ASOS JOURNAL

The Journal of Academic Social Science

Akademik Sosyal Araştırmalar Dergisi, Yıl: 9, Sayı: 118, Temmuz 2021, s. 184-199

ISSN: 2148-2489 Doi Number: <http://dx.doi.org/10.29228/ASOS.51318>

Yayın Geliş Tarihi / Article Arrival Date
7.05.2021

Yayımlanma Tarihi / The Publication Date
29.07.2021

Dr. Negin BAVİLİ

Ankara Üniversitesi, Yönerim ve Strateji
neginbavili@gmail.com

KARŞILAŞTIRMALI REFAH SİSTEMLERİ VE POLİTİKALARIN ANALİZİ COVID 19'A KARŞI ALMANYA, ÇİN VE RUSYA ÜLKELERİN'DE

Öz

Almanya, Çin ve ABD farklı idari ve refah sistemleri vardır. Refah sistemleriyle ilgili farklı politikalar uygulanmaktadır. COVID 19 gibi salgın hastalıklar bir çok alanda dönüşüme sebep olmaktadır. Bu dönüşümler politikaları, devlet yükümlülüklerini, hükümetlerin sorumluluk alanını ve sağlık hizmetlerine erişim gibi alanlardaki müdahaleleri etkilemektedir. Bu çalışmada, söz konusu ülkelerin politikaları, stratejileri ve refah sistemlerini karşılaştırılacaktır. Bu çalışma, “İnsan haklarını ve milletin sağlığını en çok ne tür bir yönetim korur?” Sorusuna cevap vermektedir. Ayrıca bu çalışma, sosyal demokrasilerin, sosyalistlerin ve liberal sistemlerin covid 19 krizine karşı nasıl farklı bir tavır sergilediğini ve minimumun nasıl sağlandığını görmeye çalışmaktadır. sağlık hizmetlerine erişim? Çin, Almanya ve ABD'de sağlık hizmetlerine erişimin karşılaştırılması için küresel sağlık güvenliği endeksi kullanılacaktır. Bu çalışma, refah politikalarını, sağlık sistemi ve sağlık hizmetleri politikalarını ve bunlara erişimi karşılaştırmaktadır. Global sağlık güvenliği endeksi aracılığıyla sağlık hizmetleri bu çalışmada uygulanmaktadır.

Anahtar kelimeler: Refah Politikalarının Karşılaştırmalı Analizi, Sağlık Hizmetlerine Erişim, Temel Haklar

COMPARATIVE ANALYSIS OF WELFARE SYSTEM AND POLICIES TOWARDS COVID 19 IN GERMANY, CHINA AND RUSSIA

Abstract

Germany, China and US have different administrative and welfare systems. They have implemented different policies regarding their welfare systems. Pandemics like covid 19 have caused transformation in many areas. These transformations have affected policies, state obligations, Governments area of responsibility and interference in domains like access to health care. In this study, policies, strategies and welfare system of mentioned countries will be compared. This study answers the question of “What kind of administration protects human rights and health of nation at most?”, Moreover, this study attempts to see how social democracies, socialists and liberal systems have had different attitude towards covid 19 crisis and how provided minimum access to health care? Global health security index will be used for comparison of access to health care in China , Germany, and US. This study compares welfare policies, health system and health care policies, and access to health care by means of Global health security index is implemented in this study.

Keywords: Comparative Analysis of Welfare Policies, Access to Health Care, Preliminary Rights

1. INTRODUCTION

The medieval international system was transformed at a particular point in history into a system of modern sovereign states, each with an effective government exercising exclusive and absolute control over territory and people, is difficult to sustain when we look to those decisions of international arbitrators and tribunals concerned with competing claims to sovereignty over territory. After second world war, governments and their area of activities have transformed. New system are constructed after world war. New mechanisms and new institution are created and constructed. Before second world war governments and their interior issues were related to the governments. After second world war, new mechanisms were implemented in order to support and protect individuals in front of the governments.

Globalized system of human rights were constructed in order to protect citizens in front of the governments. International law as a source of constraints on the abuses of hegemonic power. Institutional and political developments since the end of the Cold War have led to a revival of international law and cosmopolitan legality. International law, through the institutionalization of human rights, also produces the techniques by which the law attempts to mediate that violence (Anghie, 2004).Government and duties of governments have transformed and reshaped as transformation at global level happened. Biopolitics, turns bodies and population into the objects of political aims through medical strategies. Biopolitics, is what makes life and its mechanisms enter the explicit calculation of government. Political interference of state and governments have transformed, then human right zone have faced transformations. Domains of government interference have been transformed as the need for presence of government has transformed. In some countries government's interference is not an acceptable and people don't prefer to see presence of government in their private domain of their lives. And they prefer to keep their government out side the private zone of citizens.

