Navigating healthcare systems: Is there a solution to healthy ageing?

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Abstract

Across cultures and countries, people have different understandings of what health entails, so improving the health of the elderly would also mean improving different health factors. Universal health as a notion is an illusionary idea, because it is context-dependent. Countries face different issues with elderly populations, and so they have different objectives for their healthcare systems. Even when elderly populations have similar problems, the social, political and cultural differences between countries make the implementation of universal health measures impossible. Countries' healthcare systems are already different due to the different circumstances, and so healthy ageing should be promoted in a more localised fashion. Healthcare systems are not efficient in addressing local issues when the different understandings of health are not respected. For a healthcare system to work to its full potential, measures have to be adapted to local needs, local values, and local priorities. Healthy ageing might be a universal problem, but it has no universal solution.

Health is essential to living. The international community acknowledges the importance of health by including health as a basic Human Right (Art. 25). Every community in the world needs to provide health to its members in some form of healthcare, addressing especially those vulnerable in society: the elderly and the young. As we have to deal with a growing elderly population, healthcare systems need to be increasingly adept at tackling issues that this proportion of our population faces. Healthy ageing is a term that has recently been coined to point at these issues. The term especially hints at the fact that adding extra years to our lives does not necessarily equate with being more active during those years (WHO, 2015b). One cannot say, however, that healthy ageing can be promoted in similar

ways across the world. After all, healthcare systems already differ between countries, and even defining what one regards as universal health is difficult. This paper investigates the struggle of localised universal health, and examines to what extent a universal approach to promoting healthy ageing is appropriate.

Health is a controversial topic because of its universal need, and its variety of implementations (Huber et al., 2011; "What is Health?", 2009). Due to changing views of political parties, cultural norms, values and social habits, countries address health issues in ways that fit their societies. Even though most countries face ageing populations, the health of these populations is addressed differently. Therefore, this paper argues that universal healthcare is problematic or even illusionary because of cultural, social and political circumstances. Every country needs an adapted programme to promote healthy ageing. The need for specific care is even strengthened by countries' diverse demographics. Naturally, universal prog-rammmes do exist, and they will differ in practice (WHO, 2012; WHO, 2015a), but this paper argues that the very idea of universality is debatable. This paper regards healthcare as intrinsically local: the functioning of healthcare, its prioritisation of certain treatments and its response to critical situations depend on specific circumstances. Therefore, according to this viewpoint, healthy ageing cannot be promoted in the universal manner programmes like the Millennium Development Goals (MDGs) or Sustainable Development Goals (SDGs) advocate health.

There has been some criticism by scholars on the standard definitions of health (Huber et al., 2011; "What is Health?", 2009), but there has been little research on structural differences in conceptualising health and how these differences in turn affect the functioning of healthcare systems. This paper thus attempts to reconsider healthcare systems as structures that cannot be taken for granted, focussing on health of the elderly as a niche topic. Furthermore, the paper aims at challenging the reader on their belief in universal healthcare, because universality seems to be an assumption that is criticisable, yet often overlooked. First, the notion of health will be analysed. The concept of health can refer to different things, and so its conceptualisation influences prioritisation and implem-entation of healthcare policies regarding healthy ageing (Hurst, 1991; Kraaijvanger, 2014). In the second section the appeal of a universal healthcare system will be discussed, followed by an investigation of whether similar problems lead to similar solutions. Lastly, different healthcare systems will be elaborated upon, focussing especially on the Netherlands, the United States of America, Canada and Uganda. The different ways in which their healthcare systems are organised can shed light on how different conceptualisations lead to different approaches in healthcare systems, while also offering different roadmaps for addressing healthy ageing.

