Definition: **Healthcare** from *Dictionary of Information Science and Technology*

the prevention, treatment, and management of illness and the preservation of mental health through the services offered by the medical, nursing, and allied health professions (McDonnell & Salazar, 2010)

Summary Article: **Health Care**

From *Encyclopedia of Governance*

Health care refers to services provided by medical professionals aimed at promoting physical and mental welfare, through the prevention, treatment, and management of illness. This includes care by the medical and allied health professionals, curative care for acute conditions, management of chronic disease, rehabilitation, and palliative care.

Although the aim of health care is to promote individual and public health, health care is a distinct concept from “health.” Factors outside of the provision of health care (e.g., diet, genetics) play an important role in determining individual health, and the provision of health care is only one aspect of the governance of health. Equally though, governing health care extends beyond promoting health. Health care is a major industrial sector, a growing component of many developed countries’ national economies, and an important component of their labor force. In 1960, Organization for Economic Co-operation and Development (OECD) countries spent an average of 3.79 percent of their gross domestic product (GDP) on health care, and in 2003, the corresponding number was 8.3 percent of GDP. In 2004, 12 percent of the nonfarm private labor force in the United States worked in the health care sector, with rapid and sustained job growth during the past two decades. Expenditure on pharmaceuticals and technology is also a central component of overall health care expenditure.

Governance of the health care sector, then, is complex and multifaceted. In many countries, the public sector plays a direct role in both financing and delivering services; however, public involvement extends to a range of policies from the regulation of medical malpractice to supporting technical innovation. Many welfare states incorporate a “health care state” in which the embedded nature of health care gives rise to complex forms of governance. These forms require balancing issues related to collective consumption of services and governing professionals and the production of a large industrial sector. State involvement in the health care sector is intricately entwined with governance of the labor market, industrial promotion, intellectual property rights, and technology policy, among other areas.

**Variation in the Organization of the Health Care Sector**

Most economists argue that health care is not a “perfect good” and unregulated markets may lead to inefficient and inequitable provision of health care—meaning some form of public involvement in the health care sector is necessary. However, countries vary in how they choose to coordinate public involvement in the organization of the financing and delivery of health care.

Many continental European health care systems operate on a social insurance model. In these systems, the provision of health care is organized around multiple quasi-public payers (the social insurance funds) and is funded through statutory social insurance contributions on wages rather than actuarial risks. The
public guarantee for health care was often layered onto the mutual society that provided insurance to lower-income workers at the end of the nineteenth century, formalizing and extending the position of social insurers in managing the system. In these systems, much of the care is also provided privately, often by nonprofit organizations with links to major social groups. In the past decade, a number of Eastern European and former Soviet states have moved toward a social insurance model, building on the logic of the systems in continental Europe.

The United Kingdom, the Scandinavian countries, and to a large part, Spain, Portugal, Italy, Canada, Australia, and New Zealand, operate national health insurance and service models, in which a large part of the expenditure on health care is financed via general taxation rather than via contributions raised through taxes on wages. In these countries, the public sector operates as a single payer for health care and much of the health care is financed through a single public purchaser at the national or subnational level. Although early health care coverage in these countries often developed through mutual societies similar to those in the Continental European countries, the government assumed a more extensive and direct government role as insurance or services were extended in the mid- to late-twentieth century. Many of these countries combine the central role of the public sector in financing and managing services with a direct role in delivering care, with only Canada combining a single-payer system with a primarily private not-for-profit provision.

The health care system in the United States combines a multipayer private insurance system with a large system of public financing based primarily on social insurance contributions. Direct public financing in the United States remains linked to programs that target particular social groups, namely Medicare, Medicaid, and benefits for veterans. Most of the working-age population and children are covered through private voluntary insurance or remain uninsured. However, governance of the private insurance sector remains extensive, namely through a policy that aims at promoting private voluntary insurance through the tax system and ensuring some portability of benefits for workers changing jobs. The provision of health care in the United States is provided almost exclusively privately, by a combination of for-profit and not-for-profit providers.

Through much the 1960s and 1970s, health care policy in many advanced industrial countries aimed at expanding coverage and access to health care and at introducing tools of planning into the health care sector. However, growing economic difficulties and aging populations have produced rising costs alongside growing expectations, bringing a range of new issues onto the agenda in many countries. First, many countries have looked to control costs and have introduced reforms to do so through more direct state involvement in setting global budgets, the introduction of greater individual financing of services, and the increased use of incentives for micro-efficiency. These policies—which are often introduced in a single context—have a range of implications for public governance, simultaneously increasing state control, recasting state regulation, and reducing state responsibility for financing services. However, a second trend, which can lead to greater expenditure and new forms of public intervention, is toward greater emphasis on quality and innovation in the health care sector. Increasingly, issues of improving health care outcomes, reducing variation in quality, and improving patient satisfaction have become prominent in health policy debates. Many countries have begun gathering more performance information, setting targets, and monitoring the delivery of services, in an attempt to reform the delivery of health care services. Both trends have reshaped the role of the state vis-à-vis both patients and professionals, with the state assuming more responsibility for ensuring adequate quality and costs and often challenging professional autonomy over clinical processes to do so. In the
United States, many private health care insurers have played a similar role, attempting to recast professional practices to cut costs and potentially improve quality. Thus, governance of the health care sector is in transition, with a tendency toward more state control and responsibility as well as pressure for reducing state expenditure.

See also
Clinical Governance; Organisation for Economic Co-operation and Development; Welfare Reform; Welfare State

Further Readings and References

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