2. Emergence of Covid 19 And Transformation of Different Interrelated Arena

Pandemic of Covid 19 imposed transformation over the human relationship, international relationship and foreign policies. Also, this pandemics would establish new political understanding in a globalized world. Moreover, the role and duties of governments were redefined under this pandemics. In other words, the power of states and governments were redefined. What kind of states and governments performed more effectively in front of Covid 19 Pandemics? It should be declared that non of the systems have performed perfectly and most of the systems in the world were unprepared for the global crisis like covid 19. But analyzing these performances comparatively. Some of the administrative systems have performed more properly than the rest. Some of the administrative systems ignored and underestimated the crisis and this caused more problems for the citizens of these countries. Some administrative systems who could have protected their citizens and individuals more effectively. But non of them performs perfectly.

Moreover, those countries that had more affective performance in front of these pandemics may have a more prominent role in the post covid 19 era. To answer this question we need to see how prepared were different administrations in front of these pandemics. How much they were prepared for pandemics like this? Because pandemics like covid 19 may be an inevitable in a globalized context. It may be impossible to close the doors and construct walls to protect the members of the nations. Infrastructure and investment on health sector are important features of the leading administrations of the globalized world.

What does investment on health sector mean?, Does it means that those countries who have had the highest technology on the health care sector are less vulnerable in front of pandemics?

It should be declared that access to the preliminary health care is considered as necessity for survival of human being and according to Maslow's hierarchy can be considered the necessities for survival in globalized world. Maslow's hierarchy prioritize the needs as physiological needs, psychological needs and self fulfillment needs. Access to health care can be considered as preliminary needs which would provide survival of human being. Satisfaction of these needs of human beings can be recognized as positive obligations of states and governments.

It is the purpose of all international instruments for the protection of the human person primarily to set forth rights, that protection depends – apart from the guarantee mechanisms put in place – on the obligations on the states parties. Positive obligations stem from the duty to protect persons (Jean-François & Akandji-Kombe, 2007). As mentioned previously, by emergence of Covid 19 new political understanding is constructed. Tasks and duties of governments faced transformations. After emergence of covid 19, biological threats and protection of nation in front of these threats become an important ingredient in recognition of governments as an effective governments who have capability to protect the nation in front of different crisis.

And international relations also reevaluated after Globalized Crisis like covid 19. Covid 19, opened a new page for tasks and duties of governments. Moreover, it should be declared that Covid 19 pandemic has shown that governments and their policies can have vital or mortal affect on daily life of nations. Maybe pandemics become inevitable in a globalized world. Then governments need to have different approach towards these pandemics. How efficient governments work are determining element. This study will research on how different

administrative types had different reactions in front of this pandemics. Which type of governments and their health policies have been more efficient in Pandemics. Moreover, how much these administrative systems have been successful to fulfill their obligation and protect human rights.

3. Access To Health Care As Preliminary Rights

Health and access to health care are important issue which debate on these issues have increased. Human rights are a particularly strong category of norms. Human rights claim priority over other legal norms.

The human right to health cannot, however, be found in the UDHR in a separate article as would be expected and as was discussed in the Human Rights Commission. But this right has been mentioned implicitly. In order to keep the UDHR short and concise, it was enshrined as part of the right to an adequate standard of living which guarantees everyone health and wellbeing, including food, clothing, housing and medical care and necessary social services (Article 25). With regard to the right to health, which in the UDHR is not clearly differentiated from the other components of the right to an adequate standard of living, it should be noted that the UDHR identifies medical care as a central but not the only element of this right (Sabine Klotz, Heiner Bielefeldt, Martina Schmidhuber, Andreas Frewer, 2017). Also social security, especially in cases of illness and invalidity, as well as access to healthy living conditions (food, housing, etc.) can be considered as an adequate of standard of living.

The International Covenant on Economic, Social and Cultural Rights (ICESCR) is the fundamental UN Human Rights Convention on Economic, Social and Cultural rights (ESC rights) including the right to health. Two aspects need to be emphasized here. Firstly, the ICESCR moves away from the notion of a right to be healthy. Such a right appears to still be laid down in the preamble to the WHO constitution which talks about a state of complete physical, mental and social wellbeing. Secondly, in the International Covenant on Economic, Social and Cultural Rights (ICESCR) the highest attainable standard refers only to physical and mental health but not, for example, to “social wellbeing” or even to “moral wellbeing” .

