Journal of Pharmacovigilance

Salmon, J Pharmacovigilance 2014, 2:3
http://dx.doi.org/10.4172/2329-6887.1000134

Short Communication Open Access

Global Health Systems

Jack Warren Salmon*

School of Public Health, University of Illinois, Chicago, USA

***Corresponding author:** Jack Warren Salmon, Ph.D., Professor of Health Policy and Administration, School of Public Health, University of Illinois, Chicago, USA, Tel: 708 771-0854; Fax: 708 689-8151; E-mail: jsjwsalmon@gmail.com

Received date: June 12, 2014, **Accepted date:** July 21, 2014, **Published date:** July 28, 2014

Abstract

Changing world conditions impact health and health services across nations. The design of a specific country's national health system historically evolved, but many times cannot cope with pressures of new social epidemics, growth in aging cohorts, and the spiraling access, cost, and quality problematic, which all nations face to varying degrees. Analysts have investigated global health systems and compared and contrasted their salient characteristics, which can aid in devising better means to address health needs in populations amidst the challenges common to all nations.

This essay seeks to briefly present complex and ever-changing health care delivery systems that are increasingly being recognized for interventions in the policy and programmatic realms to improve effectiveness. It is often difficult to grasp overall national health systems in their societal contexts. A number of scholars have attempted to provide students with sufficient background for work in international health, which texts are mentioned below.

Keywords: National health systems; Social epidemics; Multinational drug firms; Clinical pharmacy; CAM; Pharmacovigilance

Introduction

Our world is growing in complexity and diversity, and a nation's political economic and socio-cultural dynamics have vast implication for health and healthcare. Consider 3-5 years ago, the nations of Syria, Ukraine, Nigeria, Egypt, and Thailand (to pull a few from the current news) seemed so different than the ongoing turmoil facing such populations. Health and health care implications abound for each today.

Over the years, several public health scholars have engaged in conceptualizing global health systems within an international health framework [1,2] with attempts to make greater sense of the varying approaches nations have chosen. Thorough analyses are key to strategizing how health care can be more effectively organized, financed, and delivered to varying groups. Rarely are the social determinants of health and the broader health needs of the population matched well to the particular configuration of health services, though international advocacy for such has been influential of late.

In the literature, country versus country depictions seem to prevail [3,4]. One's experience abroad stimulates interest in particular places to ascertain comparative threads, usually to the United States or the predominant Western system models. Although the desire to compare can lead to bias in perspective, they do offer a chance to contrast systems on specific public health issues (from reproductive health, maternal health care, and injury control through the use of services and technology) [5]. Overall generalizations on the design of systems can fall short in determining the vastly different national approaches that were historically evolved, though today system convergence across the globe may be the trend. Beyond this, breakthroughs in science and technology (along with administrative systems) are not that easily transferable to other settings. Important learning as to fit can aid the pursuit of "best practices". Concern for social epidemiology can enable improved strategies for public health activism [6].

In 1991 Roemer's two volume typology [7] laid out various system structures in light of each societal context to attempt a more comprehensive categorization (e.g., structures, ownership, financing, performance). Now twenty-some years later, societal wealth and economies (i.e, industrialized, welfare-oriented, entrepreneurial, socialist health systems) have been modified across the globe, even as new unanticipated public health challenges have emerged. Continuing engagement with policymakers and practitioners across national boundaries with sponsorship of technical assistance and engagement in projects has led to fuller knowledge of health care system strengths and weaknesses [8].

Since all societies struggle with access, costs, quality, efficiency and effectiveness, and accountability, expanded formal studies of national systems may allow for assessing performance and chosen national strategies for health sector development. While a nation's health care system plays a significant role in alleviating medical issues, its population's social and environmental conditions and economic resources' distribution are more determinant to health and well-being. Additionally, attributes of individuals, families, and communities have impact on morbidity patterns and the subsequent demand for health services. Greater numbers of practitioners and patients in communities must learn "observation-based epidemiology", especially in the Civil Society in their unique social, cultural and political economic contexts. This can be useful in alleviating disparities, which have contentiously deepened between the North and South, and also between richer and poor within many nations.

