Structural and Comparative Analysis of the Best Health Systems in the World Versus Mexico

By

Suberbiel Ramírez Karla Valeria Barrera Cortés Rosa Isela Muller Sanjuan José Alejandro Sánchez Martínez Diana Veronica Ruvalcaba Ledezma Jesús Carlos
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Suberbiel Ramírez Karla Valeria¹, Barrera Cortés Rosa Isela¹, Muller Sanjuan José Alejandro¹, Sánchez Martínez Diana Veronica¹, Ruvalcaba Ledezma Jesús Carlos²*

¹Maestro(a) en Salud Pública [ICSa-UAEH] Instituto de Ciencias de la Salud-Universidad Autónoma del Estado de Hidalgo, México.
²Investigador de Tiempo Completo [ICSa-UAEH] Instituto de Ciencias de la Salud-Universidad Autónoma del Estado de Hidalgo, México.

*Corresponding Author’s Email: dcspjcarlos@gmail.com; Cel: 5548817657

ABSTRACT

The foundation of a Healthcare System is to reduce the damage to health in the population through the planning, financing, and administration of human and material resources. Two aspects to be considered include: the equitable distribution of health services among its inhabitants, their co-responsibility and homogeneity of their indicators.

OBJECTIVE: To analyze the quality of the best global Healthcare Systems and compare with the Mexican Healthcare System.

METHODS: We performed a systematic review in the network through a structural and comparative analysis of the best Healthcare Systems in the world versus the current situation in México.

RESULTS: In Mexico, the Healthcare System is fragmented from the outset, and its integration is difficult. Although the leading Healthcare Organization is the Ministry of Health [SSA], each institution presents its own policies, so it could mean each one represents a separate Healthcare System of its own.

CONCLUSION: Indicators that evaluate a healthcare system depend on inequity in health, access to health services, adequate treatment in both distribution and financial protection as well as fair financing, thus concluding that expenditures excessive in processes or actors do not guarantee the quality and effectiveness of a Healthcare System.

Keywords: Healthcare System, health services, patient co-responsibility.

INTRODUCTION

A Health System encompasses all organizations, institutions, resources and people whose purpose is to improve health. Strengthening health systems can identify the main constraints related to human resources and health infrastructure, health products and planning, monitoring of progress and effective financing of the sector (WHO, 2016).

In terms of the performance measurement of 191 global health systems, conducted by the World Health Organization (WHO) in 2000, the list of the top ten systems is headed by France, followed in decreasing order by: Italy, San Marino, Andorra, Malta, Singapore, Spain, Oman, Austria, and Japan (Appleby, 2011; Murray et al., 2001). France holds the first place for a sufficient and inclusive health system for WHO, while per to the 2009 Euro-health Consumer index, this country ranks ninth in 33 countries, while the Netherlands is the first. In the Euro-health Consumer 2015 study, it ranked # 11 by reducing access to specialist services in 2009, as well as the highest percentage of abuse by indiscriminate drug use.

In the performance measurement carried out by WHO, it ranks last in Sierra Leone, the Canadian system is in the 30th place. For Mexico, its place is 61 (Appleby, 2011; Murray et al., 2001).

The ability to choose which health system is better depends on the complexity and multidimensionality of each system, being relative to health but also to efficiency, efficacy, affordability, and acceptability (Murray et al., 2001). An example of this is England which occupies the second place in terms of the distribution of health services in the population but in terms of patient awareness is in number 26 (Murray et al., 2001).

Murray and Frenk in 2000 proposed 5 intrinsic goals and their percentage of estimation for all health systems: health (25%), health inequity (25%), adequate treatment (12.5%), adequate treatment in the distribution of...
Human resources and materials (12.5%), financial protection and fair financing (25 and 25%) (INSPE, 2005; Murray et al., 2001).

For the purpose of these goals, health was assessed through mobility, self-care, pain, mental function, social functioning, sleep and energy and affection, proper treatment of the patient depended on eight domains: autonomy, prompt attention, communication, decent treatment, confidentiality, choice, quality of basic amenities and access to social networks and support, financial protection assessed by the percentage of households with catastrophic expenditures and the ability to pay as extra income after subtracting the Expenditure on food (INSPE, 2005).