Social and cultural rights like the rights to education, housing or health remain merely conditional, given their resource dependency. Social and Cultural rights require expensive infrastructural investments in schooling, housing or healthcare. They impose positive duties upon the state. Social and cultural rights rights postulate far-reaching state activities – or so is the assumption. Social and cultural rights rectify the consequences of social inequalities (Sabine Klotz, Heiner Bielefeldt, Martina Schmidhuber, Andreas Frewer, 2017) .

Human rights differ from moral postulates in that they impose binding obligations on the state, which under international law figures as the formal guarantor of the rights of those living under its jurisdiction. how can a certain standard of health become a legally binding entitlement?

The state cannot implement the right to food without respecting people’s dietary customs, including dietary rules based on moral or religious convictions. This is part of the right to food itself. To give another example, the right to education presupposes respect for specific needs and vulnerabilities of students from minorities and their parents. There are different cultural political, religious, social, economical features that affect norm creation and human rights claim priority over other legal norms.

Covid 19 and pandemics like this have caused transformation in tasks and duties of states and functions and fundamental rights of humans. Access to health care are converted to main issue that citizens of different countries expect their government to provide for them. Health and access to health care can be considered as positive obligations of states which are resource dependent and minimum standard of this access to health care can be different in different cultures and in different countries.

This study will attempt to see how social democracies, socialists and liberal systems have worked different attitude towards covid 19 crisis and how provided minimum access to health care?

In other words it can be claimed that the fulfillment of human rights is the bedrock of social justice. The 1948 UN Declaration of Human Rights sparked an ongoing debate over the obligation of governments to ensure the welfare of individuals by protecting their social and economic as well as civil and political rights. To put it in a nutshell, there are direct relationship in access to health care and fulfillment of human rights. The European Court of Human Rights¹ has for its part opted for a simpler, two-pronged approach, dividing states' obligations into two categories: (a) negative obligations and (b) positive obligations. On this basis, the European Court of Human Rights today ensures broader protection for the rights secured in the Convention of which it is the ultimate guardian. Access to health care can be considered as positive obligations of government (Jean-François & Akandji-Kombe, 2007).

Facilitating access to health care is concerned with helping people to command appropriate health care resources in order to preserve or improve their health. There are at least four aspects (Martin Gulliford, Myfanwy Morgan, David Hughes, Roger Beech, Jose Figeroa-Munoz, Barry Gibson, Meryl Hudson, Chitra Arumugam, Patricia Connell, Abdu Mohiddin, James Sedgwick, 2001). Access to health care can be summarized in four domains: If services are available, in terms of an adequate supply of services, then a population may 'have access' to health care. Secondly, the extent to which a population 'gains access' to health care also depends on financial, organizational and social or cultural barriers that limit utilization. Thus utilization is dependent on the affordability, physical accessibility and acceptability of services and not merely the adequacy of supply. Thirdly, the services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. Fourthly, the availability of services, and barriers to utilization, have to be evaluated in the context of the differing perspectives, health needs and the material and cultural settings of diverse groups in society.

Moreover, it should be declared that in time of globalized pandemic crisis like covid 19 crisis just those administrations which were technically equipped are not adequate to prevent and control these pandemics. These global crisis needs more than technical and financial support. In order to protect the people, there needs to be institutional and disciplined interference of Governments at different levels such as, prevention, detection, responding, and creation of health norms and declining the risks at difference levels. There needs to be coordination and governance at different levels in order to act more successfully in front of these unknown pandemics.² The Global Health Security (GHS) Index is the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries. The GHS

Index seeks to illuminate those gaps to increase both political will and financing to fill them at the national and international levels.

According to GHS index, no country is fully prepared for epidemics or pandemics. Collectively, international preparedness is weak. Many countries do not show evidence of the health security capacities and capabilities that are needed to prevent, detect, and respond to significant infectious disease outbreaks. At least 75% of countries receive low scores on globally catastrophic biological risk-related indicators, the greatest vulnerability being oversight of dual-use research. Although 86% of countries invest local or donor funds in health security, few countries pay for health security gap assessments and action plans out of national budgets.

The average overall Global health security Index, score among all 195 countries assessed is 40.2 of a possible score of 100. Among the 60 high-income countries, the average GHS Index score is 51.9. In addition, 116 high- and middle-income countries do not score above 50. Overall, the GHS Index finds severe weaknesses in country abilities to prevent, detect, and respond to health emergencies; severe gaps in health systems; vulnerabilities to political, socioeconomic, and environmental risks that can confound outbreak preparedness and response; and a lack of adherence to international norms. Specific scores for the GHS Index categories are prevention, detection and reporting, rapid response, health system, compliance with international norms, risk environment (Cui W.,2008) .

