

Bismarck vs. Beveridge: is there increasing convergence between health financing systems?

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Outline

- Health financing models and myths
- Public finance and health finance: some important policy interactions for sustaining good performance
- Summary messages



History, models and myths in health financing



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Roots of government-mandated health insurance

- Bismarck and "Social Health Insurance" (1883)
 - Compulsory funding by employers and employees, administered by pre-existing "sickness funds"
 - Similar laws in Japan (1922) and elsewhere in Europe
- A "right" associated with labor status
 - Keep workers healthy to improve productivity
 - Pre-empt labor unrest
- Was not aimed at "universal coverage"

Post-WWII: towards Universal Coverage

- Beveridge: the National Health Service (1948)
 - Funded from general government revenues, coverage for entire population
 - Funding base similar to that of USSR system, but providers much more independent
- More generally in high income countries (and then globally), a shift from health coverage as a right of labor, to "health as a human right" or health coverage as a constitutional or legal right
 - Concern with universality, social cohesion/solidarity



Stylized models

Feature	Bismarck	Beveridge
Entitlement basis	Contribution	Citizenship/ residence
Funding base	Wages	All public revenues
"Insurer"	Occupational	State
Benefit package	Explicit	Implicit
Management	Independent	Government
Providers	Privately contracted	Salaried and publicly contracted

Independent or "government"??

- "Compulsory contributions" of employers and employees (i.e. payroll taxes), are considered part of "fiscal space"
- SHI funds are treated as public entities
 - Estonian Health Insurance Fund was initially restricted by MOF from using its accumulated reserves because this would have made the fiscal deficit appear larger at a time when the country was trying to enter € zone (was allowed later in that year and the next, enabling the Fund to benefit from its prudent management over time)



Freeing from historical constraints...

- Similarities in different models
 - Purchaser-provider split in the UK and Germany, each using innovative methods to change the incentive environment
- Differences within the same model
 - Single SHI insurer in Estonia, France, Hungary, Korea...
 - Multiple competing SHI insurers in Germany, and also (including some commercial for-profit) in Czech Republic, Germany, Netherlands, Slovak Republic...
 - Multiple non-competing SHI insurers in Japan



Health financing design questions to be addressed in different types of systems

Bismarck/SHI

- What are the sources of funds, and how are they collected?
- How are funds pooled on behalf of the population?
- How are providers paid?
- How do funds flow through the system, and what are the associated institutional arrangements?
- What are the entitlements and obligations of the people?
- What is the basis for entitlement?

Beveridge/NHS

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So today's reality is more like this

Feature	Bismarck	Beveridge
Entitlement basis	Contribution	Citizenship/ residence
Funding base	Varies	Varies
"Insurer"	Varies	Varies
Benefit package	Varies	Varies
Management	Varies	Varies
Providers	Varies	Varies

As per the new System of Health Accounts (OECD, WHO, Eurostat), the only difference between the "models" has to do with the nature of entitlement. We observe variation along all the other dimensions.

Implications of shift from health as a labor right to a right of citizenship

- Since not everyone is employed in large firms, and contributions for some may not be affordable, the move to Universal Coverage in "SHI countries" required subsidies from general revenues
 - Countries do this to varying degrees
 - If not, they leave part of their population without entitlements (e.g. Estonia)
 - Growing recognition that "everyone contributes" in the sense that virtually everyone is paying VAT