I.   The 'health' in healthy ageing

Health is a basic necessity of life, yet its meaning is not as clear-cut as one might assume. The seemingly universal concept is applied so diversely in different places that one is inclined to think that the meaning attached to the concept depends on context and culture. It seems that people in a certain place or a certain environment define health according to their necessities and values, indicating that health would be dependent on geographic location ("What is Health?", 2009). Moreover, when people rate their health, they are subjective in how they perceive their condition. In Idler and Benyamini's study, participants stated that their health depended on many things, and that how healthy they felt depended on the day and on what body part they were talking about (1997, p. 27). Health is thus not a state that can be decided upon externally, nor a state that is unchangeable. A universal notion of health, in similar sense, can hardly exist.

Initially, health was understood as a "state of being free from illness or injury" while also referring to "[a] person's mental or physical condition" ("Health", 2016). These are two different things, since being free from illness or injury might not necessarily mean one is in perfect health (Huber et al., 2011). Therefore, one might favour a broader definition such as the one the World Health Organisation (WHO) uses:

"[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"
 (WHO, 2006, p. 1).

The WHO's definition was so broad that even though it was criticized on its open interpretation, the definition has not been amended since its formulation (Huber et al., 2011). However, this notion of health has its own problems, because it is unclear how it differs from well-being or quality of life (Peter, 2001). The WHO's definition might capture every person's understanding of health, but it might be less useful when implementing health policies, as a meaning so broad does not give a clear direction (Huber et al., 2011). The definition has also been criticised on the word "complete", because it medicalises health in the sense that many people who normally consider themselves healthy may be categorised as unhealthy (Kraaijvanger, 2014; "What is Health?", 2009). Ageing populations have chronic diseases that might not make the elderly very ill per se, but that do contribute to the elderly's medical histories.

When looking at health on a more local level, one can see that different communities have different understandings of what is means to be healthy (Farmer, Kleinman, Kim & Basilico, 2013). Communities' notion of health possibly includes spiritual health, mental health or group (social) health (Kraaijvanger, 2014; Maastricht University, 2014). What conception of health one prioritizes for a healthcare system should then depend on

the community, because a healthcare system addresses the problems that a community regards as detrimental to health (Frenk, 2010). If a community does not perceive depression as a problem of mental health, the solution should not be sought in the medical sphere. How a health problem is defined is thus related to how it is solved, as the health treatment should correspond to the health problem. Improving the elderly's health is dependent on the community in a similar way: health measures should treat those issues that the community regards as most pressing, or in other words, issues that the elderly regard as part of the healthcare system. Therefore, health and healthcare are intrinsically tied to and dependent on social surroundings ("What is Health?", 2009).

II. Universal healthcare programmes

Healthcare mostly refers to the treatment of a large variety of diseases. The question is whether it is possible to implement one set of health measures that adequately responds to all diseases all over the world, or whether such a health system would be so elaborate and unspecific that implementation would never function. Organisations like the United Nations (UN) present health as an issue that can be addressed on a global scale: the MDGs and SDGs are the visible proof. Health is to be tackled by a global community, and the

WHO has set a guideline of ways by which to approach it (WHO, 2015a). The way in which these health measures are implemented will differ in practice, but the idea behind them is universal none the less. It can be questioned why health measures are advocated in this universal manner when healthcare implementation is so different in different countries.

Universal healthcare measures seem appealing because of their global possibilities: the belief is that because they are universal, they can be implemented worldwide. These measures are specific enough to be attractive but vague enough to leave their practical implications up to governments and NGO's. Organisations like the UN strive for universal systems because it simplifies the task governments often face: pushing through changes in countries' healthcare systems. Publicised universal health measures to health problems should be solutions, exactly because the UN has promoted them as universal. They are designed to work everywhere, and so healthcare improvement seems easier: governments merely have to implement what the UN has set out for them. One such a project that did seem to be effective was the programme 'Health for All'. This programme did not involve governments, but it did, in contrast to most projects, take differences in health conceptualisations into account. The programme was by developed by the WHO and has been ongoing since 1979. The project views health as a flexible concept, thus taking local wishes and restraints into account

when implementing measures (Taylor, 1992). Inequality and access to health services are viewed as part of the basic health necessary for citizens to enjoy life. Another action the WHO took to ensure the project's success was the project's response to situational changes and epidemics, thus shifting the priorities of the project to what was urgently needed (Taylor, 1992). Whereas 'Health for All' did take social contexts into account, usually healthcare measures are not localised. Even governments tend to ignore this basic step when organising their public healthcare systems, in the name of unification and ease of administration (Taylor, 1992). Accordingly, adequate responses to growing elderly populations are often lacking.

