Course Name	**:** Health Care Administration & Management
Course Code	**: APBPH 2103**
Course level	**: level 3**
Course Credit	**: 4 CU**
Contact Hours	**: 60 Hrs**

Course Description

The Course describes the definition of health care, the philosophy of health care, the political philosophy of health care. It further involves the ideas about the health care delivery systems, in-depth discussion about the Primary Health Care (PHC), understanding emergency health care, health insurance, meaning of first aid versus universal first aid.

Course Objectives

· To help students get exposed to the different health systems prevalent in their country.
· To equip students with capacities to analyze weakness and strengths of different health care systems.
· To help introduce students to new debates concerning health insurance to the country's citizens.
· To enable students learn the appropriate mechanisms through which health care can be well delivered.

Course Content

Introduction to Health Care Administration

· Definition of Health Care
· Philosophy of Health Care
· Ethics of health care
· Political philosophy of healthcare

Health Care delivery

· Meaning of health care delivery
· Primary health care
· Secondary health care
· Tertiary health care
· Health care industry
· Health care research
· Health care financing
· Health care administration and regulation
· Health care information technology

Primary Health Care (PHC)

· Aims of Primary Health Care
· Community health
· Goals and principles of Primary Health Care
· Approaches of PHC
· PHC and mental health

Emergency Health Care
· Defining an Emergency
· Types of Emergencies
· Systems of classifying emergencies
· Agencies involved in dealing with emergencies
· Summoning emergency services
· Key emergency principle
Health Insurance
· Meaning of Health Insurance
· Definition of health Insurance policy
· Health Plan Vs health insurance
· Factors affecting insurance prices
· Community health insurance in Uganda
· Standards of hospitals and clinics used by insurance companies
· How health insurance can work for Uganda
First Aid
· Meaning of First Aid
· Aims of first aid
· Several types of first aid
· Symbols of first aid
· Conditions that often require first aid
· First Aid resources
· Basic First Aid; What to do
Universal First Aid
· Definition of Universal First Aid
· The birth of Universal Health Care System
51
· Case studies of Universal first aid
Mode of delivery Face to face lectures
Assessment
Coursework 40%
Exams 60%
Total Mark 100%

HEALTH SERVICE ADMINSTRATION

Introduction to Health care system

Health care systems are designed to meet the health care needs of target populations. There are a wide variety of health care systems around the world. In some countries, the health care system has evolved and has not been planned, whereas in others a concerted effort has been made by governments, trade unions, charities, religious, or other co-ordinated bodies to deliver

planned health care services targeted to the populations they serve. However, health care planning has often been evolutionary rather than revolutionary.

Goals

The goals for health systems, according to the *World Health Report 2000 - Health systems: improving performance* (WHO, 2000), are good health, responsiveness to the expectations of the population, and fair financial contribution. Duckett (2004) proposed a two dimensional approach to evaluation of health care systems: quality, efficiency and acceptability on one dimension and equity on another.

Providers

Health care provider

Health care providers are trained professional people working self-employed or as an employee in an organization, whether a for-profit company, a not-for profit company, a government entity, or a charity. Organisations employing people providing health care are also known as health care providers. Examples are doctors and nurses, dentists, medical laboratory staff, specialist therapists, psychologists, pharmacists, chiropractors, and optometrists.

Financing

There are generally five primary methods of funding health care systems:

1. direct or out-of-pocket payments,
2. general taxation,
3. social health insurance,
4. voluntary or private health insurance, and
5. donations or community health insurance.

Most countries' systems feature a mix of all five models. One study [5] based on data from the OECD concluded that all types of health care finance "are compatible with" an efficient health care system. The study also found no relationship between financing and cost control.

The term health insurance is generally used to describe a form of insurance that pays for medical expenses. It is sometimes used more broadly to include insurance covering disability or long-term nursing or custodial care needs. It may be provided through a government-sponsored social insurance program, or from private insurance companies. It may be purchased on a group basis (e.g., by a firm to cover its employees) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high or unexpected health care expenses. Similar

benefits paying for medical expenses may also be provided through schemes organized by the government and funded through contributions from users.

By estimating the overall cost of health care expenses, a routine finance structure (such as a monthly premium or annual tax) can be developed, ensuring that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization, most often either a government agency or a private or not-for-profit entity operating a health plan.[6]

Many forms of commercial health insurance control their costs by restricting the benefits that are paid by through deductiblesco-paymentscoinsurance, policy exclusions, and total coverage limits and will severely restrict or refuse coverage of pre-existing conditions. Many government schemes also have co-payment schemes but exclusions are rare because of political pressure. The larger insurance schemes may also negotiate fees with providers.

Many forms of government insurance schemes control their costs by using the bargaining power of government to control costs in the health care delivery system. For example by negotiating drug prices directly with pharmaceutical companies, or negotiating standard fees with the medical profession. Government schemes sometimes feature contributions related to earnings as part of a scheme to deliver universal health care, which may or may not also involve the use of commercial and non-commercial insurers. Essentially the more wealthy pay a little more into the scheme and to cover the needs of the relatively poor who therefore contribute a little less. There are usually caps on the contributions of the wealthy and minimum payments that must be made by the insured (often in the form of a minimum contribution, similar to a deductible in commercial insurance models).

Payment models

Primary care

There are three ways to pay general practitioners. There has been growing interest in blending elements of these systems.[7]

Fee-for-service

Fee-for-service arrangements pay general practitioners based on the service.[7] They are even more widely used for specialists working in ambulatory care.

There are two ways to set fee levels:

- By individual practitioners.

- Central negotiations (as in Japan, Germany, Canada and in France) or hybrid model (such as in Australia, France's sector 2, and New Zealand) where GPs can charge extra fees on top of standardized patient reimbursement rates.

Other

In *capitation payment systems*, GPs are paid for each patient on their "list", usually with adjustments for factors such as age and gender. According to OECD, "these systems are used in Italy (with some fees), throughout the United Kingdom (with some fees and allowances for specific services), Austria (with fees for specific services), Denmark (one third of income with remainder fee for service), Ireland (since 1989), the Netherlands (fee-for-service for privately insured patients and public employees) and Sweden (from 1994). Capitation payments have become more frequent in “managed care” environments in the United States."

According to OECD, "Capitation systems allow funders to control the overall level of primary health expenditures, and the allocation of funding among GPs is determined by patient registrations. However, under this approach, of GPs may register too many patients and under-serve them, select the better risks and refer on patients who could have been treated by the GP directly. Freedom of consumer choice over doctors, coupled with the principle of "money following the patient" may moderate some of these risks. Aside from selection, these problems are likely to be less marked than under salary-type arrangements."

In several OECD countries, general practitioners (GPs) are employed on *salaries* for the government. According to OECD, "Salary arrangements allow funders to control primary care costs directly; however, they may lead to under-provision of services (to ease workloads), excessive referrals to secondary providers and lack of attention to the preferences of patients." There has been movement away from this system.

Health informatics

Health informatics or medical informatics is the intersection of information science, medicine and health care. It deals with the resources, devices and methods required to optimize the acquisition, storage, retrieval and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems.

Management

Public health is concerned with threats to the overall health of a community based on population health analysis. The population in question can be as

small as a handful of people or as large as all the inhabitants of several continents (for instance, in the case of a pandemic). Public health is typically divided into epidemiology, biostatistics and health services. Environmental, social, behavioral, and occupational health are also important subfields.

Vaccination policy refers to the policy a government adopts in relation to vaccination. Vaccinations are voluntary in some countries and mandatory in some countries. Some governments pay all or part of the costs of vaccinations for vaccines in a national vaccination schedule.

Today, most governments recognize the importance of public health programs in reducing the incidence of disease, disability, and the effects of aging, although public health generally receives significantly less government funding compared with medicine. In recent years, public health programs providing vaccinations have made incredible strides in promoting health, including the eradication of smallpox, a disease that plagued humanity for thousands of years.

An important public health issue facing the world currently is HIV/AIDS[8]. Another major public health concern is diabetes[9]. In 2006, according to the World Health Organization, at least 171 million people worldwide suffered from diabetes. Its incidence is increasing rapidly, and it is estimated that by the year 2030, this number will double. A controversial aspect of public health is the control of smoking[10].

Antibiotic resistance is another major concern, leading to the reemergence of diseases such as Tuberculosis.

Special health care systems

- Occupational safety and health
- School health services
- Military medicine

Cross-country comparisons

Direct comparisons of health statistics across nations are complex. The Commonwealth Fund, in its annual survey, "Mirror, Mirror on the Wall", compares the performance of the health care systems in Australia, New Zealand, the United Kingdom, Germany, Canada and the U.S. Its 2007 study found that, although the U.S. system is the most expensive, it consistently underperforms compared to the other countries.[11] A major difference between the U.S. and the other countries in the study is that the U.S. is the only

country without universal health care. The OECD also collects comparative statistics, and has published brief country profiles.

