

The Disparity of Motivational Drivers in International Health Care Systems

Roderick A. Slavcev

School of Pharmacy, University of Waterloo, 200 University Ave., Waterloo, Ontario, Canada

Abstract

Healthcare systems are highly convoluted and nontransparent systems that face the immense challenge of disparaging economic and ethical drivers from each player in this complicated continuum. Economic slack is a critical obstacle that is generated through the misalignment of needed outcomes for each of these silos. Understanding the economic needs of each additional and overlapping player in the continuum is the first important step toward universal health care sustainability.

Editorial

Health of a population is a highly complicated, emotional and multi-level issue that incorporates the stressors of living, work, and aging, access to pharmacotherapeutic and clinical services as well as education and prevention. Obviously a well-functioning system requires financing necessary for such a large, multi-component undertaking. It is probably not surprising that low income countries have populations that possess the greatest disparity in socio-economic classes. Here, the poor that constitute the largest tier of the population, also endure the highest levels of environmental stresses and are also plagued by unavailable or inefficient deployment of finances toward health care access. Scarce access to healthcare for some basic, yet essential services can be as low as 10%, while the rich share similar service to that seen in developed countries [1]. The converse situation is the induction of poverty due to healthcare access, a situation that is estimated to force 100 million people annually, including those from developed countries, into poverty due to overwhelming individual health care costs [2].

Access to health care is an extraordinary human need and priority and although many developing nations have made significant improvements toward this end over the past decade, this ethical imperative is far from universal. Many envision limited access as specific to poorer nations, but this is hardly the case as there are a number of pathways by which access may be diminished that can make rich and poor countries equally susceptible. The WHO outlines that access is impeded internationally due to three fundamental problems: 1) the availability of resources and immediate access to latest technology and treatment modalities; 2) overreliance on direct payments, whether completely or in part, that can lead to impoverishment; and 3) economic slack due to resource wastage [3]. While the poorest countries suffer from little access to any health care, no country can claim universal access to the best treatment options, and most developed countries fall short to some extent by requiring direct payments, even where these costs may eventually be reimbursed [4]. While the first two points diminish the size of an individual's "slice" of access to healthcare arising from a lack of resources, wastage accounts for 20 to 40 percent globally. Such economic appropriation is particularly insidious in that it diminishes the size of the entire healthcare pie, but if corrected could confer the greatest impact and even aid in remedying resource scarcity and need for direct payment. Building an efficient system thus minimizes the losses associated with raising and disbursing revenue and facilitates the development of a progressive system that can redistribute resources with equality among rich and poor alike.

The practice of ethics and ethical decision-making has to do with values, and values can and are more likely to conflict when one necessary

part of a system doesn't know the values that motivate the other parts. While we may look to some countries as ethical benchmarks of equity, and for good ideas along the road to effective and universal healthcare access, each country's environment that impacts its value system is different and as such, the path to universal healthcare will evolve uniquely for each country. In the 49 lowest income nations, there are fewer stakeholder and access points in the healthcare continuum to accumulate slack and resource wastage, but here resources are also very scarce and the role and power of a stakeholder such as government may be highly unstable, whereby its economic imperatives and values are often not directed appropriately toward universal health care [5]. Change here, will of course need to come from within and while a few governments have honoured agreements and allocated the agreed upon double digit percentages of their GDP to healthcare, others have either fallen short or decreased access. However, for more than 80% of these poor nations, even these changes will not suffice, where per capita spending will essentially need to double—an endpoint that cannot be achieved by internal strategies alone [6]. Thus, while these countries may look to universal health care providers like Canada, which allocates 11% of its GDP to healthcare provision, as a benchmark of ethics and equality, the true test of ethics will need to occur on a global scale, whereby the industrialized world makes good on its global commitment to both guide and support poorer nations toward this end.