Undoubtedly, the field of global health has been chiefly shaped by the agencies, actors, and social movements. These players have greatly affected how we all tend to view the work where many of us participate and the how and what gets done. International health activists and those at grassroots levels in non-governmental organizations (NGOs)

are beginning to understand that many international health agencies (UN, WHO, Clinton, Gates) and financial institutions (World Bank, International Monetary Fund, G-8) hold agendas beyond merely improving health care conditions [2]. Seemingly, many Ministries of Health, and NGOs are more sophisticated through the Internet, visiting exchanges, and their policy involvement; they are critical of past strategic deficiencies and are now demanding not just economic resources, but questioning program assumptions and designs while seeking greater participation.

Since the discipline of public health emerged out of mainstream biomedical and behavioral models, explanations of how and why illnesses occur tend to be narrow and ignore the broader political, economic, and social structures that historically shaped national health systems and the content of their medicine and interventions [9,10]. Thus, the individual episodic, disease-focused, physician-centered, technological curative, hospital based, fee-for-service structures drive their costly and often times ineffective services, where as population-based preventive and health promotion approaches would improve the design of systems, an objective not easily accomplished in advanced systems, let alone across the developing world. Current tendencies for privatization of systems abroad and the export of Western technologies (pharmaceutical and medical devices) and the export of American ideologies (DRGs, HMOs, HIEs, and more) for supposedly improved delivery systems internationally, are likely to face resistance as true costs and restrictions on access are uncovered. A disturbing trend comes from both poorer nations and emerging economies investing in substantial private development for medical tourism [11,12]. This institutes what Andre Gunner Frank [13] identified as exacerbating the underdevelopment of the public sector [14].

Disruptions in health care systems have been notable with the rising social epidemics. Moreover, given expanding middle classes in the Southern Hemisphere presents new pockets of chronic degenerative diseases with people willing to pay for modern medicines. HIV/AIDS, TB, and malaria still defy eradication progress, and deeply burdening some nations. Newer scourges (swine and avian flu, cholera, EBOLA, MERS, polio, more) beset unprepared national health systems, diverting energies and scarce resources. Such challenges reveal the deficiencies in certain national systems.

The dramatic events and changes of late in international health have heightened concerns for improved global strategies and assistance for strengthening certain national health systems. Understanding the limits and costs of medical science and technology, and the slowness of its advancement, broadens such concerns for greater responsiveness, especially where disease does not respect geographic, nor class boundaries. The mix of a nation's health services from primary to tertiary, its availability and allocation of resources, and its prevention and health promotion successes are increasingly being examined by outside observers. More methodical study of the international health literature, national documents, news analyses, and publication sources can be highly useful to better system design and performance. It is key to view policies, resources, and the organization of programs in their larger historical context. Building capacity in global health systems usually requires political commitment and time to adequately respond to current crises with improved technological and managerial prowess. Sustainable development over decades is needed as societies address food shortages, climate change, migration, and war and ethnic strife that plague them beyond disease. Amidst such disruptions, national health systems must be targeted to move toward equity in health [15].

With multinational pharmaceutical firms seeking new markets in emerging economies (so-called "pharmerging nations") [16], there are critical needs for systems of pharmacovigilance to be constructed, along with the clinical upgrading of the pharmacy profession [17]. Community Pharmacists need to achieve new roles to identify drug-related problems, drug interactions, adverse reactions, contraindications, treatment guidelines, diet advice and lifestyle modifications [18]. Such clinical activities must be learned in university curricula and supported in the context of functioning health professional teams. Administrative systems and health information technology can capture useful data through active pharmacoepidemiology networks to promote the rational use of drugs across the entire health care system [19,20]. Across the world there are age-old competing systems to Western medicine, which demand thorough investigation as to their contributions to human health and their potential for a new integrative medicine

Many people in the Southern Hemisphere rely upon self-care, family, and community support and use natural, alternative and complimentary medicines and their practitioners [10]. Given this social reality, such systems of pharmacovigilance should be designed to accommodate conventional pharmaceuticals, as well as locally produced drugs and the variety of traditional medical practices that people will continue to prefer even when Western entities may become available--and not outlandishly priced out of their means, nor the nation's public sector. Research potentials here abound to discover safer medication usage, along with reshaping delivery systems to accommodate various peoples' needs and behaviors.