Country	**Life expectancy**	**Infant mortality rate**	**Physicians per 1000 people**	**Nurses per 1000 people**	**Per capita expenditure on health (USD)**	**Health care costs as a percent of GDP**	**% of government revenue spent on health**	**% of health costs paid by government**
Australia	81.4	4.2	2.8	9.7	3,137	8.7	17.7	67.7
Canada	80.7	5.0	2.2	9.0	3,895	10.1	16.7	69.8
France	81.0	4.0	3.4	7.7	3,601	11.0	14.2	79.0
Germany	79.8	3.8	3.5	9.9	3,588	10.4	17.6	76.9
Japan	82.6	2.6	2.1	9.4	2,581	8.1	16.8	81.3
Norway	80.0	3.0	3.8	16.2	5,910	9.0	17.9	83.6
Sweden	81.0	2.5	3.6	10.8	3,323	9.1	13.6	81.7
UK	79.1	4.8	2.5	10.0	2,992	8.4	15.8	81.7
US	78.1	6.7	2.4	10.6	7,290	16.0	18.5	45.4

Efficiency and effectiveness of service are the focus of these profiles. Perhaps most efficient is Healthcare in Taiwan, costing 6 percent of GDP (~1/4 US cost), universal coverage by a government-run insurer with smart card IDs to fight fraud.

Health care by country

Beginning in 1979, military conflict destroyed the **health** system of **Afghanistan**. Most medical professionals left the country in the 1980s and 1990s, and all medical training programs ceased. In 2004 Afghanistan had one medical facility for every 27,000 people, and some centers were responsible for as many as 300,000 people. In 2004 international organizations provided a

large share of medical care. An estimated one-quarter of the population had no access to health care. In 2003 there were 11 physicians and 18 nurses per 100,000 population, and the per capita health expenditure was US$28 embarked on a poverty reduction program that called for outlays in education, health, sanitation, and water. A poliovaccination campaign for 14 million children has been carried out, and a program to resettle some 2 million subsistence farmers is underway. In November 2004, the government launched a five-year program to expand primary health care. In January 2005, it began distributing antiretroviral drugs, hoping to reach up to 30,000 HIV-infected adults.

Finland

In Finland, public medical services at clinics and hospitals are run by the municipalities (local government) and are funded 78% by taxation, 20% by patients through access charges, and by others 2%. Patient access charges are subject to annual caps. For example GP visits are (11€ per visit with annual 33€ cap), hospital outpatient treatment (22€ per visit), a hospital stay, including food, medical care and medicines (26€ per 24 hours, or 12€ if in a psychiatric hospital). After a patient has spent 590€ per year on public medical services, all treatment and medications thereafter are free. Taxation funding is partly local and partly nationally based. Patients can claim re-imbursement of part of their prescription costs from KELA. Finland also has a much smaller private medical sector which accounts for about 14 percent of total health care spending. Only 8% of doctors choose to work in private practice, and some of these also choose to do some work in the public sector. Private sector patients can claim a contribution from KELA towards their private medical costs (including dentistry) if they choose to be treated in the more expensive private sector, or they can join private insurance funds. However, private sector health care is mainly in the primary care sector. There are virtually no private hospitals, the main hospitals being either municipally owned (funded from local taxes) or run by the teaching universities (funded jointly by the municipalities and the national government). In 2005, Finland spent 7.5% of GDP on health care, or US$2,824 per capita. Of that, approximately 78% was government expenditure.

Germany

Germany has a universal multi-payer system with two main types of health insurance: "State health insurance" (GesetzlicheKrankenversicherung) known as sickness funds and "Private" (Private Krankenversicherung). Compulsory insurance applies to those below a set income level and is provided through private non-profit "sickness funds" at common rates for all members, and is paid for with joint employer-employee contributions. Provider compensation rates are negotiated in complex corporatist social bargaining among specified autonomously organized interest groups (e.g. physicians' associations) at the

level of federal states (Länder). The sickness funds are mandated to provide a wide range of coverages and cannot refuse membership or otherwise discriminate on an actuarial basis. Small numbers of persons are covered by tax-funded government employee insurance or social welfare insurance. Persons with incomes above the prescribed compulsory insurance level may opt into the sickness fund system, which a majority do, or purchase private insurance. Private supplementary insurance to the sickness funds of various sorts is available. In 2005, Germany spent 10.7% of GDP on health care, or US$3,628 per capita. Of that, approximately 77% was government expenditure.

Ghana

In Ghana, most health care is provided by the government, but hospitals and clinics run by religious groups also play an important role. Some for-profit clinics exist, but they provide less than 2% of health services. Health care is very variable through the country. The major urban centres are well served, but rural areas often have no modern health care. Patients in these areas either rely on traditional medicine or travel great distances for care. In 2005, Ghana spent 6.2% of GDP on health care, or US$30 per capita. Of that, approximately 34% was government expenditure.[18]

Mali

Health in Mali, one of the world's poorest nations, is greatly affected by poverty, malnutrition, and inadequate hygiene and sanitation. Mali's health and development indicators rank among the worst in the world. In 2000 only 62–65 percent of the population was estimated to have access to safe drinking water and only 69 percent to sanitation services of some kind; only 8 percent was estimated to have access to modern sanitation facilities. Only 20 percent of the nation's villages and livestock watering holes had modern water facilities.

Mali is dependent on international development organizations and foreign missionary groups for much of its health care. In 2001 general government expenditures on health constituted 6.8 percent of total general government expenditures and 4.3 percent of gross domestic product (GDP), totaling only about US$4 per capita at an average exchange rate. Medical facilities in Mali are very limited, especially outside of Bamako, and medicines are in short supply. There were only 5 physicians per 100,000 inhabitants in the 1990s and 24 hospital beds per 100,000 in 1998. In 1999 only 36 percent of Malians were estimated to have access to health services within a five-kilometer

Health care in the Netherlands, has since January 2006 been provided by a system of compulsory insurance backed by a risk equalization program so that the insured are not penalized for their age or health status. This is meant to encourage competition between health care providers and insurers. Children under 18 are insured by the government, and special assistance is available to

those with limited incomes. In 2005, the Netherlands spent 9.2% of GDP on health care, or US$3,560 per capita. Of that, approximately 65% was government expenditure.[18]

Health care provision in Nigeria is a concurrent responsibility of the three tiers of government in the country.[33] However, because Nigeria operates a mixed economy, private providers of health care have a visible role to play in health care delivery. The federal government's role is mostly limited to coordinating the affairs of the universityteaching hospitals, while the state government manages the various general hospitals and the local government focus on dispensaries. The total expenditure on health care as % of GDP is 4.6, while the percentage of federal government expenditure on health care is about 1.5%.[34] A long run indicator of the ability of the country to provide food sustenance and avoid malnutrition is the rate of growth of per capita food production; from 1970-1990, the rate for Nigeria was 0.25%.[35] Though small, the positive rate of per capita may be due to Nigeria's importation of food products. Historically, health insurance in Nigeria can be applied to a few instances: free health care provided and financed for all citizens, health care provided by government through a special health insurance scheme for government employees and private firms entering contracts with private health care providers.[36] However, there are few people who fall within the three instances. In May 1999, the government created the National Health Insurance Scheme, the scheme encompasses government employees, the organized private sector and the informal sector. Legislative wise, the scheme also covers children under five, permanently disabled persons and prison inmates. In 2004, the administration of Obasanjo further gave more legislative powers to the scheme with positive amendments to the original 1999 legislative act.[37]

South Africa

In South Africa, parallel private and public systems exist. The public system serves the vast majority of the population, but is chronically underfunded and understaffed. The wealthiest 20% of the population uses the private system and are far better served. This division in substantial ways perpetuates racial inequalities created in the pre-apartheid segregation era and apartheid era of the 20th century. In 2005, South Africa spent 8.7% of GDP on health care, or US$437 per capita. Of that, approximately 42% was government expenditure.[18]

Sudan

Outside urban areas, little health care is available in Sudan, helping account for a relatively low average life expectancy of 57 years and an infant mortality rate of 69 deaths per 1,000 live births, low by standards in Middle Eastern but not African countries. For most of the period since independence in 1956, Sudan has experienced civil war, which has diverted resources to military use

that otherwise might have gone into health care and training of professionals, many of whom have migrated in search of more gainful employment. In 1996 the World Health Organization estimated that there were only 9 doctors per 100,000 people, most of them in regions other than the South. Substantial percentages of the population lack access to safe water and sanitary facilities. Malnutrition is widespread outside the central Nile corridor because of population displacement from war and from recurrent droughts; these same factors together with a scarcity of medicines make diseases difficult to control. Child immunization against most major childhood diseases, however, had risen to approximately 60 percent by the late 1990s from very low rates in earlier decades. Spending on health care is quite low—only 1 percent of gross domestic product (GDP) in 1998 (latest data). The United Nations placed the rate of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) infection in late 2003 at 2.3 percent for adults, quite low by regional standards. The United Nations suggested, however, that the rate could be as high as 7.2 percent. Between 400,000 and 1.3 million adults and children were living with HIV, and AIDS deaths numbered 23,000. As of late 2004, some 4 million persons in the South had been internally displaced and more than 2 million had died or been killed as a result of two decades of war. Comparable figures for Darfur were 1.6 million displaced and 70,000 dead since fighting began there in early 2003.[15]

trend. Physicians are poorly trained, modern medical techniques are rarely used, and medications are in short supply. In 2004 Niyazov dismissed 15,000 medical professionals, exacerbating the shortage of personnel. In some cases, professionals have been replaced by military conscripts. Private health care is rare, as the state maintains a near monopoly. Free public health care was abolished in 2004.