4. HEALTH CARE IN CHINA

The primary health-care system in China (Cui W.,2008), which provides basic clinical care and public health services to a fifth of the world's population, has a notable history. Since its establishment in the early 1950s, it contributed substantially to a reduction in the burden of communicable, maternal, and neonatal diseases through the 1960s and 1970s, and helped advance the global primary health-care movement enshrined in the Declaration of Alma-Ata in 1978 (Xi Li, Jiapeng Lu, Shuang Hu, KK Cheng, Jan De Maeseneer, Qingyue Meng, Elias Mossialos, Dong Roman Xu, Winnie Yip, Hongzhao Zhang, Harlan M Krumholz†, Lixin Jiang†, Shengshou Hu, 2017).The Declaration of Alma-Ata called for "Health For All" to be attained by the year 2000—a goal that required making primary health care (PHC) the cornerstone of health systems. According to the Declaration of Alma-Ata, a primary health-care system is designed to provide universally accessible essential health care to individuals and families in the community as the first level of contact with the national health system. In China, the primary health-care system provides generalist clinical care and basic public health services.

As part of China's new health-care reform, initiated in 2009, the government increased its subsidies to primary health-care institutions from ¥19 billion (US\$2.8 billion) in 2008 to ¥140 billion (\$20.3 billion) in 2015. The government instituted universal health insurance coverage, a basic public health service programme, and a national essential drug system, all of which improved access to and affordability of primary health care.

Additionally, the government's Healthy China 2030 plan envisions the primary health-care system as a means of addressing the emerging dual burden of chronic non-communicable diseases (Yang G, Wang Y, Zeng Y, et al, 2013).

Social health insurance programme have successfully covered more than 97% of residents in China. There are three social health insurance programme: Urban Employee-Based Medical

Insurance (established in 1998), New Cooperative Medical Scheme (NCMS; established in 2003), and Urban Resident-Based Medical Insurance (URBMI; established in 2007).

To put in a nut shell, China is a country that differs from the rest of the world economically and politically. Healthcare in China consists of both public and private medical institutions and insurance programs. About 95% of the population has at least basic health insurance coverage. The Chinese government is working on providing affordable basic healthcare to all residents by 2020. Healthcare policies in china;

In China, the central government has overall responsibility for national health legislation, policy, and administration. It is guided by the principle that every citizen is entitled to receive basic health care services, with local governments—provinces, prefectures, cities, counties, and towns—responsible for providing them, with variations for local circumstances. Health authorities include the National Health and Family Planning Commission and the local Health and Family Planning Commissions, which have primary responsibility for organizing and delivering health care and supervising providers (mainly hospitals). Health authorities at the prefecture, county, and town levels have limited flexibility in carrying out provincial health policies.

Coverage by publicly financed health insurance is near-universal—exceeding 9 percent of the population since 2011.

Source: <https://international.commonwealthfund.org/countries/china/>

4.1. China's Welfare System and Policies Towards Covid 19

This section of research will elaborate on how welfare system in china is different from the rest of the world? Modern-day China is mainly characterized as having a market economy based on private property ownership and is one of the leading examples of [state capitalism](#).

But "Socializing social welfare" was initially a concept raised in response to the new social needs arising from the economic reform. It later evolved into a working orientation which has identified common welfare concerns, developed significant welfare contents, and derived some guiding principles. It can be considered as a new model of social welfare designed to serve the newly adopted market socialism.

This new welfare model still have a strong residual orientation by western standards. Nonetheless, taking into consideration China's present state of social and economic development, 'socializing social welfare' as a concept or model is a big step forward in building a modern social welfare system in China (Mok, Bong-ho and Liu, Jitong,1999).Some communist administration like China have implemented strict limitations like Quarantine. Also, used legal and punishing force to keep people at home. China put health cheque.

The Chinese government has been variously described as communist and socialist, but also as authoritarian and corporatist, with heavy restrictions in many areas, most notably against free access to the Internet, freedom of the press, freedom of assembly, the right to have children, free formation of social organizations and freedom of religion. There are criticism of

How china wasn't transparent in its preventive activities. Western countries like US, and EU countries have put alot of blame that china didn't work satisfactorily in prevention of spread of covid 19. But how would they react if such a crisis would arise in European countries or in USA. Were these countries more prepared than china and would they be more prepared to protect their citizens?

