CHAPTER 1

Introduction

Do not follow where the path may lead. Go instead where there is no path and leave a trail.

—Ralph Waldo Emerson

Key Concepts

Behavioral
Behavioral health
Developed country
Developing country
Mental health
Disparities

The true measure of a nation's worth is not merely inherent in its wealth, resources, and power, but in how it responds to the health of its people. Yet, America, the wealthiest nation in the world and global leader in a business sense, has allowed its healthcare system to lag behind every other industrialized (developed) country in the world. The United States healthcare system ranks 37th in the industrialized world. In 2006, the United States was number one in terms of healthcare spending per capita but ranked 43rd for adult female mortality, 42nd for adult male mortality,

and 36th for life expectancy (Doe, WHO Statistical Information System, 2009). Its ranking for infant mortality went from 28th in 1998, to 29th in 2004, the latest year for which data are available for all countries (National Center for Health Statistics, 2007), to 39th in 2006 (Doe, WHO Statistical Information System, 2009). It still has the lowest life expectancy, and an overall poor healthcare track record compared to other global powers. It is a dysfunctional market-driven healthcare system that has managed to disrupt the quality of life and well-being of the majority of those living in America.

For over three decades, the system has significantly changed the practice of medicine to the extent that many medical providers deliberately defaulted on their independent patient practices. By joining large integrated systems, they could be free to practice without keeping their eyes on the bottom line.

The healthcare delivery system in the United States is primarily private-sector financed and operated. It has been criticized for being highly politicized and influenced, and even bought off by big business. The pharmaceutical industry and other special interest groups are so adamantly opposed to comprehensive healthcare reform that they will resort to any means necessary to prevent it.

According to Nardi and Rooda (2004), the world is shrinking. "We now live and work in an ever-shrinking global village, in which all parts of the globe and its peoples, from Antarctica to Iceland, are not only accessible, but interact with and influence each other in a transactional dance of cross-cultural behaviors, values, views, and beliefs" (Nardi & Rooda, 2004, p. 87). The race and ethnic profile in the United States is changing; the white majority is shrinking as the population ages while the underrepresented ethnic and racial groups are younger and growing in numbers (Spector, 2002). The United States as a nation is becoming a mosaic of many cultures. The long-standing homogeneous communities in which we once lived are a figment of the past (Purnell & Paulanka, 2003). Health professionals in the United States must conduct business differently if they are to improve health outcomes nationally. Health professionals, especially leaders, must be committed to effectively addressing health problems never before witnessed in this country, and it must be done expeditiously and with fiscal savvy.

This text discusses health care in 11 countries, of which six are industrialized (developed) and five are developing (once referred to as Third World). In distinguishing between countries that are developed and developing, the authors use international criteria. Although experts do not entirely agree on what makes a country developed or developing, many agree on

some strong distinguishing characteristics. The strongest distinguishing support is that *developed countries* (industrialized) have high incomes per capita, high gross domestic products per capita, industrial dominance, and the most recent criterion is that they have a high United Nations Human Development Index (HDI). In addition to the first three criteria, this Index factors in life expectancy and education. In other words, how a country converts its income and resources to develop people educationally and provide opportunities for them to enjoy good health (United Nations, 2010) is an important consideration in determining whether a country makes the developed list. Countries with HDIs of 0.788 and greater are considered by the International Monetary Fund (IMF) and the CIA as advanced (CIA, 2009), qualifying them as developed countries. In the opinion of Kofi Annan, former Secretary General of the United Nations, a developed country is "a country that allows all its citizens to enjoy a free and healthy life in a safe environment," (Kofi Annan, 2008). *Developing countries* (non-industrialized, once referred to as underdeveloped or Third World) are those countries that lack the characteristics of developed countries in that they are still struggling with their economies, are not major exporters of commodities, and/or have poorer overall life expectancy and health outcomes.

The United Kingdom was the first country to earn the distinction of developed, followed by Belgium, then the United States. The countries discussed in Chapters 4–14 of this book that are accredited with being developed countries are the United Kingdom, the United States, Canada, Japan, France, and Italy. The countries considered developing countries are Brazil, Cuba, India, the Russian Federation, and Ghana. Although there are inconsistencies in the criteria applied to determine whether a country falls into the developed or developing category, it is often expected that the more economically and fiscally secure developed countries should have better economic, education, and health outcomes.

