Cross-cutting introduction to Health Care (Table II)

The right to access health care in support of promoting well-being is a mark of a caring society. Advances in medical practice, from diagnosis and improved public health to new medicines and surgical procedures have contributed to significant improvements in morbidity and life expectancy; equally, however, the cost of medical care continues to increase. Health care is also closely related to a range of risks and associated social security benefits including sickness, employment injury and maternity. Moreover, it is well known that indicators of ill-health correlate closely with life expectancy, socio-economic status, poverty and life-chances.

The relationship between health care and government is more problematic than is the relationship between social security and the state. Although health care is a key responsibility for all governments, there are differing degrees of involvement in its planning, financing, management, delivery and quality assurance. Provision exists on a spectrum, where some countries have health care systems that are 'owned' by the state and where health care professionals are employed by social security, while other countries have a tradition in which the private and/or not-for-profit sectors have the dominant role in providing health care, often in the framework of agreements with social security.

In some countries a distinction is drawn between social security and health care, but at a European level the term 'social protection' is a term that embraces both sectors.

The basic principles underpinning the funding and provision of health vary between countries. In some, a universal (national) health service may be available to all residents and will be funded out of general taxation. In other countries, however, health care is closely linked to an individual's social insurance record, with access and entitlements determined in accordance with relevant rules and regulations. In these countries, the personal scope of the scheme will typically have been expanded to cover the bulk of the population. When individuals (or their dependants) have failed to establish or have exhausted a social insurance entitlement they will then have to secure health care via the private market or else rely on assistance-based medical care. In such cases there is a risk of variation in the range and quality of service available with correlated unequal health outcomes. In other countries, where access to health care is based on residence or citizenship rather than insurance or capacity to pay, provision may be universal but inequalities will not be fully eradicated. No matter, in such circumstances governments have greater capacity to shape health care priorities and to direct the allocation of resources – though they will still have to strike accommodation with the representatives of powerful interests such as the medical and pharmaceutical professions.

Health care systems can also be divided into benefits-in-kind systems and reimbursement systems. In the former, which include national health services, medical care is generally provided free of charge by providers owned, employed or contracted by social security - which also pays them directly. Reimbursement systems confer upon insured persons the right to be reimbursed for medical bills that they have paid for themselves. For large (e.g. hospital) expenses, this reimbursement principle is often abandoned in favour of a third-party payer system.

In both systems, the patient may have to bear a part of the medical cost him-or herself. Such patient charges come in various forms (e.g. copayments, deductibles etc.) and many schemes make provision for reductions or exemptions for weaker groups within the population.

The health care sector is far from being homogenous; indeed, there are important clinical and professional differences between ‘primary care’ usually provided by general practitioners (and their support staff including health visitors, practice and district nurses) one the one hand and ‘secondary’ or ‘acute’ care provided by specialist staff mostly in hospitals. A third and increasingly significant ‘domain’ lies in the area of ‘public health’ with its emphasis on prevention rather than cure through services that address the risks of smoking, alcohol and drug abuse while promoting sexual health, the benefits of physical exercise and good nutrition.

Past decades have seen strategic moves away from illness and disease management to prevention and well-being, from high cost services provided in acute settings to cost-effective support provided by mobile health care workers (often nurses and therapists rather than physicians) who can support people in or close to their own homes. Emphasis is placed on holistic diagnosis and seamless ‘pathways of care’ resulting in ‘packages of care’ being devised and made available to patients in ways which are congenial, provided close to their home and appropriate to their needs.

Health care also includes the provision of dental services, pharmaceutical products (which are free to certain groups in the population in some countries and available at cost in others) as well as prostheses, spectacles and hearing-aids.

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