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## Review

# Classification of healthcare systems: Can we go further?



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## ABSTRACT

This article addresses the issue of the classification of healthcare systems, with the intent to take a step further than the previously analysed models of healthcare organisation.

As concerns the financing of healthcare services, the standard tripartite classification (according to which healthcare systems are divided into three groups: voluntary insurance, social health insurance and universal coverage) is enriched with two additional types: compulsory national health insurance and residual programs.

With respect to the provision of services and the relationship between insurers and providers, it is important to distinguish between vertically integrated and separated systems.

What differentiates this analysis from the majority of previous studies is its underlying logic. Assuming that all systems are hybrid, the article proposes to put aside the classic logic for classifying healthcare systems (according to which individual countries are pigeonholed into different classes depending on the prevailing system) in favour of the identikit logic. The concept of segmentation (of healthcare services or population) proves to be remarkably useful to this purpose.

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## 1. Classifications of healthcare systems: limits

This article deals with a classic topic, already widely explored and debated in the literature: the classification of healthcare systems. The topic is worth revisiting because of its undeniable centrality. Indeed, every scientific community aims at defining firm and widely shared classification criteria, an indispensable condition for the advancement of comparative research. This applies to all subject areas, and the study of healthcare systems is no exception.

Over the years, many proposals have been put forward to classify healthcare systems. Many works propose to classify systems “on base 3” [1–5]. The most widely used classification indeed subdivides healthcare systems into

three large models [2]: (1) voluntary insurance; (2) social health insurance (SHI); (3) national health service (NHS). The breakdown of healthcare systems based on these three ideal types can be considered the *standard tripartite classification* [5], which many authors have shared and used in their research [4,6,7].

Other scholars have proposed classifications of healthcare systems “on base 4” [8–11]: each of these proposals, however, uses different classification criteria, and different labels to identify the four types.

Wendt et al. [12] went as far as theorising the existence of 27 different possible healthcare system “combinations”. However, 24 of these combinations can be considered hybrid forms, leaving only three pure models (and thus returning, even in this case, to a trichotomous classification). Böhm et al. [13] analysed the 27 combinations mentioned above and pointed out that many of them are “scarcely plausible” from a logical viewpoint, and that, in

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practice, some types are not applicable in the real world: healthcare systems in OECD countries can therefore be grouped under five main models.

Regardless of whether the classification is on base 3, 4 or 5, all the foregoing proposals seem to have – some more, some less – the same limits: (1) they end up including in the same category healthcare systems that differ from one another (some typologies also result in the opposite problem, in that similar systems fall into different categories); (2) for each country, only the *prevailing* model is taken into account, which risks being an oversimplification. Let us discuss a few examples.

Some classifications place the healthcare systems of Australia and Canada in the same category as those of countries like the UK, Italy or New Zealand [3,11,13–15]. But the Canadian and Australian systems are not organised like the British or the Italian NHS [16,17].

In many research works, Switzerland is listed with social health insurance countries like France or Germany [3,13,18,19]. But the Swiss model is substantially different from the classic Bismarckian prototype and adheres to different logics [13,20].

The United States is another example. Labelling the American system as a simple case of “voluntary private insurance” is an obvious over-simplification. The American system is a very complex patchwork [21], where government intervention is anything but minor, as demonstrated by the fact that, in the USA, public health expenditure is around 7.9% of GDP [22]; it is therefore higher than that of “universalist” countries such as the UK, Spain, Italy or Canada. Given its complex architecture, the US system cannot be classified as a mere private insurance system.

These few problematic cases – but there are many others – lead us to consider the classifications of healthcare systems proposed to date in the literature as not fully satisfactory. In this work, we ask ourselves whether we can go further.

We ought to clarify right from the start that the author does not consider the classic tripartite classification and the other types proposed so far wrong, or useless: they are certainly helpful. However, it all depends on the type of analysis that one wants to make. If a certain degree of simplification is acceptable, then the classifications proposed so far, starting from the standard tripartition, are adequate. Conversely, a deeper analysis that places greater emphasis on the differences between systems, and aims at fully understanding the architecture of each healthcare system, requires the adoption of a more sophisticated conceptual scheme.

In the following sections we shall outline 10 models of healthcare organisation: these types in part take up and in part develop the classification proposals already presented in the literature. However, this work is not limited to proposing a new typology, but rather aims to suggest a classification logic that differs from traditional pigeonholing. The classic classification logic starts off by defining some ideal models, and then tries to make the different objects of analysis – in our case, the national healthcare systems – fit into one, and only one, of the identified models, so as to obtain classes as homogeneous as possible [23]. It is, however, generally agreed that national

healthcare systems are, in actual fact, hybrid and composite systems that mix and combine elements inspired by different models [1,8,12,13,24,25]. Grouping countries on the sole basis of the prevalent model thus risks producing simplistic descriptions of the national systems that are quite far from the actual state of affairs.

To avoid this limitation, we propose to make a different use of the typology. The ideal types will serve primarily to identify and label the different elements composing each national healthcare system. The typology will therefore be the common analytical framework through which we can put the system’s components into focus, understand how each component works and grasp the relationships between the various subsystems. This will make it possible to compose a concise overview, revealing the logic underlying the overall design of each healthcare system. We shall refer to this way of proceeding as the “identikit logic”: indeed, it aims at providing more accurate and realistic descriptions of each single national healthcare system, reconstructing the various combinations based on which it was designed.

Some authors [4,26] suggest to consider the healthcare system as a triangle, due to the relationships existing between the three different categories of subjects: users, providers and insurers. When focussing on the relationship between users and insurers, we are talking about the *financing* of the system; financing methods usually also affect the manner in which providers are paid. When considering the relationship between providers and users, we are instead dealing with healthcare service *provision*; service provision methods are in turn affected by the relationship that users and providers have with insurers.

Some healthcare system classifications made in the past almost exclusively consider the financing dimension [1,25,27]. Many authors, however, believe that focussing only on financing is reductive, and that a proper classification should also include the service provision dimension [2,4,12,26,28]. Sure enough, financing mechanisms on the one side and provision methods on the other are considered the two “core dimensions” [13] required to classify healthcare systems [2,11,14,26,29]. Fully agreeing with this approach, in this work we shall take these two dimensions into account, first discussing them separately and then intercrossing them.

In Section 2, we shall start from healthcare service *financing* mechanisms, comparing five different financing systems. In Section 3, we shall discuss the provision of healthcare services and, in particular, the relationship between providers and insurers. We shall therefore make a distinction between integrated and separated systems. By intersecting the financing and service provision dimensions, we obtain 10 different types of healthcare organisation.

As already mentioned, at this point, however, the logic will not be to pigeonhole the various national systems into these 10 types. The operation suggested in this work will rather be to draw up an identikit picture of each single healthcare system. The concepts of “population segmentation” and “healthcare segmentation”, as defined in Section 4, will be key to reasoning according to the identikit logic.

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