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Global Overview of Health Systems and Investment Funds in Financing Health System in Lithuania

Aminu Levin*

Department of Management, University of Indonesia, Indonesia

Corresponding author: Aminu Levin

AminuLevin56@gmail.com

Department of Management, University of Indonesia, Indonesia

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Abstract

Malignant melanoma, usually referred to as melanoma, is a kind of skin cancer that arises from melanocytes, or cells that produce colour. In those with low amounts of the skin pigment melanin, exposure to UV radiation is the main cause of melanoma. Surgery is often used as a kind of treatment. It may be possible to check for spread in the adjacent lymph nodes in those with somewhat bigger tumours. If there hasn't been any spread, most patients are healed. Immunotherapy, biologic treatment, radiation therapy, or chemotherapy could increase survival rates in people whose melanoma has spread. Benefits evaluations for several nations are included in the global HTA database Prismaccess®. In this evaluation, Germany was the main subject. In the previous ten years, all choices about melanoma treatments launched in Germany were taken into account for a systematic reimbursement [1]. A total of 34 IQWiG assessments have been taken into account by the GBA when making judgments. 16 phase III studies, 4 phase II studies, and 2 phase I studies were included in the submissions [2]. A significant added advantage was provided to 11 of the analysed subgroups, two subgroups demonstrated an unquantifiable added benefit, 21 subgroups did not demonstrate an added benefit, and the G-BA chose a smaller benefit in two subgroups. In all, the 22 choices resulted in 12 recommendations without restrictions, 9 recommendations with restrictions, and in and Nivolumab in combination with ipilimumab in non-pretreated patients with a BRAF V600 wild-type tumour did not produce a beneficial additional benefit. In any case, Germany has access to all medications [3].

Keywords: European Structural and Investment Funds; Investment in Health; Health System Reform; Lithuania

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Introduction

Different relevant comparator therapy is the primary reasons for assessment discrepancies [4]. The pursuit of novel cancer therapies has picked up steam in the context of genetic profiling-based individualised therapy approaches [5]. Recent advances in individualised medicines have been successful in treating cancer. This study intends to assess patient access to cancer medications in Turkey for genetic profiling-based customised treatment [6]. Methods The official websites of the FDA and EMA were consulted for information about cancer medications that depend on genetic profiling The List of Licensed Products published by the Turkish Pharmaceutical and Medical Device Agency and the Health Implementation Communiqué published by the Social Security Institution are the sources for the information on the licence status, availability, and reimbursement coverage of the identified drugs in Turkey [7]. Results the analyses led to the approval of 66 cancer customised medicines by Due to improved non-small cell lung cancer genetic characterisation and the discovery of defining immunobiological traits, the treatment landscape for lung cancer is quickly evolving [8]. Despite the fact that combination immunotherapy agents are used more frequently to improve health outcomes, the societal challenges that combination immunotherapies bring are starting

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to become apparent, particularly when their high costs lead to reimbursement or payment barriers in many health systems around the world [9]. In this study, we intend to evaluate the value and cost of immunotherapy drugs when combined with currently available therapies for NSCLC [10]. The health statistics for Slovak individuals are much worse than those of the most developed nations. The issue of healthy occupants has more to do with treating poor health conditions than it does with preventing poor health [11]. In order to evaluate the health system instead of using the life expectancy indicator, an acceptable mortality indicator is utilised. It identifies a mortality that, in the event of appropriate and timely treatment, should not have happened [12]. It only considers conditions for which specialists agree that appropriate therapy is available prior to a certain age restriction. These fatalities are standardised at 100,000 people [13]. The applicable mortality indicator is very important for standard comparisons, but when used, it can lead to methodological problems with mortality data quality, diagnosis selection, diagnosis weight, etc. [14]. The fact that each country spends a varied amount of money on health is frequently used in international comparisons; however the discrepancies may be related to several factors [15]. To find combination immunotherapy medications for NSCLC, a clinical search was carried out utilising the US Food and Drug Administration, European Medicines Agency, and Clinical Trials databases. MEDLINE, the Cost Effectiveness Analysis Registry, and the Health Technology Assessment databases were used in an economic assessment search to look at the value and cost of combination immunotherapy treatments for NSCLC. Results: Four phase III studies that we identified Everyone agrees that the primary objective of health care systems is to promote population health, hence it is crucial to evaluate the effectiveness of these systems, particularly their contribution to improvements in population health. There are several ways to gauge how well the global health care systems are working. Antošová environmental variables and wealth. In fact, these factors may play a bigger part in determining health status than medical attention. Although, the health Systems from all across the world are frequently compared to assess and enhance patient care delivery. The efficacy of the health care system in industrialised countries is significantly influenced by the standard of medical treatment provided and the degree to which it may enhance a patient's health.