United States

The United States is alone among developed nations in not having a universal health care system. Healthcare in the U.S. does, however, have significant publicly funded components. Medicare covers the elderly and disabled with a historical work record, Medicaid is available for some, but not all of the poor, and the State Children's Health Insurance Program covers children of low-income families. The Veterans Health Administration directly provides health care to U.S. military veterans through a nationwide network of government hospitals; while active duty service members, retired service members and their dependents are eligible for benefits through TRICARE. Together, these tax-financed programs cover 27.8% of the population and make the government the largest health insurer in the nation.

Roughly two thirds of urban hospitals in the U.S. are non-profit hospitals and the balance evenly divided between for-profit hospitals and public hospitals. The urban public hospitals are often associated with medical schools. For

example, the largest public hospital system in America is the New York City Health and Hospitals Corporation, which is associated with the New York University School of Medicine.

Although public hospitals constitute the greatest percentage of non-federal hospitals, care in the U.S. is generally provided by physicians in private practice and private hospitals. Just over 59% of Americans receive health insurance through an employer, although this number is declining and the employee's expected contribution to these plans varies widely and is increasing as costs escalate. A significant number of people cannot obtain health insurance through their employer or are unable to afford individual coverage. The U.S. Census Bureau estimated that 15.3% of the U.S. population, or 45.7 million people, were uninsured at some time in 2007. More than 38% of the uninsured are in households earning $50,000 or more per year. The census also states that 16.7% of the 39.6 million on Medicaid incorrectly reported they were uninsured. A few states have taken serious steps toward universal health care coverage, most notably Minnesota, Massachusetts and Connecticut, with recent examples being the Massachusetts 2006 Health Reform Statute and Connecticut's SustiNet plan to provide quality, affordable health care to state residents. In 2005, the United States spent 15.2% of GDP on health care, or US$6,347 per capita. Of that, approximately 45% was government expenditure.

Consumer driven health care is a plan put forth by the National Center for Policy Analysis, a self-described conservative think tank. It refers to a method of financing health care being the combination of a savings plan with a health insurance policy that pays for the most catastrophic health care needs. As such it sits between fully comprehensive low or zero deductible/co-pay insurance policy and meeting all health insurance out of pocket. This type of arrangements relieves the insurance company for paying for all but the most catastrophic of medical expenses. This reduces the monthly premium paid by the insured but the consumer is then expected to put aside money into a Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), or similar medical payment products, from which the majority of routine health care expenses and the first large slice of any catastrophic insurance claim would be used to pay health care providers and prescription medicines. The advantage of this system is that the consumer is expected to play a higher role in ensuring value for money. But this is but one option of many that have been discussed in the current debates in the U.S.Congress.

United Arab Emirates

Standards of health care are considered to be generally high in the United Arab Emirates, resulting from increased government spending during strong economic years. According to the UAE government, total expenditures on health care from 1996 to 2003 were US$436 million. According to the World Health Organization, in 2004 total expenditures on health care constituted 2.9

percent of gross domestic product (GDP), and the per capita expenditure for health care was US$497. Health care currently is free only for UAE citizens. Effective January 2006, all residents of Abu Dhabi are covered by a new comprehensive health insurance program; costs will be shared between employers and employees. The number of doctors per 100,000 (annual average, 1990–99) is 181. The UAE now has 40 public hospitals, compared with only seven in 1970. The Ministry of Health is undertaking a multimillion-dollar program to expand health facilities–hospitals, medical centers, and a trauma center–in the seven emirates. A state-of-the-art general hospital has opened in Abu Dhabi with a projected bed capacity of 143, a trauma unit, and the first home health care program in the UAE. To attract wealthy UAE nationals and expatriates who traditionally have traveled abroad for serious medical care, Dubai is developing Dubai Healthcare City, a hospital free zone that will offer international-standard advanced private health care and provide an academic medical training center; completion is scheduled for 2010.[15]

Zimbabwe

Zimbabwe now has one of the lowest life expectancies on Earth - 44 for men and 43 for women, down from 60 in 1990. The rapid drop has been ascribed mainly to the HIV/AIDS pandemic. Infant mortality has risen from 59 per thousand in the late 1990s to 123 per 1000 by 2004. The health system has more or less collapsed: By the end of November 2008, three of Zimbabwe's four major hospitals had shut down, along with the Zimbabwe Medical School and the fourth major hospital had two wards and no operating theatres working. Due to hyperinflation, those hospitals still open are not able to obtain basic drugs and medicines. The ongoing political and economic crisis also contributed to the emigration of the doctors and people with medical knowledge. In August 2008, large areas of Zimbabwe were struck by the ongoing choleraepidemic.

Out-of-pocket expenses

Out-of-pocket expenses are direct outlays of cash which may or may not be later reimbursed.

In operating a vehicle, gasoline, parking fees and tolls are considered out-of-pocket expenses for the trip. Insurance, oil changes, and interest are not, because the outlay of cash covers expenses accrued over a longer period of time.

The services rendered and other in-kind expenses are not considered out-of-pocket expenses, nor are depreciation of capital goods or depletion.

Organizations often reimburse out-of-pocket expenses incurred on their behalf, especially expenses incurred by employees on their employers' behalf. In the

United States, out-of-pocket expenses for such things as charity, medical bills, and education may be deductions on federal income taxes, according to IRS regulations.

To be **out of pocket** is to have expended personal resources, often unexpectedly or unfairly, at the end of some enterprise.

Since at least 1970, the phrase *out of pocket* has been occasionally used as a synonym for *out of contact.*[*citation needed*]

Health Financing

In the health care financing sector, this represents the share of the expenses that the patient or the family pay directly to the health care provider, without a third-party (insurer, or state). This usually means that the family has to bear the costs, without risk sharing or solidarity mechanisms involved, and without the possibility to spread the cost overtime.

National health insurance

National health insurance is health insurance that insures a national population for the costs of health care and usually is instituted as a program of healthcare reform. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular program and country. National health insurance does not equate to government run or government financed health care, but is usually established by national legislation.

History

Germany has the world's oldest national health insurance, through the world's oldest universal health care system, with origins dating back to Otto von Bismarck's social legislation, which included the Health Insurance Bill of 1883, Accident Insurance Bill of 1884, and Old Age and Disability Insurance Bill of 1889. In Britain, the National Insurance Act 1911 marked the first steps there towards national health insurance, covering most employed persons and their financial dependents and all persons who had been continuous contributors to the scheme for at least five years whether they were working or not. This system of health insurance continued in force until the creation of the National Health Service in 1948 which extended health care security to all legal residents. Most other countries national health insurance systems were implemented in the period following the Second World War as a process of deliberate healthcare reform, intended to make health care affordable to all, in the spirit of Article 25 of the Universal Declaration of Human Rights of 1948 by nations which had adopted the declaration as signatories. The US did not ratify the social and economic rights sections, including Article 25's right to health.[1]

Types of programs

Health care systems, Single-payer health care, and Universal health care

National healthcare insurance programs differ both in how the money is collected, and in how the services are provided. In countries such as Canada, payment is made by the government directly from tax revenue. In the UK an additional contribution is collected for all workers, paid by employees and employers based on the level of salary paid. In both of these cases the collection is administered by government. In France a similar system of compulsory contributions is made, but the collection is administered by non-profit organisations set up for the purpose. This is known in the United States as single-payer health care. The provision of services may be either through health care providers that may be publicly or privately owned.

An alternative funding approach is where countries implement national health insurance by legislation requiring compulsory contributions to competing insurance funds. These funds (which may be run by public bodies, private for-profit companies, or private non-profit companies), must provide a minimum standard of coverage and are not allowed to discriminate between patients by charging different rates according to age, occupation, or previous health status. To protect the interest of both patients and insurance companies, the government establishes an equalization pool to spread risks between the various funds. The government may also contribute to the equalization pool as a form of health care subsidy. This is the model used in the Netherlands.

Other countries are largely funded by contributions by employers and employees to sickness funds. With these programs, funds do not come from the government, and neither from direct private payments. This system operates in countries such as Germany and Belgium. These countries have so-called social health insurance systems, characterized by the presence of sickness funds, which can be based on professional, regional, religious, or political affiliation. Usually characterization is a matter of degree: systems are mixes of these three sources of funds (private, employer-employee contributions, and national/sub-national taxes). These funds are usually not for profit institutions run solely for the benefit of their members.

In addition to direct medical costs, some national insurance plans also provide compensation for loss of work due to ill-health, or may be part of wider social insurance plans covering things such as pensions, unemployment, occupational retraining, and financial support for students. National schemes have the advantage that the pool or pools tend to be very very large and reflective of the national population. Health care costs, which tend to be high at certain stages in life such as during pregnancy and childbirth and especially in the last few years of life can be paid into the pool over a lifetime and be higher when earnings capacity is greatest to meet costs incurred at times when

earnings capacity is low or non existent. This differs from the private insurance schemes that operate in some countries which tend to price insurance year on year according to health risks such as age, family history, previous illnesses, and height/weight ratios. Thus some people tend to have to pay more for their health insurance when they are sick and/or are least able to afford it. These factors are not taken into consideration in NHI schemes. In private schemes in competitve insurance markets, these activities by insurance companies tend to act against the the basic principles of insurance which is group solidarity.