Undeniably, some industrialized countries, particularly in Europe, are far closer to attaining sustainable, universal (timely) healthcare access than others and yet no country can claim perfection. In Canada, we arguably enjoy reasonable equality to healthcare. Whether to medication or vital clinical services, access is perhaps our greatest national and internationally recognized landmark achievement that differentiates us from our southern neighbour despite that they spend more per capita than we do (17% vs. 11%) [7]. While the ethical imperative demonstrated in Canada is strong in its intent for equity and very fit to serve as an international model, its implementation is

Corresponding author: Roderick A. Slavcev, School of Pharmacy, University of Waterloo, 200 University Ave., Waterloo, Ontario, Canada, Tel: 519-888-4567 Fax: 519-888-7910; Email: slavcev@uwaterloo.ca

Received November 12, 2011; **Accepted** November 14, 2011; **Published** November 17, 2011

Citation: Slavcev RA (2012) The Disparity of Motivational Drivers in International Health Care Systems. *Pharmaceut Reg Affairs* 1:e101. doi:10.4172/2167-7689.1000e101

Copyright: © 2012 Slavcev RA. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

compromised by high bureaucratic costs and ethical disparities that particularly in light of a massive aging population and reduced work force may quickly diminish the underlying goal. To this point, while Canada is recognized as the nation with the fairest mechanism of health system finance in North America, we still ranked 30th in the world in health systems, and that was over a decade ago [8]. The ethical imperative of equal access is thus hindered by varying value drivers of each player in the healthcare mix. This access framework from bench (drug discovery) to bedside (clinical service) consists of various participants including, “drug manufacturers”, “health providers”, “policy makers”, public/private payers, and it embodies an evolved and integrated collaboration between its many phases for what can be best described as a continuum of access. The stakeholders, each of whom controls access in its own way, are driven by their own set of values and economic drivers, in both decision making and operation. The practice of ethics and ethical decision-making has to do with values that are more likely to conflict when one necessary part of a system doesn't know the values that motivate the other parts.

Healthcare must be thought of as a continuum from bench to bedside, and while each phase is motivated by different economic incentives, a bottleneck anywhere along the way accumulates economic slack and compromises downstream healthcare access. On a global scale, despite having fewer access points, these bottlenecks are magnified, given the differences in values of global players, economic incentives and mandates of the primary stakeholders, regulatory approaches (if any), and the situational economic complexities involved in providing healthcare [9].

Ethical practices or ethically-informed decision may only relieve such bottlenecks if we can first agree on a universal set of stakeholders' values and align economic incentives—this is difficult enough intranationally, let alone internationally, which will require global solidarity and the understanding that ethics and economics cannot be separated. Canada is a world leader, alongside the U.K. and Australia, in Health

economics that is quickly developing and ever improving as a universal language of ethical economics for policy makers to help decide who is eligible, to what therapeutic, and at what cost, based on incremental value/cost ratio. Health economics is arguably still in its infancy, largely subject to ethical debate unto itself and certainly not (yet) globally accepted as an economic/ethical paradigm of policy making and may never be. However, as this outcomes-based system continues to evolve, it benchmarks ethical practice toward universal drug access (pharmacoeconomics), including clinical access and therapeutic modalities in totality (health economics) that could serve to remove slack from the system. It may even serve as tool to wield ethical and gaugeable taxation of commercial firms (cigarettes, alcohol, junk food, etc) that profit, while taxing healthcare systems [10].

References

1. World Health Report (2000) Health systems: Improving performance.
2. World Health Report (2005) Make every mother and child count.
3. World Health Report (2010) Health systems financing: The path to universal coverage.
4. Schieber G, Maier M (2006) Financing Health Systems in the 21st Century, 225-242.
5. McCoy D, Brikci N (2010) Taskforce on Innovative International Financing for Health Systems: what next?. *Bulletin of the World Health Organization* 88: 478-480.
6. Disease Control Priorities Project (2006) Financing Health Systems: Severe Challenges Exist for Low-Income Countries in Setting Health Priorities and Financing Health System.
7. World Health Organization (2006) WHO Statistical Information System: Total expenditure on health as percentage of gross domestic product.
8. World Health Report (2000) Health systems: Improving performance.
9. Jamison DT (2006) Investing in Health 3-34.
10. Holt E (2010) Romania mulls over fast food tax. *Lancet* 375: 1070.