The publication of the "International Profiles of Health Systems in 2014" by the English School of Economics and Political Science in 2015 described the dynamics of funding in each health system in 15 countries (Australia, Canada, Denmark, England, France, Germany, Italy, Japan, Netherlands, New Zealand, Norway, Singapore, Sweden, Switzerland, and the United States of America), as explained in Table 1 (The Commonwealth Fund, 2015)

<table>
<thead>
<tr>
<th>Country</th>
<th>Governmental Role</th>
<th>Public Financing</th>
<th>Role of Private Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Regionally managed national and state funding, universal public health insurance program (Medicare)</td>
<td>Income tax</td>
<td>50% purchase complementary (medical, dental and optometry clinics) and supplementary coverage (greater choice)</td>
</tr>
<tr>
<td>Canada</td>
<td>Regionally administered universal public insurance program. Plans and provision funds (especially private)</td>
<td>Income tax</td>
<td>67% complementary coverage</td>
</tr>
<tr>
<td>Denmark</td>
<td>National system of health National Financing: Benefit by regions and municipal authorities</td>
<td>Income tax</td>
<td>40% complementary coverage</td>
</tr>
<tr>
<td>England</td>
<td>National Health Service</td>
<td>Collection of general taxes</td>
<td>11% complementary coverage</td>
</tr>
<tr>
<td>France</td>
<td>Compulsory sickness insurance scheme</td>
<td>Income and tax payroll</td>
<td>90% buy or receive government vouchers for supplemental coverage</td>
</tr>
<tr>
<td>Germany</td>
<td>Compulsory sickness insurance scheme</td>
<td>Income and tax payroll</td>
<td>11% complementary coverage</td>
</tr>
<tr>
<td>Italy</td>
<td>National Health System</td>
<td>Tax revenue and regional tax</td>
<td>15% complementary coverage</td>
</tr>
<tr>
<td>Japan</td>
<td>Compulsory sickness insurance scheme, quasi - public, and insurers based on the National Employer</td>
<td>Tax revenue and regional tax</td>
<td>70% complementary coverage</td>
</tr>
<tr>
<td>Holland</td>
<td>Compulsory insurance system</td>
<td>Private insurance regulated by the government</td>
<td>Private plans offer legal benefits; 85% Supplementary coverage</td>
</tr>
<tr>
<td>New Zealand</td>
<td>National Health System</td>
<td>General tax revenues</td>
<td>33% complementary coverage</td>
</tr>
<tr>
<td>Sweden</td>
<td>National Health System</td>
<td>General tax revenues</td>
<td>5% complementary coverage</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Private insurance. State responsible for providing, planning and financing through subsidies</td>
<td>General tax revenues</td>
<td>Private plans provide universal basic benefits</td>
</tr>
</tbody>
</table>
OBJECTIVE
Analyze the quality of the best global Healthcare Systems and compare with the Mexican Healthcare System.

METHODS
A systematic review was carried out in the network for a structural and comparative analysis on the best Health Systems in the world versus the current situation in Mexico and where the strategies for its integration point and the establishment or search of the universal coverage in health, of the quality of health care.

Based on this critical-structural analysis (Table 1), some of the countries with the highest quality indicators to qualify as the best health system are:

<table>
<thead>
<tr>
<th>Country</th>
<th>Indicator</th>
</tr>
</thead>
</table>
| Australia | **Health and Inequity in Health**: Access to services: citizens, Australian residents, and allied countries (New Zealand, Sweden and Spain)  
**Appropriate treatment and adequate treatment in distribution**: 100% free  
**Financial Protection and Fair Financing**: Income tax and 50% is supplementary coverage, Medicare insurance, 100% in the public service, (50% state and 50% federal) in the private sector contributes per private insurance coverage |
| Canada | **Health and Inequity in Health**: Access to services: citizens and residents  
**Appropriate treatment and adequate treatment in distribution**: 75% free  
**Financial protection and fair financing**: Income tax and 67% is complementary coverage.  
Symbiotic national system: Public, private, users and government |
| Denmark | **Health and Inequity in Health**: Access to services: citizens and residents  
**Appropriate treatment and adequate treatment in distribution**: 100% free  
**Financial Protection and Fair Financing**: Income tax and 40% is complementary coverage |
| France | **Health and Inequity in Health**: Access to services: citizens and residents  
**Appropriate treatment and adequate treatment in distribution**: 100% free  
**Financial Protection and Fair Financing**: Income and Payroll, 90% purchase or receive government vouchers for supplemental coverage |
| Japan | **Health and Inequity in Health**: Access to services: citizens and residents  
**Appropriate treatment and adequate treatment in distribution**: 100% free  
**Financial Protection and Fair Financing**: Income tax and 70% is complementary coverage |