Just as much as anyone else, the elderly want and need to be in good health too. As people age, a variety of problems loom: memory loss, heart problems, dementia, and many more. Even though many of these problems are seen on a wider span of time and space, it does not seem like all elderly are affected by the same set of diseases. Whereas in developing countries elderly are still feeling the burden of infectious or communicable diseases such as lung infection or malaria, elderly in first world countries mainly face diseases such as diabetes, cancer and Alzheimer's (WHO, n.d.). Nevertheless, these diseases have also reached the developing world, creating a double burden – as elderly have to treat them next to communicative diseases that are typical for the mostly

tropical regions (WHO, n.d.). The double burden does mean that elderly across the world face similar diseases coupled with ageing – the chronic diseases-, at least next to illnesses specific to regions or developmental status (WHO, n.d.). This realisation means that certain measures could be effective beyond country boundaries: different healthcare systems could possibly implement similar measures advocating healthy ageing. However, implementing measures across borders does not immediately mean a universal system would also be appropriate. This assumption is crucial, because it means measures that are country specific can be implemented elsewhere, yet they are not universal.

The solution for promoting healthy ageing is thus not simple in the sense that one can design a universal measure and implement it afterwards. One can only start local and relatively small, after which, if successful, the measure can be transported to another region facing a similar problem. Even then, the measure cannot be implemented right away – taking a health measure to another region does not mean implementing it without adaptation to local values. Social, political and cultural values in which a healthcare system functions cannot simply be ignored ("What is Health?", 2009). A health measure taken from another region can be used as inspiration, or as a role-model, but it will have to be remodelled to local values in order to be most effective (Frenk, 2010). Healthcare systems are not different without a reason; therefore, governments

cannot simply take a WHO advice on a measure and implement it directly. The argument is that local differences will make health measures intrinsically local, because even if the healthcare system's target group (the elderly) is facing similar diseases as the elderly in another region, the success of the health measure will depend on how well local needs are catered to.

III. Similar problems, similar solutions?

Improving the increasingly longer life of the increasingly larger older population seems to be an issue many countries are facing. Often quoted is the (approaching) burden healthcare systems have to bear, pointing at the strain that elderly are likely to bring to healthcare systems regarding their capacities and needs. A larger proportion of the population being older explains why: the working force decreases in size, while the amount of people that needs care increases (WHO, 2015b). Fewer people have to generate the capital to pay for the healthcare of a larger amount of older people, diminishing the resilience and productivity of healthcare systems. The WHO points out that current healthcare systems are often not adept to the increasing elderly population, and already-stressed healthcare systems in developing countries cannot carry the abovementioned double burden that is currently taking its toll on vulnerable populations (Huber et al., 2011; WHO,

2015b). Yet, as mentioned before, many populations in the world are ageing, and so many countries in the world will have to find ways to promote healthy ageing.

Surprisingly, where one would think that countries with similar health problems would have similar healthcare systems, nothing seems to be less true than that. Canada and the Netherlands, for example, foster very different healthcare measures even though they have experienced similar economic growth and socio-political development (Hurst, 1991). This contradiction indicates that there might be other reasons than developmental status for the diversity in healthcare provision: whether that is social, political or cultural (Hurst, 1991). There does not seem to be one clear answer to why the differences persist. Is it because of their political ideologies or because of a different understanding of health (Farmer, Kleinman, Kim & Basilico, 2013)? An answer might be found when comparing the different healthcare systems concerning their applications of health and their objectives (Frenk, 2010). What is clear, though, is that because of these differences, healthy ageing cannot be promoted in a universal fashion, simply because each 'universal' method would have to be tailored to every country's specific healthcare system in order to be implemented effectively.