4.2. Policies Of China in Meeting Covid 19 Challenge

In this section the policies of Chinese government to impede covid 19 is declared. China shaped a standard in meeting Covid 19 challenge. China has stepped aggressively to impede covid 19. China implemented hard and strict quarantine to prevent covid 19 pandemic. Great discipline was shown by Chinese in prevention of out break of this pandemic. Quarantine and isolation which were used by Chinese in order to break the virus transition chain. Moreover, as speed of transmission of this virus decreases, the medical sector has opportunity to revive and refresh itself.

Quarantine is applied by china in order to break the chain of this covid 19 pandemic. The number of infected people will be doubled every three days if Quarantine wasn't applied. Covid 19 is a pandemic illness which needs respiratory equipment as medical aid.

Also, it helps the researchers to buy time to impede the pandemic. Quarantine policies in china included; suspended travel, closed schools, universities, shutdown business, imposed restriction for transportation of people and forced people to stay at home. Local specialist in china shared the genome of this virus. Built specialized hospitals in several days.

There were some discussions that the authoritarian regimes are more successful in managing a global crisis and covid 19. pandemic. Authoritarian regimes like Chinese regime cover up events and stories that don't love. This is deliberate policy of authoritarian systems. Moreover,

it can be declared that in authoritarian regimes, language of force and fear are dominant ingredients of authoritarian regimes.

Lack of transparency is an important feature of policies implemented by China. It should be mentioned that China there are suspicions about the figures and real number of people who have died of Covid 19. Transparency is absent. China has tried to cover up the truth about this disease and suppressed information in order not to come out. And detain doctors. This is rutin of authoritarian regimes which attempt to clean up the dirtiness under the carpet and hide it.

4.3. Evaluation of Healthcare In China

GHS, Global health Security, is the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries that index of China is 48.2 Index Score out of 51/195. Average score for Health capacity in clinics, hospitals and community care centers is 24.4 which is above average. Moreover, average score for access to health care is 38.4. Health care access in China is 31.4. which is under average score.

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	45.7	26.4
Health capacity in clinics, hospitals and community care centers	38.3	24.4
Medical countermeasures and personnel deployment	33.3	21.2
Healthcare access	31.4	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	100	20.8
Capacity to test and approve new medical countermeasures	75	42.2

www.ghsindex.org

5. Anglo Saxon Understanding of Welfare

US is a prototype of Liberal welfare state regime. Liberal welfare states are usually understood to largely depend on market provision and means-tested public social policy. There are both private and public insurers in the U.S. health care system. What is unique about the U.S. system in the world is the dominance of the private element over the public element. In the United States, the responsibility for these two functions is shared by private insurance companies as well as the government, both of which are known in policy terms as “payers.” As such, the United States can be thought of as a “multi-payer” system (Martin Seeleib-Kaiser, 2013).

The U.S. health care system is the subject of much polarizing debate. At one extreme are those who argue that Americans have the “best health care system in the world”, pointing to the freely available medical technology and state-of-the-art facilities that have become so highly symbolic of the system. At the other extreme are those who berate the American system as being fragmented and inefficient, pointing to the fact that America spends more on health care

than any other country in the world yet still suffers from massive unemployment, uneven quality, and administrative waste (Chau, 2012).³

United States of America with Anglo Saxon culture has different culture from the European countries and the rest of the world. USA cultural, political, and social background is different from the rest of the world. The role of state is always restricted by means of different paradigms and different dimensions.

Liberalism and individualism are important characteristics which have been highlighted. And attempted to keep state and its intervention as minimal as possible. Welfare state which has been an important ingredient of administrative system of European culture hasn't been crucial ingredient of USA administrative system. Autonomy and tendency for self-governing activities are distinctive features of USA administration and culture.

US people don't prefer state interference in any dimension even Obama care which wanted to improve and protect health care policies wasn't acceptable for Americans. And making every thing even obligatory insurance policies weren't acceptable for Americans. In brief, Anglo Saxon's understanding of welfare is different from European understanding of welfare system. Kaufmann classifies the United States as 'capitalism' with a highly fragmented welfare sector.

The Anglo-Saxon type of welfare state is based on direct taxes that are progressive or at least – as regards corporation tax – proportional, the tax scale with regard to income tax is comparatively flat. The Anglo-Saxon tax state is characterized by comparatively unequal distribution (Petring et al, 2012).

5.1. Liberal Democracies And Challenge of Covid 19 In USA

In USA, covid 19 outbreak was so fast that government and forces were summoned in order to take action in front of this pandemic.

The USA government ratified to provide a budget to prevent outbreak of Covid 19. US government is not a socialist government and government doesn't consider any interfering role for itself. Both democrats and republicans cooperated and compromised on ratification of budget for the people in order to implement quarantine all over the USA and keep people at home. The USA government would pay 1200 dollar for every adult and 500 dollar for every child in order. Federal reserve of US helps with companies in order not to get broken.