National health insurance schemes

- Health care in Ghana - National Health Insurance Scheme (NHIS)
- Health care in Colombia - Law 100 - National Health Insurance Scheme: Contributory Vs. Subsidized coverage (NHIS)
- Health care in Japan - People without insurance through employers can participate in a national health insurance program administered by local governments.
- Health care in South Korea
- Health care in Switzerland - A compulsory health insurance covers a range of treatments which are set out in detail in the Federal Act.
- Health care in Taiwan - National Health Insurance (NHI)
- Health care in Nigeria - National Health Insurance Scheme (NHIS)
- Health care in Canada

Health policy

Health care often accounts for one of the largest areas of spending for both governments and individuals all over the world, and as such it is surrounded by controversy. For example, it is now clear that medical debt is now a leading cause of bankruptcy in the United States.[1] Though there are many topics involved in health care politics, most can be categorized as either philosophical or economic. Philosophical debates center around questions about individual rights and government authority while economic topics include how to maximize the quality of health care and minimize costs.

Background

The modern concept of health care involves access to medical professionals from various fields as well as medical technologies such as medication and surgical techniques. One way that a person gains access to these goods and services is by paying for them. Many governments around the world have established universal health care, which attempts to provide the same level of access to every person in a country. Many citizens are against universal health care for a variety of reasons.

Philosophy

Right to Health Care

The United Nations' Universal Declaration of Human Rights (UDHR) asserts that medical care is a right of all people. Many religions also impose an obligation on their followers to care for those in less favourable circumstances, including the sick. Humanists too would assert the same obligation and the right has been enshrined in many other ways too.[2][3]

An opposing school of thought rejects this notion. They (laissez-faire capitalists for example) assert that providing health care funded by taxes is immoral because it is a form of legalized robbery, denying the right to dispose of one's own income at one's own will. They assert that doctors should not be servants of their patients but rather they should be regarded as traders, like everyone else in a free society."

Government Regulation

A second question concerns the effect government involvement would have. One concern is that the right to privacy between doctors and patients could be eroded if governments demand power to oversee health of citizens.

Another concern is that governments use legislation to control personal freedoms. For example, some Canadian provinces have outlawed private medical insurance from competing with the national social insurance systems for basic health care to ensure fair allocation of national resources irrespective of personal wealth. Laissez-faire supporters argue that this blocks a fundamental freedom to use one's own purchasing power at will.

Controlling the Industry

When a government controls the health care industry, it defines what health care is available, and how it is paid for, privately or with taxes. Public regulation, investor owned HMOs and medical insurance companies (which are not under the democratic control of health care users) may all determine what health care a person might get.

Universal health care requires government involvement and oversight.

Impact on quality of health care

One question that is often brought up is whether publicly-funded health care provides better or worse quality health care than market driven medicine. There are many arguments on both sides of the issue.

Arguments which see publicly-funded health care as improving the quality of health care:

- For those people who would otherwise go without care, any quality care is an improvement.
- Since people perceive universal health care as *free*, they are more likely to seek preventative care which makes them better off in the long run.
- A study of hospitals in Canada found that death rates are lower in private not-for-profit hospitals than in private for-profit hospitals.

Arguments which see publicly-funded health care as worsening the quality of health care:

- It slows down innovation and inhibits new technologies from being developed and utilized. This simply means that medical technologies are less likely to be researched and manufactured, and technologies that are available are less likely to be used.
- Free health care can lead to overuse of medical services, and hence raise overall cost.
- Publicly-funded medicine leads to greater inefficiencies and inequalities.
- It is alleged that uninsured citizens can simply pay for their health care. Even indigent citizens can still receive emergency care from alternative sources such as non-profit organizations. Some providers may be required to provide some emergency services regardless of insured status or ability to pay, as with the Emergency Medical Treatment and Active Labor Act in the United States.

Impact on medical professionals

Proponents of universal health care contend that universal health care reduces the amount of paperwork that medical professionals have to deal with, allowing them to concentrate on treating patients.

Impact on Medical Research

Those in favor of universal health care posit that removing profit as a motive will increase the rate of medical innovation. Those opposed argue that it will do the opposite, for the same reason.

Economic Impact

Universal health care affects economies differently than private health care.

Those in favor of universal health care contend that it reduces wastefulness in the delivery of health care by removing the middle man, the insurance companies, and thus reducing the amount of bureaucracy.

Those opposed to universal health care argue that socialized medicine suffers from the same financial problems as any other government planned economy. They argue that it requires governments to greatly increase taxes as costs rise year over year. Their claim is that universal health care essentially tries to do the economically impossible. Opponents of universal health care argue that government agencies are less efficient due to bureaucracy. However, supporters note that modern industrial countries with socialized medicine tend to spend much less on health care than similar countries lacking such systems.

In the United States, opponents of universal health care also claim that, before heavy regulation of the health care and insurance industries, doctor visits to the elderly, and free care or low cost care to impoverished patients were common, and that governments effectively regulated this form of charity out of existence. They suggest that universal health care plans will add more inefficiency to the medical system through additional bureaucratic oversight and paperwork, which will lead to fewer doctor patient visits.

Means

Many forms of universal health care have been proposed. These include mandatory health insurance requirements, complete capitalization of health care, and single payer systems among others.

Hyperbole

Hyperbole has become a dominant feature of health care politics in the United States. Some examples are these.

Publicly-funded health care

Publicly-funded health care is a form of health care financing designed to meet the cost of all or most health care needs from a publicly managed fund. Usually this is under some form of democratic accountability, the right of access to which are set down in rules applying to the whole population contributing to the fund or receiving benefits from it. The fund may be a not-for-profit trust which pays out for health care according to common rules established by the members or by some other democratic form. In some countries the fund is controlled directly by the government or by an agency of

the government for the benefit of the entire population. This distinguishes it from other forms of private medical insurance, the rights of access to which are subject to contractual obligations between an insurer (or his sponsor) and an insurance company which seeks to make a profit by managing the flow of funds between funders and providers of health care services.

Financing

Publicly funded health care systems are usually financed in one of two ways: through taxation or via required national health insurance.

When taxation is the primary means of financing health care, everyone receives the same level f coverage regardless of their ability to pay, their level of taxation, or risk factors.

In compulsory insurance models, healthcare is financed through a "sickness fund", which can receive income from a number of places such as employees' salary deductions, employers' contributions, or top-ups from the state.

Varieties of public systems

Health care system

Most developed countries currently have partially or fully publicly funded health systems. For example, each country of the United Kingdom has a National Health Service (NHS). Other examples would be the Medicare systems in Canada and in Australia. In most countries of Europe, a system of social insurance based on the principle of social solidarity shields the citizen from bearing the burden of most health care expenditures at the time of consumption. The citizen contributes to these costs in taxation during his or her lifetime.

Among countries with significant public funding of health care there are many different approaches exist to the funding and provision of medical services. Systems may be funded from general government revenues (as in the United Kingdom and Canada), or through a government social security system (as in France, Belgium, Japan, and Germany) with a separate budget and hypothecated taxes. The proportion of the cost of care covered also differs: in Canada, all hospital care is paid for by the government, while in Japan patients must pay 10 to 30% of the cost of a hospital stay. Services provided by public systems vary. For example, the Belgian government pays the bulk of the fees for dental and eye care, while the Australian government covers only eye care.

Publicly funded medicine may be administered and provided by the government, as in the United Kingdom; in some systems, though, medicine is publicly funded but most health providers are private entities, as in Canada.

The organization providing public health insurance is not necessarily a public administration, and its budget may be isolated from the main state budget. Some systems do not provide universal healthcare, or restrict coverage to public health facilities. Some countries, such as Germany, have multiple public insurance organizations linked by a common legal framework. Some, like Holland, allow private for-profit insurers to participate.

Innovations in health care can be very expensive. Population aging generally implies more health care, at a time when the taxed working population decreases.[*citation needed*]

Two-tier health care

Almost every major country that has a publicly funded health care system also has a parallel private system, generally catering to private insurance holders. While one goal of public systems is to provide equal service to all, this egalitarianism is often partial. Every nation either has parallel private providers or its citizens are free to travel to a nation that does, so there is effectively a two-tier healthcare system that reduces the equality of service.

From the inception of the NHS model (1948), public hospitals in the United Kingdom have included "amenity beds" which would typically be siderooms fitted more comfortably, and private wards in some hospitals where for a fee more amenities are provided. Patients using these beds are in an NHS hospital for surgical treatment, and operations are generally carried out in the same operating theatres as NHS work and by the same personnel but the hospital and the physician will receive funding from an insurance company. These amenity beds do not exist in all publicly funded systems, such as in Spain. From time to time, the NHS pays for private hospitals (*arranged hospitals*) to take on surgical cases under contract.

Policy discussion

Many countries are seeking the right balance of public and private insurance, public subsidies, and out-of-pocket payments.

Many OECD countries have implemented reforms to achieve policy goals of ensuring access to health-care, improving the quality of health care and health outcomes, allocating an appropriate level of public sector other resources to health care, whilst at the same time ensuring that services are provided in a cost-efficient and cost-effective manner (microeconomic efficiency). A range of measures, such as better payment methods, have improved the microeconomic incentives facing providers. However, introducing improved incentives through a more competitive environment among providers and insurers has proved difficult.

There are deaths from insufficient coverage, of both people and procedures, by private health insurance in the US. A 2009 Harvard study published in the American Journal of Public Health found more than 44,800 excess deaths annually in the United States due to Americans lacking health insurance, equivalent to one excess death ever 12 minutes. More broadly, the total number of people in the United States, whether insured or uninsured, who die because of lack of medical care were estimated in a 1997 analysis to be nearly 100,000 per year.