Versus México:

| México | **Health and Inequity in Health**: Access to citizen and resident services.  
**Adequate treatment and adequate treatment in the distribution**: 45.30% Social Security  
80% IMSS, 18% ISSSTE, 2% SEDENA, SEMAR and PEMEX  
25.5%. Population with Popular Insurance  
29.2% Uninsured Population  
**Financial protection and fair financing**: GDP 6.9%, right of residence |

ORGANIZATION OF HEALTH SYSTEMS IN LATIN AMERICA AND IN THE WORLD

Health posts organize most Health Systems in Latin America, regional, provincial or state hospitals and reference national or metropolitan hospitals, as well as specialized care units (Organization Pan American Health, 1983).

It is important to note that there are different approaches and criteria for the analysis of each of the Health Systems that exist in the world. On many occasions, both developed and underdeveloped countries focus the greatest percentage of their efforts in the curative area of the health-disease process through primary health care, when it is also necessary to generate strategies that will prolong the lives of the population, not only in terms of life expectancy, but in terms of life expectancy, which fulfills the best possible conditions of health, well-being, and happiness (Morales et al., 2016).

Therefore, the purpose of the economic development of a territory should not be focused exclusively on the increase of gross domestic product, but on achieving high levels of health, well-being, and equity for access to basic services, especially in populations that remain vulnerable and which present the highest percentage of health risk
In addition, it is the responsibility of both the State and individuals to make improvements in the policies and practices that are generated in the Health Systems in order to meet the objectives established for this millennium, this is from the implementation of improvements in the Policies and strategies, to generate a more critical and conscious sense, to identify the shortcomings in which it is involved, to promote proposals in search of solutions in an effective, truthful, gradual and lasting approach that allows educational processes and information to be included. This is perhaps the most difficult point for Health System actors, depending on the promotion of health, a process that still presents areas of opportunity in all countries, since it is easy at the Worldwide level through the analysis of the main causes of death worldwide by chronic degenerative diseases, whose genesis in most cases is by the unhealthy lifestyles that the population incurs together with the current socio-demographic characteristics where the Marginalization, inefficient education, and limited access to health services increase the vulnerability of individuals to the increasing development of infectious diseases and those related to nutritional deficiency, among others. Thus, the analysis of the Health Systems is a challenge for the modern Public Health in each country, since the impact of the decisions of each Health System will be reflected in the health of the populations, and particularly in Mexico, which turns out to be a Health System dependent on the pocket of the individuals, of contributions forced by the workers that until this moment, it does not count on the sustainability to guarantee the quality in the services and the effectiveness of the treatments by the lack of the human resources and financial institutions in health institutions. It is seen here again that the policies and strategies that are developed in the matter of promoting healthy lifestyles represent a necessity that becomes indispensable by constitutional right (Laurell, 2013; Lozano, Gómez Dantes, Garrido Latorre, Jiménez-Corona, & Campuzano Rincón, JC Franco Marina, 2013; Puentes Rosas, 2015; Ruvalcaba Ledezma & Cortes Ascencio, 2012; Subsecretariat for integration and development of health sector, 2015; Uribe, 2013).

It is important to emphasize that Health Systems are dynamic, they can always include improvements and integrate new elements that solve real problems, as the population evolves, even eliminate aspects that do not go per the demands of a society that is influenced by aspects of Economic and cultural differences.