All fifty state governments in USA have been infected by covid 19. CDC, center for disease control and prevention, is a leading public health institute which is federally funded. Center for disease control and prevention, has a long distinguished history. Objectivity and accuracy of CDC which is a leading public institute in USA. CDC publishes regular information about infected diseases. This is a valid and trustworthy resource for evaluation of covid 19 crisis. No manipulation was done. There is no government interference in this institution. And does research on how to protect society. There is no fear of executive power to manipulate. Critical source of information for citizens in order federally funded but it is independent.

And it is claimed that USA system has transparent attitude in which all information was at hand for everyone. No one attempted to manipulate information in USA and valid information was provided in order to take more precise decisions in policy making process.

5.2. GLOBAL HEALTH SECURITY IN USA (2019)

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	73.8	26.4
Health capacity in clinics, hospitals and community care centers	60.4	24.4
Medical countermeasures and personnel deployment	66.7	21.2
Healthcare access	25.3	38.4
Communications with healthcare workers during a public health emergency	100	15.1
Infection control practices and availability of equipment	100	20.8
Capacity to test and approve new medical countermeasures	100	42.2

www.ghsindex.org

According to global health security, average score to access to health care is 38.4. US is below the average. US score is 25.3 which is under average score of 38.4.

6. Health System in Germany

Germany can be considered as a prototype of conservative (or alternatively Christian-Democratic or Bismarckian). The health system is effective at preventing amenable mortality, which is lower in Germany than the EU average – but considerably higher than in France or Spain. A comparatively strong separation between ambulatory and hospital care, as well as between primary and specialist care, has led to problems with continuity and coordination. These problems persist despite a high uptake of disease management programmes and other forms of integrated care.

The German health care model dates from 1883. The Law on workers' health care insurance introduced uniform compulsory health care insurance for workers up to a certain level of income. All those subject to compulsory insurance became members of the statutory health insurance scheme set up for their profession.

The current system of social health care insurance is decentralized and federal. It is characterised by the fact that various non-state (corporatist) institutions are in a strong position. For example, on the side of the service providers the doctors' and dentists' associations and on the purchasers' side the health insurance funds and their associations are the main actors in the health care insurance system. The German health insurance system is divided into statutory and private health insurance funds. Statutory health insurance (GKV) is financed predominantly from insurance contributions. Until 2005, contributions were collected from employers and employees on an equal basis. Germany led the world in the founding of state health and accident insurance – in 1883 and 1884 – compulsory unemployment insurance was introduced only in 1927. Until then, there had been only local insurance schemes organized by the trade unions and subsidized by municipalities (Petring et al, 2012).

The introduction of nationwide unemployment insurance in place of poor relief meant that the unemployed were no longer compelled to accept just any work. It was not in the interests of

German employers to have extensive unemployment insurance run by the trade unions and eventually they called for an unemployment insurance scheme run by the employers and the employees themselves. This was introduced in 1927. Administration of the new insurance scheme now devolved upon the state, the trade unions and the employers (Petring et al, 2012).

Germany, therefore, has basic state insurance, in which there is the obligatory income-related state pension insurance. In Germany provisions are based on these three pillars: (i) basic protection regardless of previous earnings, (ii) a compulsory income-related pension insurance and (iii) options for voluntary private provision. The arrangements and relative significance of the three pillars can be very different.

In brief, Access to health care in Germany is good, with very low numbers reporting unmet needs for medical care. However, the self-employed with low incomes may fall between the cracks of the Social Health Insurance system and migrants have access only to a restricted set of benefits.

6.1. Christian-Democratic or Bismarckian Welfare States

Germany and most European countries are classified as social or welfare states. Germans think of Bismarck as the founding father of their social insurance state. The origin of social policy under Chancellor Bismarck in the 19th century has left its mark till the present day (Leisering, 2020).

Various systems of health insurance share some very important Bismarckian traits: access to health protection based on work, financing based on social contributions paid by employee and employer, administration by para-public structures governed by social partners: the sickness funds. Primary education had already been made compulsory in Prussia (the largest German state before 1871) in 1825. During World War I the foundations were laid for modern industrial relations between trade unions and employers.

The German model is sometimes termed 'Bismarckian' after Chancellor Bismarck who established social insurance in the 1880s in Imperial Germany although the changes in welfare provisions in the century after Bismarck have gradually but substantially transformed the original blueprint.