Universally advocated measures do not only need to be implemented differently between countries, also within countries inequalities exist that diminish the effectiveness of healthcare measures.

Countries that struggle with inequality, such as the United States of America (USA), often see differences between groups reflected in different demands and needs for healthcare (Van Ginneken, Swartz & Van der Wees, 2013). In order to solve this problem of inequality, the USA started to look at Western European countries such as the Netherlands (Van de Ven & Schut, 2008). Every healthcare system has a particular understanding of health that forms its foundation, yet most countries do not address this foundation when looking at each other as examples. What is included and excluded by a healthcare system is strongly influenced by this foundation, and thus this ignorance is problematic (Huber et al., 2011; Kraaijvanger, 2014). The problematic shows when one country adopts measures used in another country: the copied measures do not work out well because circumstances are not alike.

IV. Country-specific healthcare

Healthy ageing thus needs to be addressed country-specific, still, there are countries that inspire others with their healthcare models (Frenk, 2010). The Dutch healthcare system is interesting because it is an "efficient, universally-accessible system that has successfully integrated a strong competitive market component into it" (Tunstall, 2014, "Overview"). The Netherlands is the only country in the world that has integrated Alain Enthoven's theory of managed competition into its basic healthcare system. This theory has set out a competition of healthcare insurers according to the free market principle, however, the insurers are ultimately regulated by the state (Enthoven, 1978; Tunstall, 2014). The insurance companies cannot turn new applicants down: they must accept every one, and demand a set price per region that cannot be changed personally. This means that the Dutch healthcare system is relatively accessible (Tunstall, 2014). Furthermore, there is financial help provided by the government for those with an income too low to afford health insurance (Tunstall, 2014). Finally, a small percentage of a worker's salary is deducted to contribute to the long term care and risk adjustment system that is used for vulnerable groups such as elderly (Van de Ven & Schut, 2008). This means that the cost of elderly care is a shared responsibility of the entire working force, as is typical of a welfare system. Hence, a stability or potential reduction of costs will be enjoyed by everyone, meaning that healthy ageing is likely to be promoted nation-wide.

When comparing the Dutch healthcare system to the American system, opposite strengths and weaknesses can be witnessed (Davis, Stremikis, Squires & Schoen, 2014; Van de Ven & Schut, 2008). When one looks at access to healthcare and consumer choice, the Dutch system performs better, because the USA is severely lagging behind on basic health insurance coverage (Davis, Stremikis,

Squires, & Schoen, 2014). However, the challenge of the Dutch system is "to create integrated delivery systems that provide high-quality care in response to consumers' preferences" whereas in the US this integration is well-developed (Van de Ven & Schut, 2008, p. 780). Whether these systems could be combined to create a healthcare system that scores high on all aspects remains an open question (Van de Ven & Schut, 2008). For now, it seems to be a question of prioritizing. According to Kapiriri and Norheim, "[p]riority setting is one of the most important issues in healthcare policy because no health system can afford to pay for every service it wishes to provide" (2004, p. 172). Scandinavian countries try and do indeed perform quite well, but their health services are expensive in return, and thus those countries must compromise on other public expenses (Davis, Stremikis, Squires, & Schoen, 2014). Canada's health indicators show that the Canadian government prioritises equity (Canadian Institute for Health Information, 2011, p. ix). Yet, the country is lacking in several other aspects of health, such as patient-centred care, safe care and efficiency (Davis, Stremikis, Squires, & Schoen, 2014).