Healthcare reform

Healthcare reform is a general rubric used for discussing major health policy creation or changes—for the most part, governmental policy that affects healthcare delivery in a given place. Healthcare reform typically attempts to:

- Broaden the population that receives health care coverage through either public sector insurance programs or private sectorinsurance companies
- Expand the array of health care providers consumers may choose among
- Improve the access to health care specialists
- Improve the quality of health care
- Decrease the cost of health care

Universal health care.

Universal health care is health care coverage for all eligible residents of a political region and often covers medical, dental and mental health care. Typically, costs are borne in the majority by publicly-funded programs.

Universal health care systems vary according to the extent of government involvement in providing care and/or health insurance. In some countries, such as the UK, Spain, and the Nordic countries, the government has a high degree of involvement in the commissioning or delivery of health care services and access is based on residence rights not on the purchase of insurance. Others have a much more pluralistic delivery system based on obligatory health with contributory insurance rates related to salaries or income, and usually funded by employers and beneficiaries jointly. Sometimes the health funds are derived from a mixture of insurance premiums and government taxes. These insurance based systems tend to have a higher proportion of private medical providers obtaining reimbursement, often at heavily regulated rates, through mutual or publicly owned medical insurers. A few countries such as the Netherlands and Switzerland operate via privately owned but heavily regulated private insurers. Americans use the term "single-payer health care" to describe the pooling of health care funds into a single not-for-profit fund for a region or nation. The term is frequently ascribed to the Canadian health care system.

Universal health care is implemented in all industrialized countries, with the exception of the United States.[1] It is also provided in many developing countries.

History

Germany has the world's oldest universal health care system, with origins dating back to Otto von Bismarck's social legislation, which included the Health Insurance Bill of 1883, Accident Insurance Bill of 1884, and Old Age and Disability Insurance Bill of 1889. In Britain, the National Insurance Act 1911 marked the first steps there towards universal health care, covering most employed persons and their financial dependents and all persons who had been continuous contributors to the scheme for at least five years whether they were working or not. This system of health insurance continued in force until the creation of the National Health Service in 1948 which extended health care security to all legal residents. Most current universal health care systems were implemented in the period following the Second World War as a process of deliberate healthcare reform, intended to make health care available to all, in the spirit of Article 25 of the Universal Declaration of Human Rights of 1948, signed by every country doing so. The US did not ratify the social and economic rights sections, including Article 25's right to health.[2]

Implementation and Comparisons

Universal health care is a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards. Most implement universal health care through legislation, regulation and taxation. Legislation and regulation direct what care must be provided, to whom, and on what basis. Usually some costs are borne by the patient at the time of consumption but the bulk of costs come from a combination of compulsory insurance and tax revenues. Some programs are paid for entirely out of tax revenues. In others tax revenues are used either to fund insurance for the very poor or for those needing long term chronic care. The UK government's National Audit Office in 2003 published an international comparison of ten different health care systems in ten developed countries, nine universal systems against one non-universal system (the U.S.), and their relative costs and key health outcomes. A wider international comparison of 16 countries, each with universal health care, was published by the World Health Organization in 2004 In some cases, government involvement also includes directly managing the health care system, but many countries use mixed public-private systems to deliver universal health care.

Medicare

In Australia, Medibank — as it was then known — was introduced, by the Whitlam Labor government on 1 July1975, through the Health Insurance Act 1973. The Australian Senate rejected the changes multiple times and they were passed only after a joint sitting after the 1974 double dissolution election. However, Medibank was supported by the subsequent FraserCoalition (Australia) government and became a key feature of Australia's public policy landscape. The exact structure of Medibank/Medicare, in terms of the size of the rebate to doctors and hospitals and the way it has administered, has varied over the years. The original Medibank program proposed a 1.35% levy (with low income exemptions) but these bills were rejected by the Senate, and so Medibank was funded from general taxation. In 1976, the Fraser Government introduced a 2.5% levy and split Medibank in two: a universal scheme called Medibank Public and a government-owned private health insurance company, Medibank Private.

During the 1980s, Medibank Public was renamed Medicare by the Hawke Labor government, which also changed the funding model, to an income tax surcharge, known as the Medicare Levy, which was set at 1.5%, with exemptions for low income earners. The Howard Coalition government introduced an additional levy of 1.0%, known as the Medicare Levy Surcharge, for those on high annual incomes ($70,000) and do not have adequate levels of private hospital coverage. This was part of an effort by the Coalition to encourage take-up of private health insurance. According to WHO, government funding covered 67.5% of Australia's health care expenditures in 2004; private sources covered the remaining 32.5% of expenditures.

Funding models

Universal health care in most countries has been achieved by a mixed model of funding. General taxation revenue is the primary source of funding, but in many countries it is supplemented by specific levies (which may be charged to the individual and/or an employer) or with the option of private payments (either direct or via optional insurance) for services beyond that covered by the public system.

Almost all European systems are financed through a mix of public and private contributions. The majority of universal health care systems are funded primarily by tax revenue (e.g. Portugal and Spain). Some nations, such as Germany, France and Japan employ a multi-payer system in which health care is funded by private and public contributions. However, much of the non-government funding is by defined contributions by employers and employees to regulated non-profit sickness funds. These contributions are compulsory and vary according to a person's salary, and are effectively a form of hypothecated taxation.

A distinction is also made between municipal and national healthcare funding. For example, one model is that the bulk of the healthcare is funded by the municipality, speciality healthcare is provided and possibly funded by a larger entity, such as a municipal co-operation board or the state, and the medications are paid by a state agency.

Universal health care systems are modestly redistributive. Progressivity of health care financing has limited implications for overall income inequality.[75]

Single-payer

The term single-payer health care is used in the United States to describe a funding mechanism meeting the costs of medical care from a single fund. Although the fund holder is usually the government, some forms of single-payer employ a public-private system.

Public

Some countries (notably the United Kingdom, Italy and Spain) have eliminated insurance entirely and choose to fund health care directly from taxation. Other countries with insurance-based systems effectively meet the cost of insuring those unable to insure themselves via social security arrangements funded from taxation, either by directly paying their medical bills or by paying for insurance premiums for those affected.

Compulsory insurance

This is usually enforced via legislation requiring residents to purchase insurance, though sometimes, in effect, the government provides the insurance. Sometimes there may be a choice of multiple public and private funds providing a standard service (e.g. as in Germany) or sometimes just a single public fund (as in Canada).

In some European countries where there is private insurance and universal health care, such as Germany, Belgium, and The Netherlands, the problem of adverse selection (see Private insurance below) is overcome using a risk compensation pool to equalize, as far as possible, the risks between funds. Thus a fund with a predominantly healthy, younger population has to pay into a compensation pool and a fund with an older and predominantly less healthy population would receive funds from the pool. In this way, sickness funds compete on price and there is no advantage to eliminate people with higher risks because they are compensated for by means of risk-adjusted capitation payments. Funds are not allowed to pick and choose their policyholders or deny coverage, but then mainly compete on price and service. In some countries the basic coverage level is set by the government and cannot be modified.

Ireland at one time had a "community rating" system through VHI, effectively a single-payer or common risk pool. The government later opened VHI to competition but without a compensation pool. This resulted in foreign insurance companies entering the Irish market and offering cheap health insurance to relatively healthy segments of the market which then made higher profits at VHI's expense. The government later re-introduced community rating through a pooling arrangement and at least one main major insurance company, BUPA, then withdrew from the Irish market.

In some countries with universal coverage, private insurance often excludes many health conditions which are expensive and which the state health care system can provide. For example in the UK, one of the largest private health care providers is BUPA which has the following list of general exclusions.

Dental/oral treatment (such as fillings, gum disease, jaw shrinkage, etc)†; pregnancy and childbirth†; temporary relief of symptoms†; convalescence, rehabilitation and general nursing care†; drugs and dressings for out-patient or take-home use†; screening and preventive treatment; birth control, conception, sexual problems and sex changes†; allergies or allergic disorders; chronic conditions†; eyesight†; physical aids and devices†; *deafness; cosmetic, reconstructive or weight loss treatment† ; ageing, menopause and puberty ; dialysis† ; complications from excluded or restricted conditions/ treatment ; HRT and bone densitometry†; learning difficulties, behavioural and developmental problems ; overseas treatment and repatriation ; AIDS/HIV† ; pre-existing or special conditions ; experimental drugs and treatment† ; sleep problems and disorders ; speech disorders†

all of which (except overseas repatriation) are available for free or very low cost from the NHS. († indicates that treatment may be provided in certain circumstances)

Where voluntary insurance (often private) is predominant, such as in the U.S., medical (health) insurance is subject to the well-known economic problem of adverse selection which may also be referred to as a market failure. Adverse selection in insurance markets occurs because those providing insurance have limited information with which to estimate the health risks on which they may need to pay future claims. In simple terms, those with poor health are more likely to apply for insurance and more likely to need treatments requiring high insurance company payouts. Those with good health may find the cost of insurance too high for the perceived benefit, and some will remove themselves from the risk pool. This adverse selection concentrates the risk pool, thereby further raising costs. In practical terms, the potential for adverse selection means that private insurers have an economic incentive to use medical underwriting to 'weed out' high cost applicants in order to avoid adverse selection. Among the potential solutions posited by economists are single payer systems as well as other methods of ensuring that health insurance is

universal, such as by requiring all citizens to purchase insurance and limiting the ability of insurance companies to deny insurance to individuals or vary price between individuals.