Health policies as an important component of Bismarckian welfare systems for three main reasons. First, health insurance is historically at the core of these systems. In Germany, mandatory health insurance – created in 1883. Second, the various systems of health insurance share some very important Bismarckian traits: access to health protection based on work, financing based on social contributions paid by employee and employer, administration by para-public structures governed by social partners: the sickness funds.

The welfare state in Germany represents organized solidarity between the strong and the weak, the young and the old, the healthy and the sick, those who are working and the unemployed, the able-bodied and the handicapped. The basis of the welfare state is formed – and this will continue to be the case in the future – by state guaranteed social security and participation, the legally enforceable entitlement to social benefits and workers' rights where puts the emphasis on preventive health care (Petring et al, 2012).

6.2. Access To Health Care in Germany

National health systems are open to all those residing legally within a country, without any particular conditions, whereas health insurance systems were first intended for employees and their dependants. In Europe, they have been extended to cover everyone, via free personal insurance for the most deprived. In Germany over a long period, the richest had not been obliged to sign on within the compulsory system of health insurance and had been privately insured (10 percent in Germany). However, in 2007 reform (Germany) made health insurance compulsory for all. In all the health care systems of western Europe, the costs of the most expensive treatments, required for treatment of the most serious illnesses (cancer, cardiovascular diseases, AIDS, diabetes, etc.) and for long-term illnesses (degenerative disease), are extremely well covered (Patrick Hassenteufel & Bruno Palier, 2007).

Access to primary and ambulatory specialist care for people insured in the statutory health system is generally good in Germany. The proportion of people reporting an unmet medical need due to financial reasons, distance or waiting times is close to zero. However, especially in rural areas, perceived waiting times for an appointment with GPs or specialists, e.g. with pediatricians, are much longer. In addition, privately insured patients are financially more attractive for ambulatory care physicians than those with statutory health insurance (SHI), which leads to equity concerns related to longer waiting times.

In May 2019, the German parliament passed a law in order to increase service availability in the SHI system. The “Act to Strengthen Appointment Service Centers and Care Delivery” (Terminservice- und Versorgungsgesetz) bundles several measures that predominantly aim to improve accessibility of primary and outpatient care providers and to expand the benefit basket within the statutory health insurance system.

6.3. Policies of Germany In Combatting Covid 19

How Germany has have reacted differently toward this Covid 19 pandemy?, In today's world how nation states protect their citizens in front of these pandemics are important. And protection of people has become important issue for nation states to protect citizens.

Pandemic crisis brought in no uncertain terms how vital the welfare state is. Particularly in the crisis its power and importance were self-evident. It functioned as an automatic stabiliser, shored up domestic demand and helped to prevent poverty and safeguard jobs. This covid 19 pandemic becomes doubled every three days. But Germany attempts to break this chain. And gain time in order to refresh its medical care system. Germany increased the number of tests and protected citizens by suspension of daily activities. Germany has an effective attitude in combating with covid 19. Efficiency of health system was an important factor.

The German health care system has one of the most comprehensive benefit catalogues and one of the highest levels of supply quality. Furthermore, the services are associated with comparably low cost-sharing. As, furthermore, the per capita expenditure for health care in Germany is only in the upper middle range, the German health care system has a relatively high level of efficiency in a comparison of the costs with the available resources and the benefits provided.

In an international comparison, the German health service is seen as being efficient but expensive (OECD, 2011). Total expenditure on health amounted to 11.3% of GDP in 2011, which is 2 percentage points above the average of the OECD countries (9.3%). At the same

time, with per capita health expenditure of US\$ 4495 (in purchasing power parity), Germany ranks seventh among OECD countries (OECD, 2013). Expenditure on health in Germany rose by an average of 2.1% a year in real terms between 2000 and 2011. In comparison with all other OECD countries, this was a relatively low increase in this period when the factor of a comparatively.

	COUNTRY SCORE	AVERAGE SCORE*
HEALTH SYSTEM	48.2	26.4
Health capacity in clinics, hospitals and community care centers	77.1	24.4
Medical countermeasures and personnel deployment	66.7	21.2
Healthcare access	44.9	38.4
Communications with healthcare workers during a public health emergency	0	15.1
Infection control practices and availability of equipment	50	20.8
Capacity to test and approve new medical countermeasures	50	42.2

www.ghsindex.org

According to Global health Security index, Germany's access to health care is 44.9. Average score for Global health security is 38.4. Germany's access to health care is above that.

7. CONCLUSION

To sum up, welfare system, access to welfare system and policies of these three system are different. Each welfare system has its own benefits and disadvantages. All these systems have been formed during history in response to the needs of the target community. All these have their own distinctive features. But in answering to the question of which one has invested more on provision of access to health care and satisfy the rights of citizens is Germany.