The major rationale for the selection of countries was author interest. Each of the 11 systems of health care is examined within the framework of a true acces*s* model developed by the authors. The motivation for the book emerged from annual class discussions about the problems in the United States Health Care Delivery System (USHCDS) including major disparities in care, and similarities to and differences among other systems of care. The Institute of Medicine and *Healthy People 2010* have identified the elimination of health disparities as priority initiatives for health professionals to address. As a consequence, a special chapter in the book is devoted to a discussion of disparities in the USHCDS with age- and race-based case scenarios.

The text builds on the premise that the current system of healthcare delivery in the United States is in need of major transformation. In attempting to fix the United States system, much can be learned from healthcare systems around the world. It also demonstrates how imperative it is for healthcare leaders to shift their focus from management to leadership.

Perhaps the most compelling reason for writing *Global Health Systems: Comparing Strategies for Delivering Health Services* is to make an appeal to the reader to consider new ways of conducting healthcare business. The text's comparative perspectives are discussed in Chapter 16 with a brief overview of global perspectives in general and a summarizing discussion of the 11 systems addressed in the book. The U.S. healthcare system has been so busy managing that it has managed its way into disrepair. In the words of Warren Bennis, "managers are people who do things right, while leaders are people who do the right thing" (Bennis, 2009, p. 1). True leaders must be visionaries prepared to delegate the responsibility for managing to those capable of handling the day-to-day system operations. This will allow leaders to shift their attention to proactively planning for a brighter healthcare future. If they fail to do so, the system loses much more than could ever be imagined.

Developing countries are challenged daily because they lack the necessary resources to meet the healthcare needs of their people. For example, India, despite already lacking resources to address its healthcare challenges, must now contend with the problems created by new slums that emerged during the 20th century. The Russian Federation, with its extremely high death rate, is committing new financial resources in an attempt to reverse this devastating trend.

What makes this text different from other health systems books is that it offers a novel view of systems globally and suggests what the managers of one system can learn from those of another. *Global Health Systems: Comparing Strategies for Delivering Health Services* challenges healthcare leaders around the world to approach their healthcare delivery in new ways, by taking innovative measures. In the United States for example, healthcare leaders must suspend their exhaustive, time-consuming national healthcare debate, engage in civil, across the aisle collaboration, and seize control of an out-of-control system. Working together to closely examine what is wrong, might finally result in implementing the necessary processes to fix the system and eliminate *health disparities* defined by the Institute of Medicine as "racial or ethnic differences in the quality of health care that are not due to access-related factors such as, insurance coverage, or clinical needs, preferences, and appropriateness of intervention" (Smedley, Stith, & Nelson, 2002, p. 5).

An Eight Factor Model for striving to achieve *"true access"* is introduced (in Chapter 3) and defined by the authors as being able to get to and from services, having the ability to pay for the services, and getting your needs met once in the system. Far too often, when discussions occur regarding access to health care there is no consideration given to the quality of the service consumers receive once in the system. The premise of true access suggests that even when a patient is able to make it to and from healthcare services, and have the ability to pay, they have been denied access if they leave that encounter without receiving what they needed.

The Eight Factor Model derives from extensive discussions with consumers and healthcare providers about the true meaning of *access, health disparities,* and the relatively poor outcomes achieved in the United States healthcare delivery system. The model provides a framework for examining each of the 11 healthcare systems introduced in the book. Healthcare leaders and policymakers are encouraged to consider these eight foundational factors when attempting to determine the extent to which a system is providing *true access* to health care. All eight factors depicted in the model must be assessed before a final decision is made about access. The fundamental assumption behind utilizing this model is that it will inform health policy decisions. When informed about what prevents a system from providing access, policymakers are better positioned to implement corrective strategies. The model is presented in detail in Chapter 3.

Objectives and key concepts introduced at the beginning of each chapter are of particular relevance to the healthcare system being discussed, and are significant complements to the book. Discussion questions at the end of each chapter, designed to stimulate critical thinking about healthcare delivery, are an added feature of the text. A list of references at the end of each chapter affords readers an opportunity to retrieve citations easily and engage in enrichment reading if desired. The final feature of the text is a glossary of terms, and an easy to use index catalogued by topic.