Mental health professional

A **mental health professional** is a person who offers services for the purpose of improving an individual's mental health or to treat mental illness. This broad category includes psychiatrists, clinical psychologists, clinical social workers, psychiatric nurses, mental health counselors as well as many other professionals. These professionals often deal with the same illnesses, disorders, conditions, and issues; however their scope of practice often differs. The most significant difference between mental health professionals are the laws regarding required education and training in the various groupings.

Professional distinctions

Comparison of American mental health professionals

Occupation	**Degree**	**Common Licenses**	**Prescription Privilege**	**Average Income** ($US)
Psychiatrist	MD/DO	Psychiatrist	Yes	$190,000
Clinical Psychologist	PhD/PsyD	Psychologist	Varies	$75,000
School Psychologist	Doctoral Level PhD/EdD Post-Master's Terminal Degree (not doctoral level) EdS Masters Level MA/MS	Certified School Psychology, National Certified School Psychologist	No	$78,000
Counselor/Psychotherapist (Doctorate)	PhD/EdD/DMFT	MFT/LPC	No	$65,000
Counselor/Psychotherapist (Masters)	MA/MS/MC	MFT/LPC/LPA/LMHC	No	$49,000
Clinical Social Worker	MSW/DSW/PhD plus two to three years of post-master's supervised clinical experience	LCSW/LICSW	No	$50,700
Social Worker (agency based master's level)	MSW/DSW/PhD	LMSW/GSW/LSW	No	$46,170
Social Worker (bachelor level)	BSW	RSW, SWA, Social Work Assistant	No	$29,170

Psychiatric Nurse	BSN/MSN/DNP/PhD	MHNP/NPP	Varies	$75,711
Physician assistant	MPAS/MHS/MMS/DScPA	PA/PA-C/APA-C/RPA/RPA-C	Yes	$80,356[2]
Expressive/Art Therapist	MA	ATR/MT-BC	No	$45,000

Treatment diversity

Mental health professionals exist to improve the mental health of individuals, couples, and families. Because mental health covers a wide range of elements, the scope of practice greatly varies between professionals. Some professionals may enhance relationships while others treat specific mental disorders and illness. Often, as with the case of psychiatrists and psychologists, the scope of practice may overlap.

Most qualified mental health professionals will refer a patient or client to another professional if the specific type of treatment needed is outside of their scope of practice. Additionally, many mental health professionals may sometimes work together using a variety of treatment options such as concurrent psychiatric medication and psychotherapy. Additionally, specific mental health professionals may be utilized based upon their cultural and religious background or experience.

Psychiatrist

Main articles: Psychiatrist and Psychiatry

Psychiatrists are physicians and one of the few professionals in the mental health industry who specialize and are certified in treating mental illness using the biomedical approach to mental disorders including the use of medications.

Psychiatrists may also go through significant training to conduct psychotherapy and cognitive behavioral therapy; however psychologists and clinical psychologists specialize in the research and clinical application of these techniques. The amount of training a psychiatrist holds in providing these types of therapies varies from program to program and also differs greatly based upon region.

Specialties of psychiatrists

As part of their evaluation of the patient, psychiatrists are one of only a few mental health professionals who may conduct physical examinations, order and interpret laboratory tests and EEGs, and may order brain imaging studies such as CT or CAT, MRI, and PET scanning. A medical professional must evaluate the patient for any medical problems or diseases that may be the cause of the mental illness.

Historically psychiatrists have been the only mental health professional with the power to prescribe medication to treat specific types of mental illness. However Physician Assistants, psychiatric nurses, and clinical psychologists have gained the ability to prescribe psychiatric medications in a few U.S. states.

Educational requirements for psychiatrists

Typically the requirements to become a psychiatrist are substantial but differ from country to country.

In the United Kingdom, the Republic of Ireland, and most Commonwealth countries, a would-be psychiatrist must first obtain Bachelor of Medicine and Bachelor of Surgery degrees. These degrees are most often abbreviated MB BS: MB ChB, MB BCh, MB BChir (Cambridge), BM BCh (Oxford), BM BS, or plain BM also occur. Following this, the individual in the UK will in future act as a "foundation programme trainee" for two additional years. The foundation programme allows new graduates to experience the different specialties of medicine, as well as learn important attributes and qualities of a doctor. Upon completion, a postgraduate student can apply for training to specialize in psychiatry. Following acceptance, this specialized training will last for about 6 years. After one year of training a written and clinical examination would be taken and after three years or so and experience in a range of subspecialties the Specialist Trainee would pass the examination for Membership of the Royal College of Psychiatrists: abbreviated as MRCPsych. In the past a few trained in internal medicine (qualifying as MRCP) or, more recently, general practice (MRCGP) before starting psychiatric training. After obtaining a Certificate of Specialist Training, the individual can apply for a consultant post and work independently as a psychiatrist or, more often, as part of a multi-disciplinary team.

In the United States and Canada one must first complete a Bachelor's degree. Students may typically decide any major of their choice, however they must enroll in specific courses, usually outlined in a pre-medical program.[10] One must then apply to and attend 4 years of medical school in order to earn their MD or DO and to complete their medical education. Following this, the individual must practice as a psychiatric resident for another four years. Psychiatry residents are required to complete at least four post-graduate months of internal medicine (pediatrics may be substituted for some or all of

the internal medicine months for those planning to specialize in child and adolescent psychiatry) and two months of neurology, usually during the first year.[10] Occasionally, some prospective psychiatry residents will choose to do a transitional year internship in medicine or general surgery, in which case they may complete the two months of neurology later in their residency. After completing their training, psychiatrists take written and then oral board examinations.[10] The total amount of time required to qualify in the field of psychiatry in the United States is typically 4 to 5 years after obtaining the MD or DO.

Clinical psychologist

A clinical psychologist studies and applies psychology for the purpose of understanding, preventing, and relieving psychologically-based distress or dysfunction and to promote subjective well-being and personal development. In many countries it is a regulated profession that addresses moderate to more severe or chronic psychological problems, including diagnosable mental disorders. Clinical psychology includes a wide range of practices, such as research, psychological assessment, teaching, consultation, forensic testimony, and program development and administration. Central to clinical psychology is the practice of psychotherapy, which uses a wide range of techniques to change thoughts, feelings, or behaviors in service to enhancing subjective well-being, mental health, and life functioning. Unlike other mental health professionals, psychologists are trained to conduct psychological assessment. Clinical psychologists can work with individuals, couples, children, older adults, families, small groups, and communities.

Specialties of clinical psychologists

Clinical psychologists who focus on treating mental health specialize in evaluating patients and providing psychotherapy. There are a wide variety of therapeutic techniques and perspectives that guide practitioners, although most fall into the major categories of Psychodynamic, Cognitive Behavioral, Existential-Humanistic, and Systems Therapy (e.g. family or couples therapy).

In addition to therapy, clinical psychologists are also trained to administer and interpret psychological personality tests such as the MMPI and the Rorschach inkblot test, and various standardized tests of intelligence, memory, and neuropsychological functioning. Common areas of specialization include: specific disorders (e.g. trauma or depression), neuropsychological disorders, child and adolescent, family and relationship counseling, health, sport, forensic, organization and business, and school psychology.

[Educational requirements for clinical psychologists

Clinical psychologists undergo many hours of postgraduate training—usually 4 to 6 years post-Bachelors—in order to gain demonstrable competence and experience. Today, in the U.S., about half of the licensed psychologists are being trained in the Scientist-Practitioner Model of Clinical Psychology (PhD)—a model that emphasizes both research and clinical practice and is usually housed in universities. The other half are being trained within a Practitioner-Scholar Model of Clinical Psychology (PsyD), which focuses on practice (similar to professional degrees for medicine and law).[11] A third training model called the Clinical Scientist Model emphasizes training in clinical psychology research. Outside of coursework, graduates of both programs generally are required to have had 2 to 3 years of supervised clinical experience, a certain amount of personal psychotherapy, and the completion of a dissertation (PhD programs usually require original quantitative empirical research, whereas the PsyD equivalent of dissertation research often consists of literature review and qualitative research, theoretical scholarship, program evaluation or development, critical literature analysis, or clinical application and analysis).

Counseling psychologist or psychotherapist

Counseling generally involves helping people with what might be considered "normal" or "moderate" psychological problems, such as the feelings of anxiety or sadness resulting from major life changes or events.[12][13] As such, counseling psychologists often help people adjust to or cope with their environment or major events, although many also work with more serious problems as well.

One may practice as a counseling psychologist with a PhD or EdD, and as a counseling psychotherapist with a Masters degree. Compared with clinical psychology, there are fewer counseling psychology graduate programs (which are commonly housed in departments of education), counselors tend to conduct more vocational assessment and less projective or objective assessment, and they are more likely to work in public service or university clinics (rather than hospitals or private practice).[14] Despite these differences, there is considerable overlap between the two fields and distinctions between them continue to fade.

Certified Mental Health Professional

The Certified Mental Health Professional (CMHP) certification is designed to measure an individual's competency in performing the following job tasks. The job tasks are not presented in any particular order of importance.