According to GHS Index analysis no country is fully prepared for epidemics or pandemics. Collectively, international preparedness is weak. Among the 60 high-income countries, the average GHS Index score is 51.9. In addition, 116 high- and middle-income countries do not score above 50.

Average score for access to health care in is 38.4. Health care access in China is 31.4. which is under average score. US is below the average. US score is 25.3 which is under average score of 38.4. Germany's access to health care is 44.9. Average score for Global health security is 38.4. Germany's access to health care is above average score and above the score of US and China. To sum up, Germany and Bismarkian welfare have been more successful in provision of access to healthcare as a result satisfaction of human rights their citizens.

REFERENCES

- Anghie, Antony, (2004), "Imperialism, Sovereignty and the Making of International Law", S. J. Quinney School of Law, University of Utah, *Cambridge University Press*, 1-381.
- Cui W., (2008), "China's village doctors take great strides", *Bull World Health Org* ; 86: 914-15.

- Jean-François & Akandji-Kombe, (January 2007), “Positive Obligations Under The European Convention On Human Rights”, Human Rights Handbooks, Directorate General Of Human Rights Council of Europe Strasbourg Cedex, Printed in Belgium, 1-72.
- Kao-Ping Chua, (2006), “Overview Of The U.S. Health Care System”, Amsa Jack Rutledge Fellow, February 10,1-6.
- Lutz, Leisering, (2000), “The Welfare State In Postwar Germany – Institutions, Politics And Social Change, [Shortened Version Forthcoming As “Germany – Reform From Within”. In: Pete Alcock Und Gary Craig (Eds.), International Social Policy: Welfare Regimes In The Developed World, London: Palgrave, 1-41.
- Martin Gulliford, Myfanwy Morgan, David Hughes, Roger Beech, Jose Figeroa-Munoz, Barry Gibson, Meryl Hudson, Chitra Arumugam, Patricia Connell, Abdu Mohiddin, James Sedgwick, (26 February 2001), Report of a Scoping Exercise for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO), 1-143.
- Martin Seeleib-Kaiser,(2013),“Welfare Systems in Europe and the USA: Conservative Germany Converging towards the US Model?”, Barnett Papers In Social Research, University Of Oxford Barnett House, Working Paper 13-06, 1-25.
- Mok, Bong-ho and Liu, Jitong, (1999), "In the Service of Market Socialism: The Quest for a Welfare Model in China", The Journal of Sociology & Social Welfare: Vol. 26 : Iss. 3 , Article 9, 1-15.
- OECD, (2011), OECD Health At a Glance 2011: OECD Indicators. Paris, Organization For Economic Co-operation And Development.
- OECD (2013b), Health At a Glance 2013: OECD Indicators. Paris, Organization For Economic Co-Operation and Development, <http://www.oecd.org/els/health-systems/health-at-a-glance-2013.pdf>, accessed 17 may 2014).
- Patrick Hassenteufel & Bruno Palier, (December 2007), “Towards Neo-Bismarckian Health Care States? Comparing Health Insurance Reforms In Bismarckian Welfare Systems,Social Policy & Administration”, Journal Compilation © Blackwell Publishing Ltd, Vol.41, No.6, 574-596.□□□□□
- Petring, Alexander, (2012), “Welfare State And Social Democracy, Social Democracy Reader”, Friedrich-Ebert-Stiftung German Edition: Political Academy, Bonn,1-160.
- Reinhard Busse & Miriam Blümel, Health Systems in Transition, European Observatory on Health Systems and Policies and Department of Health Care Management, Berlin University of Technology , Department of Health Care Management, Berlin University of Technology, 311.
- Sabine Klotz, Heiner Bielefeldt, Martina Schmidhuber, Andreas Frewer (Eds.), (2017), “Healthcare As a Human Rights Issue, Healthcare As a Human Rights Issue Normative Profile”, Conflicts And Implementation,Volume 4, The Deutsche National Bibliothek, 1-427.
- Xi Li, Jiapeng Lu, Shuang Hu, KK Cheng, Jan De Maeseneer, Qingyue Meng, Elias Mossialos, Dong Roman Xu, Winnie Yip, Hongzhao Zhang, Harlan M Krumholz†, Lixin Jiang†,

Shengshou Hu, (2017), The primary health-care system in China, Lancet 2017; 390: 2584–94.

Yang G, Wang Y, Zeng Y, et al. (2013), “Rapid health transition in China”, 1990–2010: findings from the Global Burden of Disease Study 2010; 381: 1987–2015.