The text is divided into four parts and 17 chapters. Part I includes three sections and provides the motivation for writing the text. This motivation, fueled by an extensive examination of the delivery of health care in the United States and the major role health disparities played in catapulting the country toward reform, suggested the importance of including a section in the text exclusively devoted to disparities in the U.S. health system. The introductory discussion (Chapter 1) provides some background and an overview of the healthcare system in the United States and how it is ranked among other countries in the world. It also discusses the transcultural nature of health, challenges to be addressed, and opportunities for change. "Disparities in Health Care: Race and Age Matters" (Chapter 2) focuses

on major health disparities seen in the United States. As Marmot and colleagues advise:

> George Orwell notwithstanding, all people are not born equal. Individual differences in genetic endowment may well control differences in life-expectancy. Even if all individuals are subject to the same environmental influences they would not flourish, age, and die at the same rate (Marmot, Bobak, & Smith, 1995, p. 174).

"The Eight Factor Model for Evaluating True Access" (Chapter 3) introduces the reader to the Eight Factor Model, a framework for assessing the strengths and weaknesses of systems in order to determine the extent to which a system is providing what the authors refer to as true access. The eight factors in the model are 1) historical, 2) structure, 3) financing, 4) interventional, 5) preventive, 6) resources, 7) major health issues, and 8) health disparities.

"Health Care in Industrialized (Developed) Countries" (Part II, which comprises Chapters 4–9 of the text) discusses health delivery in six systems: the United States, Canada, France, Japan, the United Kingdom, and Italy. The remaining five countries, Brazil, Cuba, Ghana, India, and the Russian Federation are discussed in Part III of the text. Starting with the United States health system, discussions regarding each country's provision for long-term care and care of older adults are presented from a comparative viewpoint. The intent is to bring clarity and understanding to these care options. Behavioral healthcare costs and challenges are integrated into a separate discussion (see Chapter 15).

"The Healthcare System in the United States" (Chapter 4) provides an in-depth look at the system of healthcare delivery in the United States during the critical period from 1984 to 2010. It also discusses the challenges as the country emerged cyclically from primary care being provided in emergency departments thirty years ago, to receiving care in Community/Migrant Health Centers (C/MHCs) during the late eighties and nineties, and today where patients once again are seeking primary care in emergency departments.

After a brief introduction and overview, the historical perspectives of each country are discussed, followed by a country-by-country examination of performance based on achievement of the remaining seven factors in the model. Again, the emphasis is on what one country might learn from another. For example, one might wrongfully assume that the wealthier the country, the better the health outcomes. However, a country that has historically lacked the fiscal capacity and infrastructure to support a well-qualified staff, with uniquely different ways of providing services, may have

better outcomes and greater success in providing true access than a country rich in fiscal and human resources.

In examining major health issues, financing priorities, and serious system challenges such as health disparities, the discussions within each of the 11 countries (Chapters 4–14) offer enriching case scenarios with commentaries designed to bring collaborative excitement to the learning experience. Discussion questions are included to emphasize, with clarity, the extent to which disparities in health occur. The questions should also stimulate discussion about ways in which disparities might be eliminated. These scenarios provide the learner with opportunities to thoroughly discuss health issues with special attention to identifying solutions.

The fourth and final part of the text presents discussions in three chapters (15, 16, and 17). "Prevalence and Management of Behavioral Health Care" (Chapter 15) is devoted to a discussion about the prevalence and management of behavioral health problems in the 11 countries presented in Parts II and III of the text. Behavioral health is, in some countries, the overarching umbrella under which community-based psychiatric mental health services are often grouped. However, it is important to note that many countries make reference only to psychiatric/mental health problems with no mention of behavioral health. When discussing behavioral health in this text, the NIH definition of *behavioral* as overt actions to underlying psychological processes such as cognition, emotion, temperament, and motivation, and bio-behavioral interactions is used. The Office of Behavioral and Social Research of the NIH (2010) agreed on this definition for the purpose of engaging in research to predict or influence health outcomes or health risk factors. *Behavioral health* places emphasis on maintaining health and function and preventing illness (Matarazzo, 1980), as well as hospitalization by focusing on actions that can be managed or changed.

"Comparative Health Systems" (Chapter 16) is a culminating discussion about comparative perspectives on health. It provides a focused discussion about the health challenges internationally, the leading causes of death worldwide, common diseases of each country, the similarities and differences between Western and non-Western delivery systems, and a brief discussion about health disparities in and among countries from a comparative perspective. It appeals to the reader to utilize information without criticizing systems; rather, learning from each.

"Conclusion and Future Leadership" (Chapter 17) focuses on the future of health care globally and the leadership needed to move the healthcare agenda into the 21st century. It also reemphasizes the importance of what one country might learn from another. This discussion encourages

learners to remain optimistic as they consider the future of health care. As healthcare policymakers, administrators, and providers make informed health policy decisions, they position themselves to prepare for a brighter future in health care.

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