1. Maintain confidentiality of records relating to clients' treatment.
2. Encourage clients to express their feelings, discuss what is happening in their lives, and help them to develop insight into themselves and their relationships.

3. Guide clients in the development of skills and strategies for dealing with their problems.
4. Prepare and maintain all required treatment records and reports.
5. Counsel clients and patients, individually and in group sessions, to assist in overcoming dependencies, adjusting to life, and making changes.
6. Collect information about clients through interviews, observations, and tests.
7. Act as the client's advocate in order to coordinate required services or to resolve emergency problems in crisis situations.
8. Develop and implement treatment plans based on clinical experience and knowledge.
9. Collaborate with other staff members to perform clinical assessments and develop treatment plans.
10. Evaluate client's physical or mental condition based on review of client information.

School psychologist

School psychologists' primary concern is with the academic, social, and emotional well-being of children within a scholastic environment. Unlike clinical psychologists, they receive much more training in education, child development and behavior, and the psychology of learning, often graduating with a post-Masters Educational Specialist Degree (EdS), EdD or Doctor of Philosophy (Ph D) degree. Besides offering individual and group therapy with children and their families, school psychologists also evaluate school programs, provide cognitive assessment, help design prevention programs (e.g. reducing drops outs), and work with teachers and administrators to help maximize teaching efficacy, both in the classroom and systemically.[15]

Social worker

Social workers in the area of mental health may assess, treat, develop treatment plans, provide case management and/or rights advocacy to individuals with mental health problems. They can work independently or within clinics/service agencies, usually in collaboration with other health care professionals.

In the US, they are often referred to as clinical social workers; each state specifies the responsibilities and limitations of this profession. State licensing boards and national certification boards require clinical social workers to have a masters or doctoral degree (MSW or DSW/PhD) from a university. The doctorate in social work requires submission of a major original contribution to the field in order to be awarded the degree.

In the UK, Approved Mental Health Professionals, who are usually social workers, have a legal role in the assessment and detention of eligible mentally disordered people under the Mental Health Act (1983).

In general, it is the social model, rather ,or in addition to, the dominant medical model, that is the underlying rationale for mental health social work, including a focus on social causation, labeling, critical theory and social constructivism. Many argue social workers need to work with medical and health colleagues to provide an effective service but they also need to be at the forefront of processes that include and empower services users.[16]

Psychiatric and mental health nurse

Psychiatric Nurses or Mental Health Nurse Practitioners work with people with a large variety of mental health problems, often at the time of highest distress, and usually within hospital settings. These professionals work in primary care facilities, outpatient mental health clinics, as well as in hospitals and community health centers. MHNPs evaluate and provide care for patients who have anything from psychiatric disorders, medical mental conditions, to substance abuse problems. They are licensed to provide emergency psychiatric services, assess the psychosocial and physical state of their patients, create treatment plans, and continually manage their care. They may also serve as consultants or as educators for families and staff; however, the MHNP has a greater focus on psychiatric diagnosis, including the differential diagnosis of medical disorders with psychiatric symptoms and on medication treatment for psychiatric disorders.

Educational requirements for psychiatric and mental health nurses

Psychiatric and mental health nurses receive specialist education to work in this area. In some countries it is required that a full general nurse training be completed prior to specializing as a psychiatric nurse. In other countries, such as the U.K., an individual completes a specific nurse training course that determines their area of work. As with other areas of nursing, it is becoming usual for psychiatric nurses to be educated to degree level and beyond.

In order to become a nurse practitioner in the U.S., at least six years of college education must be obtained. After earning the Bachelor's degree (usually in nursing, although there are Masters Entry Level Nursing graduate programs intended for individuals with a Bachelors degree outside of nursing) the test for licensure as a registered nurse (the NCLEX-RN) must be passed. Next, the candidate must complete a state-approved Masters Degree advanced nursing education program which includes at least 600 clinical hours. Several schools are now also offering further education and awarding a DNP(Doctorate of Nurse Practice).

Individuals who choose a Masters Entry Level pathway will spend an extra year at the start of the program taking classes necessary to pass the NCLEX-RN. Some schools will issue a BSN, others will issue a certificate. The student then continues with the normal MSN program.[17][18][19][20]

Health law

Health Law is the federal, state, and local law, rules, regulations and other jurisprudence affecting the health care industry and their application to health care patients, providers and payors, and vendors to the health care industry, including without limitation the (1) relationships among providers, payors and vendors to the health care industry and its patients; and (2) delivery of health care services; all with an emphasis on operations, regulatory and transactional legal issues.[1]

Some areas of law it includes are:

- Contract law
- Medical malpractice
- Administrative law
- Public health law
- Consent

Basic terms

The terms "legislation" and "law" are used to refer generically to statutes, regulation and other legal instruments (e.g. ministerial decrees) that may be the forms of law used in a particular country.

In general, there are a wide range of regulatory strategies that might be used to ensure people's health and safety. Increasingly, regulators are taking an approach of "responsive regulation". This involves using mechanisms that are responsive to the context, conduct and culture of those being regulated, providing for a range of regulatory mechanisms to achieve the behaviour desired. Where appropriate, the aim is to use incentives before sanctions. However, when those being regulated do not respond accordingly, escalating sanctions can be invoked. These strategies may be broadly 3 classified into five groups:

1.voluntarism : voluntary compliance undertaken by an individual oorganization without any coercion;

2.self-regulation : for example, an organized group that regulates the behaviou of its own members through a voluntary code of practice;

3.economic instruments: for example, supply-side funding sanctions or incentives for health care providers, and/or demand-side measures that give more power to consumers;

4.meta-regulation: involving an external regulatory body to ensure that healt care providers implement safety and quality practices and programmes;

5.command and control mechanisms : involving enforcement by government

Health care

Surgery is one of the most invasive, difficult and expensive procedures in medicine.
The International Red Cross and Red Crescent Movement is a well-known international relief movement.

Health care (often **healthcare** in American English), is the treatment and management of illness, and the preservation of health through services offered by the medical, dental, complementary and alternative medicine, pharmaceutical, clinical sciences (*in vitro* diagnostics), nursing, and allied health professions. Health care embraces all the goods and services designed to promote health, including "preventive, curative and palliative interventions, whether directed to individuals or to populations".[1]

Before the term *health care* became popular, English-speakers referred to *medicine* or to the *health sector* and spoke of the treatment and prevention of illness and disease. The social and political issue of access to healthcare in the US has led to public debate and confusing use of terms such as **health care** (medical management of illness or disease), health insurance (reimbursement of health care costs), and the public health (the collective state and range of health in a population). The public health is related most to economic development and wealth distribution, and health insurance is a business which both provides and restricts reimbursement for healthcare itself in the event of disease, or in access to of medical healthcare in individual health-seeking, -promoting or -maintaining behaviours.

Provision

A health-care provider is a person or organization that provides services and/or health-care personnel to deliver proper health care in a systematic way to any individual in need of health-care services. A health-care provider could be a government, the health-care industry, a health-care equipment company, an institution such as a hospital or medical laboratory. Health-care professionals may include physicians, dentists, support staff, nurses, therapists, psychologists, pharmaconomists, pharmacists, chiropractors, and optometrists.

Practicing health care without a license is generally a serious crime that could be punished by up to several years in prison.

Health-care industry

The delivery of modern health care depends on an expanding group of trained professionals coming together as an interdisciplinary team.[2][3]

The health-care industry incorporates several sectors that are dedicated to providing services and products dedicated to improving the health of individuals. According to market classifications of industry such as the Global Industry Classification Standard and the Industry Classification Benchmark the health-care industry includes health care equipment & services and pharmaceuticals, biotechnology & life sciences. The particular sectors associated with these groups are: biotechnology, diagnostic substances, drug delivery, drug manufacturers, hospitals, medical equipment and instruments, diagnostic laboratories, nursing homes, providers of health care plans and home health care.

According to government classifications of Industry, which are mostly based on the United Nations system, the International Standard Industrial Classification, health care generally consists of Hospital activities, Medical and dental practice activities, and other human health activities. The last class consists of all activities for human health not performed by hospitals or by medical doctors or dentists. This involves activities of, or under the supervision of, nurses, midwives, physiotherapists, scientific or diagnostic laboratiories, pathology clinics, ambulance, nursing home, or other para-medical practitioners in the field of optometry, hydrotherapy, medical massage, occupational therapy, speech therapy, chiropody, homeopathy, chiropractice, acupuncture, etc.

Research

Biomedical research (or experimental medicine), in general simply known as medical research, is the basic research, applied research, or translational research conducted to aid the body of knowledge in the field of medicine. Medical research can be divided into two general categories: the evaluation of new treatments for both safety and efficacy in what are termed clinical trials, and all other research that contributes to the development of new treatments. The latter is termed preclinical research if its goal is specifically to elaborate knowledge for the development of new therapeutic strategies. A new paradigm to biomedical research is being termed translational research, which focuses on iterative feedback loops between the basic and clinical research domains to accelerate knowledge translation from the bedside to the bench, and back again.

In terms of pharmaceutical R&D spending, Europe spends a little less that the United States (€22.50bn compared to €27.05bn in 2006) and there is less growth in European R&D spending.[6][7] Pharmaceuticals and other medical devices are the leading high technology exports of Europe and the United States. However, the United States dominates the biopharmaceutical field, accounting for the three quarters of the world's biotechnology revenues and 80% of world R&D spending in biotechnology.