These different ways of providing healthcare may be assigned to the different objectives that countries foster for their healthcare systems (Hurst, 1991). The basic goals of health services may be shared – such as accessibility, adequacy and efficiency- but the main health concerns differ, especially between developing and developed countries (Farmer, Kleinman,

Kim & Basilico, 2013; Hurst, 1991). It might therefore be no surprise that Uganda's healthcare system is very much focussed on sanitation and communicable diseases such as AIDS and tuberculosis, which can be concluded from the main programs run by the Ministry of Health of the Republic of Uganda (Ministry of Health, 2015; Kavuma, 2009). On the contrary, the Netherlands is mainly concerned with smoking, excessive drinking and sport; health issues that are of a very different dimension than those in Uganda (Meessen, Van Damme, Tashobya & Tibouti, 2006; Rijksoverheid, n.d.). Promoting health at an older age will thus also concern these issues that are deemed important by the population and the government, with health measures targeting those issues that elderly are particularly weighed down by. Consequently, healthy ageing might need to be stimulated in Uganda by installing AIDS-related programmes, while this would hardly be necessary in the Netherlands.

Instead of looking at the rather obvious differences in healthcare systems between Uganda and the Netherlands, one might find it interesting to look at two developed countries, such as the Netherlands and Canada. These countries, quite similar in terms of life expectancy, income, equality and quality of living, nevertheless have different healthcare systems (United Nations Development Programme, 2014). There are many reasons that could be lying at the origin of the divergence: the history of the countries, their political ideologies or their number

and involvement of inhabitants. What the differences do show are the different mind-sets regarding healthcare, across countries with different development levels, logically, but also across countries with similar levels of prosperity. What follows is that measures of healthy ageing are as context-dependent as is healthcare in general. The Dutch system is successful in addressing different needs within this context – and thus scores high on accessibility - yet it does not provide the ultimate solution.

V.   Conclusion

Whereas healthy ageing is a relatively recent point of interest, our healthcare systems have had time to develop. Yet, this paper has seen that even developed countries like Canada or the Netherlands have difficulties in designing a holistic healthcare system that does justice to all. Healthy ageing is thus likely to become a challenge, forcing the systems to cater to the needs of more elderly when working forces are declining, and the systems already under stress. Universal health measures like the UN advocates under banners of MDG's or SDG's are not the solution, however. Healthcare systems need to locally respond to diseases or issues the elderly are facing, depending on what is considered part of healthcare treatment, and how health is locally conceptualised. Similarly, promoting healthy ageing will only be effective if health measures are adapted to local

values, and measures can thus not be extended across social, cultural and political boundaries without tailoring to local systems.

People in different countries perceive health differently, their healthcare systems work differently, and their systems prioritise different diseases and set different objectives. Hence, a universal approach to healthy ageing is hardly possible, despite organisations' advocates of health measures on a global scale. Measures that might work in one country need not be extendable into other countries, even when both are facing an ageing society. The differences in development of countries like Uganda and the Netherlands help to explain why their healthcare systems differ, but more research is needed to clarify how these differences change the implementation programmes concerning for example healthy ageing. These differences show that universal health is an illusionary idea, even though the basis on which it rests remains its global importance: health as a human right. For promoting healthy ageing one cannot rely on this foundation, because healthy ageing is an issue that is to be promoted through an existing system: the healthcare system. For this system, social, political and cultural context are determining factors of the functioning and effectiveness, and so should be taken into account.

This paper has addressed differences between healthcare systems, but future research could look into what exactly causes these differences, especially

if it concerns differences between two developed countries. Finding out why these deviations occur might also act as a guideline for tailoring health measures concerning healthy ageing. Research on these differences is important because healthcare services make up a significant part of countries budgets, so policy makers will find it helpful to know how healthcare measures can be made as effective and efficient as possible. In line with the needed response to ageing populations, health measures will have to become integrated in local systems, in order to alleviate the burden on the working force. For happy and healthy elderly, healthcare should be considered in its local context, because that is where all contextualisation of health begins.

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