indirect	Great Britain
Type 5 Socialized health service	Health care as a state-provided public service	State employee and member of medical organizations	Weak or non-existent	Entirely public	Entirely indirect	Soviet Union

Source: adapted from Rodwin (1984)

Source: Burau & Blank 2006

Cont.

Table 2.2 Types of national health systems, as classified by Roemer

		Health system policies (market intervention)			
		Entrepreneurial & permissive	*Welfare-oriented*	*Universal & comprehensive*	*Socialist & centrally planned*
Economic level (GNP/capita)	*Affluent & industrialized*	USA	West Germany Canada Japan	Great Britain New Zealand Norway	Soviet Union Czechoslovakia
	Developing & transitional	Thailand Philippines South Africa	Brazil Egypt Malaysia	Israel Nicaragua	Cuba North Korea
	Very poor	Ghana Bangladesh Nepal	India Burma	Sri Lanka Tanzania	China Vietnam
	Resource-rich		Libya Gabon	Kuwait Saudi Arabia	

Source: "Figure 4.1", from NATIONAL HEALTH SYSTEMS OF THE WORLD, VOLUME I: THE COUNTRIES by Milton I. Roemer, copyright © 1991 by Oxford University Press, Inc. Used by permission of Oxford University Press, Inc.

Source: Burau & Blank 2006

Cont.

- **Beveridge** or national health service model
  - Universal coverage funded by general taxation and public ownership and/or control of health care delivery
  - Predominantly public provision of care
  - Examples: UK, Sweden, New Zealand

- **Bismarck** or social insurance model
  - Compulsory, universal coverage within social security system, financed through contributions by employers and employees, non-profit insurance funds
  - Public and private provision of care
  - Examples: Germany, Netherlands, Japan,

(Burau & Blank 2006)

Cont.

- **Private insurance** or consumer sovereignty model
  - Private insurance purchased by individual or employer
  - Predominantly private provision of care
  - Examples: US, Australia

(Burau & Blank 2006)

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Question of Justice in Health Systems Policy and Practice

Questions of justice in public health

- **Policy**
  - Priority-setting in health policy-making
  - Selection of essential package of health services
  - Distribution of essential health services
- **Practice (Implementation)**
  - Provision of health services
  - Patient-provider interaction
- **Research**
  - Human subjects research
  - Clinical and public health evidence pertaining to and relevant across population groups

Ethical principles for research: Belmont Report

1. **Respect for persons** – acknowledges individual autonomy and requirement to protect those with diminished autonomy.
2. **Beneficence –** relates to protecting individuals from harm and securing their well-being.
   - Must "do no harm"
   - Maximize possible benefits, minimize possible harms
3. **Justice –** "Fairness in distribution" to ensure that individuals are granted benefits that they are entitled to. "Equals ought to be treated equally."

Theories of justice

- **Utilitarianism**
  - Promote maximization of net social utility
    - Greatest amount of good for the greatest number of people
    - Not concerned with distribution of benefits outside aggregate welfare
  - Teleological
    - Morality of an action is ***outcome-based*** (fulfillment of duty or obligation based on consequences or ends achieved)
  - Support social insurance programs that seek to provide basic health care for all
- **Liberalism**
  - Promote maximization of individual rights with autonomy and freedom of choice at core
  - Support private and voluntary purchase of health insurance

(Beauchamp & Childress 2009)

Cont.

Communitarianism

- Promote responsibility of community to individual and vice versa
- Solidarity and development of community-derived standards, encompassing both personal virtue of commitment and social morality (shared values of group)
- Support community-based programming that that fulfills social goals endorsed by community as a whole

Cont.

Egalitarian

- Promote equal distribution of certain basic goods, i.e. adequate (not maximal) health care, but not all social benefits
- Deontological
  - Morality of an action is ***rule-based*** (fulfillment of duty or obligation based on adherence to rules or means utilized)
- Support organization of health care in which arrangements permit each individual a "fair share of the normal range of opportunities present in that society" = equal access by all to adequate (not maximal) health care
  - Support fairness in distribution of resources in health care to achieve "fair equality of opportunity"

Procedural justice in health policy: Issues in priority-setting

- **Benchmarks of fairness for health care reform**
  - Inter-sectoral public health
  - Financial barriers to equitable access
  - Non-financial barriers to access
  - Comprehensiveness of benefits and tiering
  - Equitable financing
  - Efficacy, efficiency and quality improvement
  - Administrative efficiency
  - Democratic accountability and empowerment
  - Patient and provider autonomy

  (Daniels et al 1996)

Universal health coverage

"…ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."

(WHO)

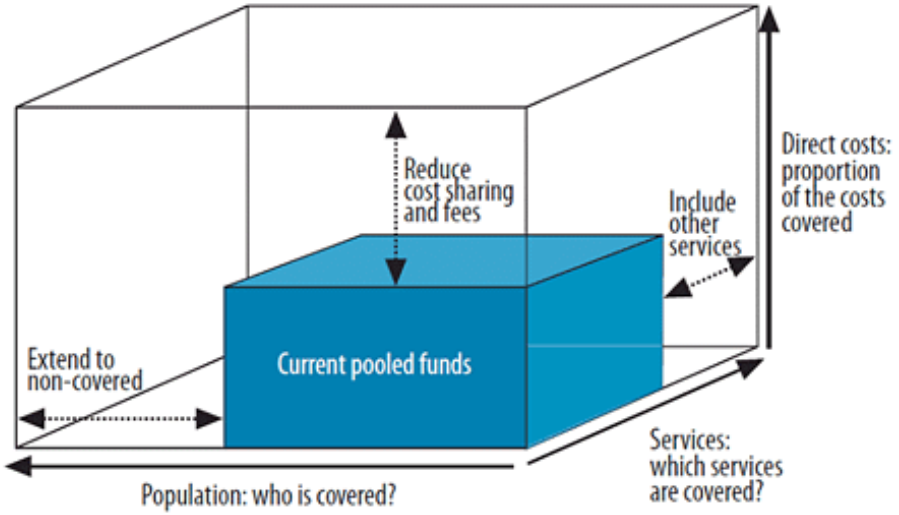
Path to universal health coverage

Progress defined by three dimensions:

1. Population: Who is covered?
2. Services: Which services are covered?
3. Direct costs: What proportion of costs are covered?

(WHO 2010)

Cont.



Three dimensions to consider when moving towards universal coverage

Source: WHO 2010

Making fair choices on path to universal health coverage

Critical dimensions and choices on the path to UHC

Dimension of progress	Critical choice
Expanding priority services	Which services to expand first?
Including more people	Whom to include first?
Reducing out-of-pocket payments	How to shift from out-of-pocket payment toward prepayment?

Source: WHO 2014

Cont.

Guiding Considerations

1. ***Fair distribution:*** Coverage and use of services should be based on need and priority should be given to the policies benefiting the worse off groups;
2. ***Cost-effectiveness:*** Priority should be given to the most cost-effective policies;
3. ***Fair contribution:*** Contributions to the health system should be based on ability to pay and not need.

(WHO 2014)

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