It is also known that the organization of a country depends to some extent on available resources, in addition, each country has different levels of progress in the quality of health care, since each country had different starting points, and with very peculiar populations that over the years have had an adaptation of behavior that has been establishing the strategies of action that are of priority (Morales et al., 2016; Subsecretariat for integration and development of health sector, 2015).

On the other hand, health workers at all levels with their academic training contribute to the synergy of the multiple components of the system and to an operative element capable of developing health promotion and disease prevention at the community and individual level. They also must be able to face the epidemiological complexity and demographic growth that we face, with updated biomedical paradigms and to the standard of any country.

The intention to establish this comparison between the "best and worst" Health Systems does not fall primarily on the non-constructive criticism that defines goodness and evil in a system, on the contrary, the exposed evidence indicates that even the countries that have reached the optimum level of sustainability in organizing the health care of their inhabitants need to implement new strategies for the best use of resources, in order to guarantee access to health, through research and critical analysis of each of the determinants and conditioning factors and the complexity of the populations. In this way, when analyzing the Health System of Mexico, it would be incorrect to say that we are far from imitating countries like Holland or France, since our social and economic conditions, as well as our available resources are different, nevertheless it prompts us to take the best of these systems that is in accordance with the needs of Mexico to reach the universalization of the right to health. This must be taken as a challenge that generates change, strengthens the system, and allows the restructuring of current ideologies that cause real and timely changes in comprehensive coverage and access to services.

Talking about the universality of health services is inadequate and confusing, rather, should be expressed as universal coverage of health services, both have different meanings and society has the right to understand this at the level of their implementation in their daily lives or merely listen to the political discourse.

**DISCUSSION**

It is important to note that there are different approaches and criteria for the analysis of each of the Health Systems that exist in the world. On many occasions, both developed and underdeveloped countries focus the greatest percentage of their efforts in the curative area of the health-disease process through primary health care, when it is also necessary to generate strategies that will prolong the lives of the population, not only in terms of life expectancy, but in terms of life expectancy, which fulfills the best possible conditions of health, well-being, and happiness.
Therefore, the purpose of the economic development of a territory should not be focused exclusively on the increase of gross domestic product, but on achieving high levels of health, well-being, and equity for access to basic services, especially in populations that remain vulnerable and present the highest percentage of risk factors for health (Lozano et al., 2013; Ruvalcaba Ledezma & Cortes Ascencio, 2012; Subsecretariat for integration and development of health sector, 2015).

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Talking about the universality of health services is inadequate and confusing, rather, it should be expressed as universal coverage of health services, since both have a different meaning and society has the right to understand this at the level of their implementation in their daily lives or merely listen to the political discourse.

For the analysis of a Health System, it is necessary to take into account aspects such as quality, equity, effectiveness, among other indicators, as indicated by the Euro Health Consumer and the sociodemographic and economic characteristics of the white population. 

CONCLUSIONS

WHO, as the international rector of health, determines the essential characteristics that allow health systems to be positioned, resulting in lasting improvements that are beneficial in the different areas of medicine and in different health programs, redoubling efforts to achieve the Millennium Development Goals (WHO, 2016).

Health systems require quality policies and strategies that focus on the promotion of health, prevention culture and human resources highly qualified for the design of strategies applicable in health education, these processes are directly interrelated and their execution obeys health education strategies, being indispensable to bring about healthy changes in the population and conform the need to be considered directly from the planning of health services.

Finally, indicators that allow for the evaluation of a health system depend on aspects such as: inequity in health, access to health services, adequate treatment in both distribution and financial protection as well as fair financing, in this way, it is conclusive that excessive expenditures on processes or actors do not guarantee the quality and effectiveness of a Health System, on the contrary, they can result in the deficiencies that exist at the global level in the face of the impossibility of improving the global sanitary conditions where the responsibility of guaranteeing physical, psychological and biological well-being is impossible in the face of global deficiencies in health care, whose co-responsibility still requires the awareness of both the State and the citizens. The Mexican health system is a fragmented system from its origins and to achieve universal coverage, requires its integration considering the rector of health, in this case the Ministry of Health has the task of focusing their efforts on such integration.

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CONFLICT OF INTERESTS. The authors declare that there is no conflict of interest for the publication of this article.

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