Discussion

Countries For starters, Rothstein defined "quality" as the impact of treatment on both population and individual health. Better health outcomes should be the result of higher-quality medical care. Investigating the factors that contribute to a higher health state is therefore highly useful. Frequently, the phrases "avoidable mortality" and "amenable mortality" are used interchangeably. The distinction is that preventable mortality includes acceptable mortality as a subset. A team of Harvard University researchers created avoidable mortality. According to their research, avoidable mortality is "deaths from certain disease categories that are thought to be either curable or preventable through health care services." They proposed a list of illnesses from which death shouldn't occur in the face of prompt and appropriate medical care in order to develop the concept of "unnecessary premature deaths." Prevention, cure, and care were defined as medical care in its fullest sense. The phrase "amenable mortality discriminating across causes" was originally used by the Harvard group. A death is treatable if, in the context of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through high-quality medical care, while a death is preventable if, in the context of knowledge of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health intervention in the broadest sense. It is important to remember that the idea of avoidable mortality is a subset of premature deaths that shouldn't be happening at that particular moment. Therefore, it is evident that there is a need to improve when preventable mortality occurs or increases. AM rates were calculated using data from the World Health Organization database, which comprised data for 2 nations for years, on deaths by cause, gender, and five-year age groups. Due to the lack of sufficient data, the remaining eight EU nations were not included in the research. Data on fatalities for the most recent year were supplied for Slovakia by the National Health Information Center.

Conclusion

The Statistical Database of the UN Economic Commission for Europe was used to download information on the population at midyear by age group and gender for each year. Age-standardizing mortality data for all illnesses in accordance with the European Standard Population will enable future study to compare mortality rates across countries. Age-specific European Standard Population statistics were chosen from the EUROSTAT website. The ambitious Sustainable Development Goals development plan necessitates significant expenditures in a number of areas, notably SDG 3 healthy lives and wellbeing. There have been no published estimates of the additional resources required to improve universal health coverage and the delivery of comprehensive health services in low- and middle-income countries in order to achieve SDG 3. In our paradigm for enhancing health systems, population- and individual-level health service coverage is steadily expanded over time. From 2016 through 2030, we created predictions for 67 low- and middle-income nations, accounting for 95% of all low- and middle-income countries' populations. We simulated two scenarios with varying levels of ambition, taking into account four service delivery platforms: a progress scenario, which shows nations' progress toward global goals we calculated the costs and health effects, which included decreased disease prevalence, lives saved, and longer life expectancies. In order to analyse affordability and financial sustainability, we projected available funds by nation and year, accounting for economic growth and anticipated allocation to the health sector. While US$371 billion would be required to reach health system targets in the ambitious scenario, we estimate that an additional $274 billion in health spending is required annually by 2030 to make progress towards the SDG 3 targets progress scenario—the equivalent of an additional $41 or $58 per person by the final years of scale-up, respectively. The ambitious scenario would result in an increase in overall health care spending to a population-weighted mean of $271 per person.

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Conflict of Interest
None

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