Introduction

In the months I was writing this book, the COVID-19 epidemic broke out. The measures taken in various countries to tackle the spread of the coronavirus have brought health systems, and the professionals who are part of them, back into the spotlight. The pandemic has confirmed what we are all aware of, but which we often tend to take for granted, and that is how very important the organization of healthcare services is.

Healthcare is a crucial sector from many points of view; from a personal point of view, first of all. We always hope to have to use it as little as possible, but when we need it, we would like to be able to count on high quality health services; to know whether we do or do not have the financial backing of an insurance scheme; to have, or not have, the right to freely choose which provider to be treated by. This makes all the difference in the world. The ways in which healthcare services are governed should interest us not only as potential users but also from a social, economic and political point of view. Suffice it to say that the most economically developed countries devote, on average, around 10 percent of their gross domestic product to healthcare, and this percentage is continuously increasing over the years.

In an era of globalization, of a push toward institutional isomorphism and policy convergence, it would be easy to expect that countries with advanced economies govern health services in a similar way. It is not so. As will be seen in the following chapters, in terms of the financing and organization of healthcare, the differences between member countries of the Organisation for Economic Co-operation and Development (OECD) are marked. In some countries,

all residents enjoy generous coverage against the risk of becoming ill; in others, there are millions of uninsured (and underinsured) people. There are systems in which the choice of a specialist doctor or of the hospital facility where one may be treated is severely limited. In other systems, on the contrary, patients – without any additional economic burden – can freely choose from all the providers in the country. There are countries where the public health service – think of the National Health Service (NHS) in the United Kingdom – manages the vast majority of inpatient and outpatient facilities themselves, and has hundreds of thousands of employees, making it the largest employer and the largest company in the country. In other countries, the State does not manage a single hospital and has no healthcare personnel on the payroll. In some systems, a referral from your family doctor is required to access specialist care; in other systems, patients have direct access to specialist visits and diagnostic tests. And the list of differences between the different national systems could continue, but it is better to stop here in order to not spoil the content of the following chapters. For the moment it is sufficient to make it clear that the healthcare systems of the OECD countries are by no means similar to each other.

I would like to make explicit the logic with which this volume is designed; it is a logic that has several similarities to the software used for creating the identikits of people sought by the police. These programs allow you to choose from a wide range of different face shapes, various hair lines, differently shaped and sized noses, multiple types of eyebrows, different eye shapes and so on. The identikit is composed of the somatic characteristics, selected from those available in the catalog, which are closest to those of the face to be reconstructed. A very similar *modus operandi* can also be applied to the study of health systems. Each health system is made up of different components. In this book, the logic followed for each of these components will be to first present the different, possible options on a theoretical and organizational level; then show which countries have adopted one solution and which another.

The theoretical framework will be tested on a large number of cases, that is, the health systems of twenty-seven OECD countries.[1] Following the "logic of the identikit," the individual national systems will all end up being described as *mestizo* creatures, which mix together – in not always a congruent and a harmonious way – elements attributable to ideally opposed models. Commenting on some of my previous works, some colleagues have defined – kindly, I hope – this way of proceeding as similar to a "Lego-like" (like building blocks) construction. Moreover, in the following chapters, the analogy of the cocktail will be evoked. Beginning with the same ingredients very different drinks can be made, depending on how they are combined.

To better focus on the content in the following chapters, it may be useful to introduce at this point the image of the "health triangle." Several authors (Mossialos and Dixon, 2002; OECD, 2002; Rothgang et al., 2005) agree in considering the healthcare system as the intertwining of interactions established among three categories of actors: users, providers and insurers. By providers we mean all entities that provide healthcare services directly, therefore, these include hospitals, outpatient clinics, healthcare labs, doctors, nurses and, in general, all healthcare professions. Insurers are either for-profit or not-for-profit entities that collect financial resources to be allocated for coverage of medical expenses of third parties. All individuals – regardless of their health conditions – are potential users of the healthcare system. Each of us can, indeed, face health problems and consequently need healthcare services. Providers, insurers and users are the vertices of the healthcare triangle.

[1] There are currently thirty-seven members of the OECD. Of these thirty-seven member states, ten are not analyzed in this book. The choice is justified by the fact that, particularly for recently joining countries, the OECD Health Statistics database does not provide the complete time series of data. Moreover, many of the excluded countries are small in size (with a population of fewer than three million inhabitants), and there is a lack of adequate scientific publications in English on the organization of the respective healthcare systems. The twenty-seven countries considered in this study are those for which the OECD Health Statistics provides a complete dataset, and for which an abundant literature in English is available.

In addition to the vertices, it is also possible to dwell on the sides of the triangle, that is, on the relationships among users, providers and insurers. When focusing on the relationship between users and insurers, we are talking about the funding of the system. When considering the relationship between providers and users, we are dealing with healthcare service provision. The third side of the triangle pertains to the relationships established between insurers and providers and, in particular, the ways in which providers are remunerated. The State has the important task of regulating the sides of the triangle. Depending on the country, in addition to regulation, the public actor can take on the role of financier of the system, and in some cases, also that of direct provider.

The book is structured as follows. The first three chapters focus on the funding side of healthcare services. Chapter 1 presents seven "primary" models through which it is possible to finance healthcare services and protect oneself from the risks of disease. In Chapter 2, many variants of the primary models are reviewed, and it will be understood how all national systems are hybrid and segmented internally. In Chapter 3, some data are provided to explain the effects produced by the individual national financing systems, in terms of overall expenditure and insurance coverage of the population.

With Chapter 4, we will move from the funding side to the provision of care. First, two rival ideal types (separated versus integrated models) and the different elements that characterize them are presented, and then we go on to see which of these organizational elements are actually applied in the individual countries. In Chapter 5, the financing methods are cross-referenced with healthcare provision arrangements. In this way, four "health families" and some outliers are identified. Chapter 6 completes the description of the delivery system, focusing on some fundamental categories of providers – hospitals, doctors and nurses – and the ways in which they are remunerated.

Health systems are in constant evolution. Chapter 7 is, therefore, dedicated to the health reforms adopted over the last few

decades. The innumerable initiatives undertaken in the various countries are condensed into some major reform themes.

Finally, Chapter 8 will try to answer the "why" question: Why do OECD countries adopt different healthcare organization models? In an attempt to answer this question, some explanations that have already been advanced in the literature will be reported, adopting, in particular, the perspective of "health politics."

*