More study of global health systems may open up greater possibilities for reform and benefit all national health systems from the successes found in improved performance. This essay introduced several texts that can provide more background, while attempting to provoke readers' consideration of a variety of issues to ponder. The world pharmaceutical industry is rapidly changing with firms facing new challenges as they expand into new markets [21]. The management of pharmaceuticals across our world requires much attention [22], obviously entailing extension of mechanisms for quality pharmacovigilance.

References

1. Merson MH, Black RE, Mills AJ (2001) International public health: Diseases, programs, systems, and policies. Aspen Publishers, Gaithersburg, MD.
2. Birn AE, Pillay Y, Holtz TH (2009) Textbook of international health: Global health in a dynamic world. Oxford University Press, New York, Oxford.
3. Fried BJ, Gaydos LM (2002) World health systems: Challenges and perspectives. Health Administration Press, Chicago, Washington DC.
4. Raffel MW (1985) Comparative Health Systems: Descriptive Analyses of Fourteen National Health Systems. Pennsylvania State University Press, University Park, PA.
5. Merson MH, Black RE, Mills AJ (2012) Global health: Diseases, programs, systems, and policies. (3rdedn), Jones & Bartlett Learning, Burlington, MA, Ontario, Canada, London.
6. Cwikel JG (2006) Social Epidemiology: Strategies for Public Health Activism. Columbia University Press, New York.
7. Roemer ML (1991) National health systems of the world (volume 1), The countries. Oxford University Press, New York, Oxford.
8. Fried BJ, Gaydos LM (2002) World health systems: Challenges and perspectives. Health Administration Press, Chicago, Washington DC.

9. McKinlay JB (1984) Issues in the political economy of medical care. Methuen and London: Tavistock Publications, New York and London.
10. Salmon JW (1984) Alternative medicines: Popular and policy perspectives. Methuen Inc. and Tavistock Publications, New York and London.
11. Salmon JW (2008) News media widely publicizes health tourism. American Health & Drug Benefits 1.
12. Salmon JW (2008) Emerging trends in outsourcing healthcare: Medical Tourism. American Health & Drug Benefits 1.
13. Frank AG (1967) Capitalism and Underdevelopment in Latin America. Monthly Review Press. New York.
14. Whiteis D, Salmon JW (1987) The proprietarization of health care and the underdevelopment of the public sector. International Journal of Health Services 17: 47-64.
15. Wallace BC (2008) Toward Equity in Health: A New Global Approach to Health Disparities. Spring Publishing, New York.
16. Simon, F., & Kotler, P. (2003). Building Global Biobrands: Taking Biotechnology to Market. Free Press, New York.
17. Hepler CD, Strand LM (1990) Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm. 47:533-43.
18. International Pharmaceutical Federation (2011) Joint FIP/WHO guidelines on good pharmacy practice: standards for quality of pharmacy services. WHO Technical Report Series No. 961.
19. Ministerio de Salud Pública. Área Medico-Farmacéutica. Centro para el Desarrollo de la Farmacoepidemiología. (2000) Estrategia de la farmacoepidemiología y de la farmacia principal municipal (FPM). RESUMED 13: 229-231.
20. Reed G (2010) Shaping a research agenda to solve health problems: Interview with Niviola Cabrera, Director of Science and Technology, Minister of Public Health, Cuba. MEDICC Review, 12: 8-10.
21. Salmon JW (2009) The pharmaceutical industry confronts the 21st century: Generic competition, compulsory licensing, and drug access and safety challenges. World Federation of Public Health Associations 12th World Congress, Istanbul, Turkey.
22. Anderson S (2004) Managing Pharmaceuticals in International Health. Birkhauser Verlag, Basel, Switzerland.