World Health Organization

The World Health Organization (WHO) is a specialized United Nations agency which acts as a coordinator and researcher for public health around the world. Established on 7 April1948, and headquartered in Geneva, Switzerland, the agency inherited the mandate and resources of its predecessor, the Health Organization, which had been an agency of the League of Nations. The WHO's constitution states that its mission "is the attainment by all peoples of the highest possible level of health." Its major task is to combat disease, especially key infectious diseases, and to promote the general health of the peoples of the world. Examples of its work include years of fighting smallpox. In 1979 the WHO declared that the disease had been eradicated - the first disease in history to be completely eliminated by deliberate human design. The WHO is nearing success in developing vaccines against malaria and schistosomiasis and aims to eradicate polio within the next few years. The organization has already endorsed the world's first official HIV/AIDS Toolkit for Zimbabwe from October 3, 2006, making it an international standard.[9]

The WHO is financed by contributions from member states and from donors. In recent years the WHO's work has involved more collaboration, currently around 80 such partnerships, with NGOs and the pharmaceutical industry, as well as with foundations such as the Bill and Melinda Gates Foundation and the Rockefeller Foundation. Voluntary contributions to the WHO from national and local governments, foundations and NGOs, other UN organizations, and the private sector (including pharmaceutical companies), now exceed that of assessed contributions (dues) from its 193 member nations.[10]

Economics

Health economics is a branch of economics concerned with issues related to scarcity in the allocation of health and health care. Broadly, health economists study the functioning of the health care system and the private and social causes of health-affecting behaviors such as smoking.

A seminal 1963 article by Kenneth Arrow, often credited with giving rise to the health economics as a discipline, drew conceptual distinctions between health and other goals. Factors that distinguish health economics from other areas include extensive government intervention, intractable uncertainty in several

dimensions, asymmetric information, and externalities.[12] Governments tend to regulate the health care industry heavily and also tend to be the largest payer within the market. Uncertainty is intrinsic to health, both in patient outcomes and financial concerns. The knowledge gap that exists between a physician and a patient can prevent the patient from accurately describing his symptoms or enable the physician to prescribe unnecessary but profitable services; these imbalances lead to market failures resulting from asymmetric information. Externalities arise frequently when considering health and health care, notably in the context of infectious disease. For example, making an effort to avoid catching a cold, or practising safer sex, affects people other than the decision maker.

The scope of health economics is neatly encapsulated by Alan William's "plumbing diagram"[13] dividing the discipline into eight distinct topics:

- What influences health? (other than health care)
- What is health and what is its value
- The demand for health care
- The supply of health care
- Micro-economic evaluation at treatment level
- Market equilibrium
- Evaluation at whole system level; and,
- Planning, budgeting and monitoring mechanisms.

Consuming just under 10 percent of gross domestic product of most developed nations, health care can form an enormous part of a country's economy. In 2001, health care consumed 8.4 per cent of GDP across the OECDcountries[14] with the United States (13.9%), Switzerland (10.9%), and Germany (10.7%) being the top three.

The United States and Canada account for 48% of world pharmaceutical sales, while Europe, Japan, and all other nations account for 30%, 9%, and 13%, respectively.[7] United States accounts for the three quarters of the world's biotechnology revenues.

Systems

The United States is currently[*when?*] debating the adoption of a national "single-payer" health care system, and these debates are contributing to biased descriptions of health care systems in the media. One case argues that a single-payer universal health care system will save money through reduced bureaucratic administration costs.[15]Social health insurance is where a nation's entire population is eligible for health care coverage, and this coverage and the services provided are regulated. In almost every country, state or municipality with a government health care system a parallel private, and usually for-profit, system is allowed to operate. This is sometimes referred to as

two-tier health care. The scale, extent, and funding of these private systems is variable.

A traditional view is that improvements in health result from advancements in medical science. The medical model of health focuses on the eradication of illness through diagnosis and effective treatment. In contrast, the social model of health places emphasis on changes that can be made in society and in people's own lifestyles to make the population healthier. It defines *illness* from the point of view of the individual's functioning within their society rather than by monitoring for changes in biological or physiological signs.[16]

The United States currently operates under a mixed market health care system. Government sources (federal, state, and local) account for 45% of U.S. health care expenditures.[17] Private sources account for the remainder of costs, with 38% of people receiving health coverage through their employers and 17% arising from other private payment such as private insurance and out-of-pocket co-pays. Opponents of government intervention into the market generally believe that such intervention distorts pricing as government agents would be operating outside of the corporate model and the principles of market discipline; they have less short and medium-term incentives than private agents to make purchases that can generate revenues and avoid bankruptcy. Health system reform in the United States usually focuses around three suggested systems, with proposals currently underway to integrate these systems in various ways to provide a number of health care options. First is single payer, a term meant to describe a single agency managing a single system, as found in most modernized countries as well as some states and municipalities within the United States. Second are employer or individual insurance mandates, with which the state of Massachusetts has experimented. Finally, there is consumer-driven health, in which systems, consumers, and patients have more control of how they access care. This is argued to provide a greater incentive to find cost-saving health care approaches. Critics of consumer-driven health say that it would benefit the healthy but be insufficient for the chronically sick, much as the current system operates. Over the past thirty years, most of the nation's health care has moved from the second model operating with not-for-profit institutions to the third model operating with for-profit institutions; the greater problems with this approach have been the gradual deregulation of HMOs resulting in fewer of the promised choices for consumers, and the steady increase in consumer cost that has marginalized consumers and burdened states with excessive urgent health care costs that are avoided with consumers have adequate access to preventive health care.

A few states have taken serious steps toward universal health care coverage, most notably Minnesota, Massachusetts and Connecticut, with recent examples being the Massachusetts 2006 Health Reform Statute[18] and Connecticut's Susti Net plan to provide quality, affordable health care to state residents.[19]

Politics

The politics of health care depends largely on which country one is in. Current concerns in England, for instance, revolve around the use of private finance initiatives to build hospitals which it is argued costs taxpayers more in the long run.[20] In Germany and France, concerns are more based on the rising cost of drugs to the governments. In Brazil, an important political issue is the breach of intellectual property rights, or patents, for the domestic manufacture of antiretroviral drugs used in the treatment of HIV/AIDS.

The South African government, whose population sets the record for HIV infections, came under pressure for its refusal to admit there is any connection with AIDS[21] because of the cost it would have involved. In the United States 12% to 16% of the citizens are still unable to afford health insurance. State boards and the Department of Health regulate inpatient care to reduce the national health care deficit. To tackle the problems of the perpetually increasing number of uninsured, and costs associated with the US health care system, President Barack Obama says he favors the creation of a universal health care system. [22] However, New York Times opinion columnist Paul Krugman said that Obama's plan would not actually provide universal coverage.[23] (In contrast, Dennis Kucinich, an early candidate who did not get on the ballot, supported a single-payer system.) Factcheck.org alleges that Obama's predicted savings were exaggerated. [24] In contrast, the state of Oregon and the city of San Francisco are both examples of governments that adopted universal healthcare systems for strictly fiscal reasons.

Donation

A **donation** is a gift given by physical or legal persons, typically for charitable purposes and/or to benefit a cause. A donation may take various forms, including cash, services, new or used goods including clothing, toys, food, vehicles, it also may consist of emergency, relief or humanitarian aid items, development aid support, and can also relate to medical care needs as i.e. blood or organs for transplant. Charitable gifts of goods or services are also called gifts in kind.

Legal aspects

Donations are gifts given without return consideration. This lack of return consideration means that, in common law, an agreement to make a donation is an "imperfect contract void for want of consideration." Only when the donation is actually made does it acquire legal status as a transfer or property. In civil law jurisdictions, on the contrary, donations are valid contracts, though they may require some extra formalities, such as being done in writing.In politics, the law of some countries may prohibit or restrict the extent to which politicians may accept gifts or donations of large sums of

money, especially from business or special interest groups (see campaign finance).

In countries where there are limits imposed on the freedom of disposition of the testator, there are usually similar limits on donations.The person or institution giving a gift is called the **donor**, and the person or institution getting the gift is called the **donee**.

Donating in the name of others

It is possible to donate in the name of a third party, making a gift in honor or in memory of someone or something. Gifts in honor or memory of a third party are made for various reasons, such as holiday gifts, wedding gifts, in memory of somebody who has died, in memory of pets or in the name of groups or associations no longer existing. Memorial gifts are sometimes requested by the survivors (e.g. "in lieu of flowers, contributions may be made to ABC Charity"), usually directing donations to a charitable organization for which the deceased was a donor or volunteer, or for a cause befitting the deceased's priorities in life or manner of death. Memorial donations are also sometimes given by people if they cannot go to the ceremonies.

Globalization and Health

Globalization and Health is an open-access, peer-reviewed, online journal that provides an international forum for high quality original research, knowledge sharing and debate on the topic of globalization and its effects on health, both positive and negative. Globalization, namely the intensification of flows of people, goods, and services across borders, has a complex influence on health. The journal publishes material relevant to any aspect of globalization and health from a wide range of social and medical science disciplines (e.g. economics, sociology, epidemiology, demography, psychology, politics and international relations). The output of the journal is useful to a wide audience, including academics, policy-makers, health care practitioners, and public health professionals. The journal is affiliated with the London School of Economics

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