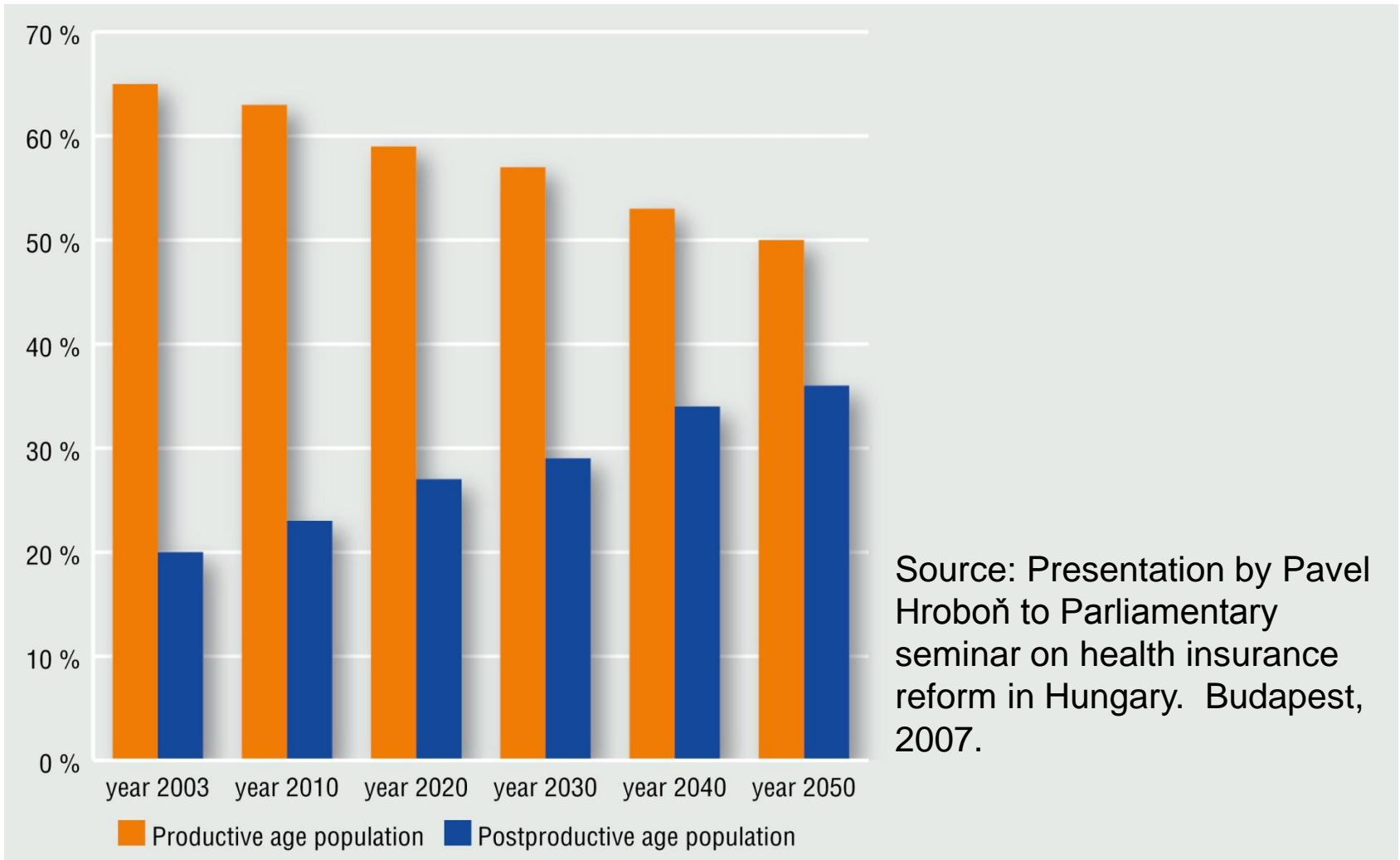


More challenges for "pure Bismarck" model

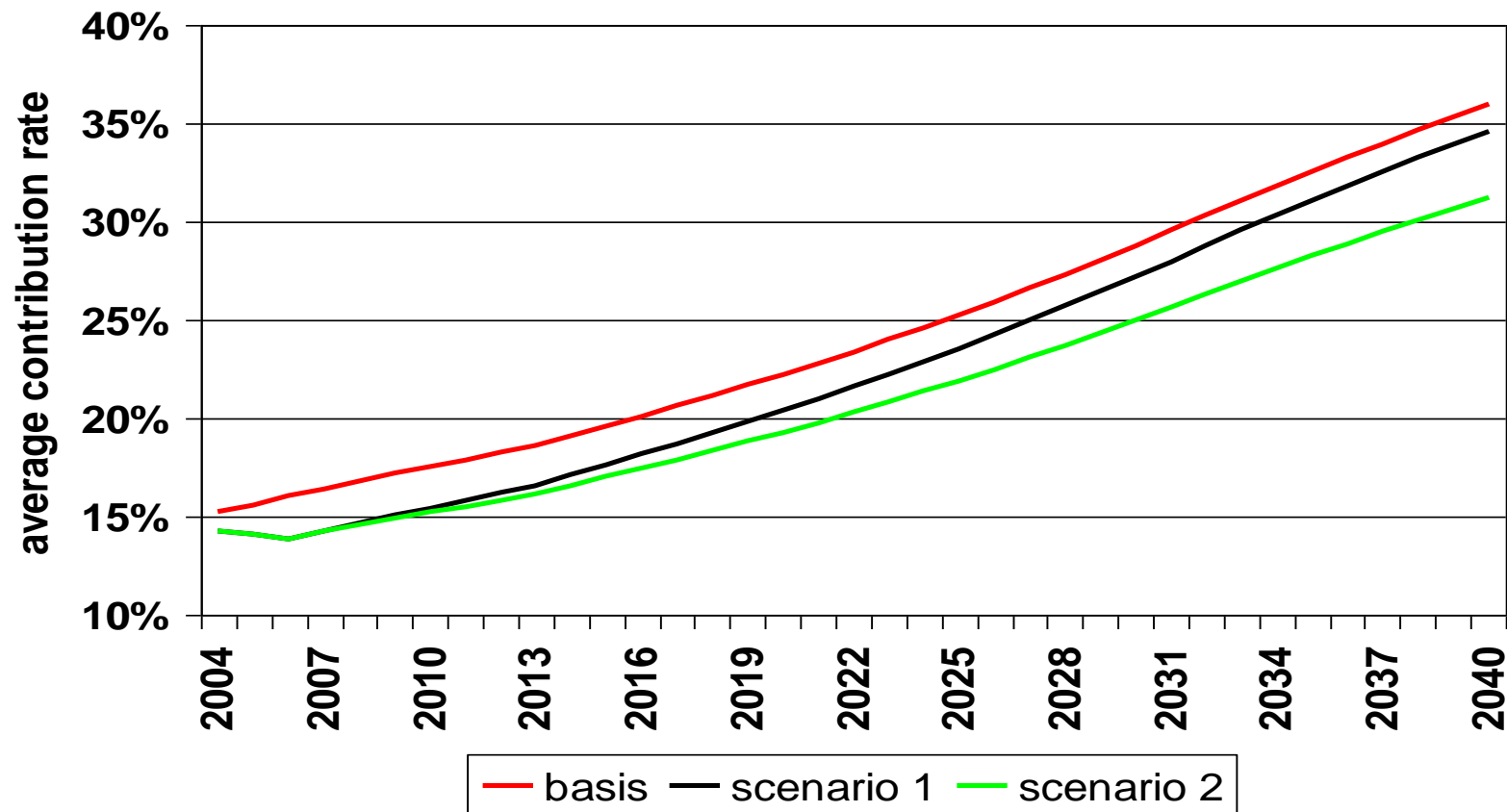
- Demographic change/aging
 - Smaller share of total population will be “economically active”
- Competitiveness and employment concerns
 - International competition to attract firms and maintain/increase employment will put downward pressure on labor taxes
- How to sustain Universal Coverage in this context?



Expected demographic change in the Czech Republic



Can payroll contributions continue to account for at least 90% of Germany's SHI revenue? What options to avoid harmful impact on labor market and competitiveness?



Source: Dirk Sauerland, WHL Graduate School of Business and Economics, presentation to 6th European Conference on Health Economics, 6-9 July 2006, Budapest

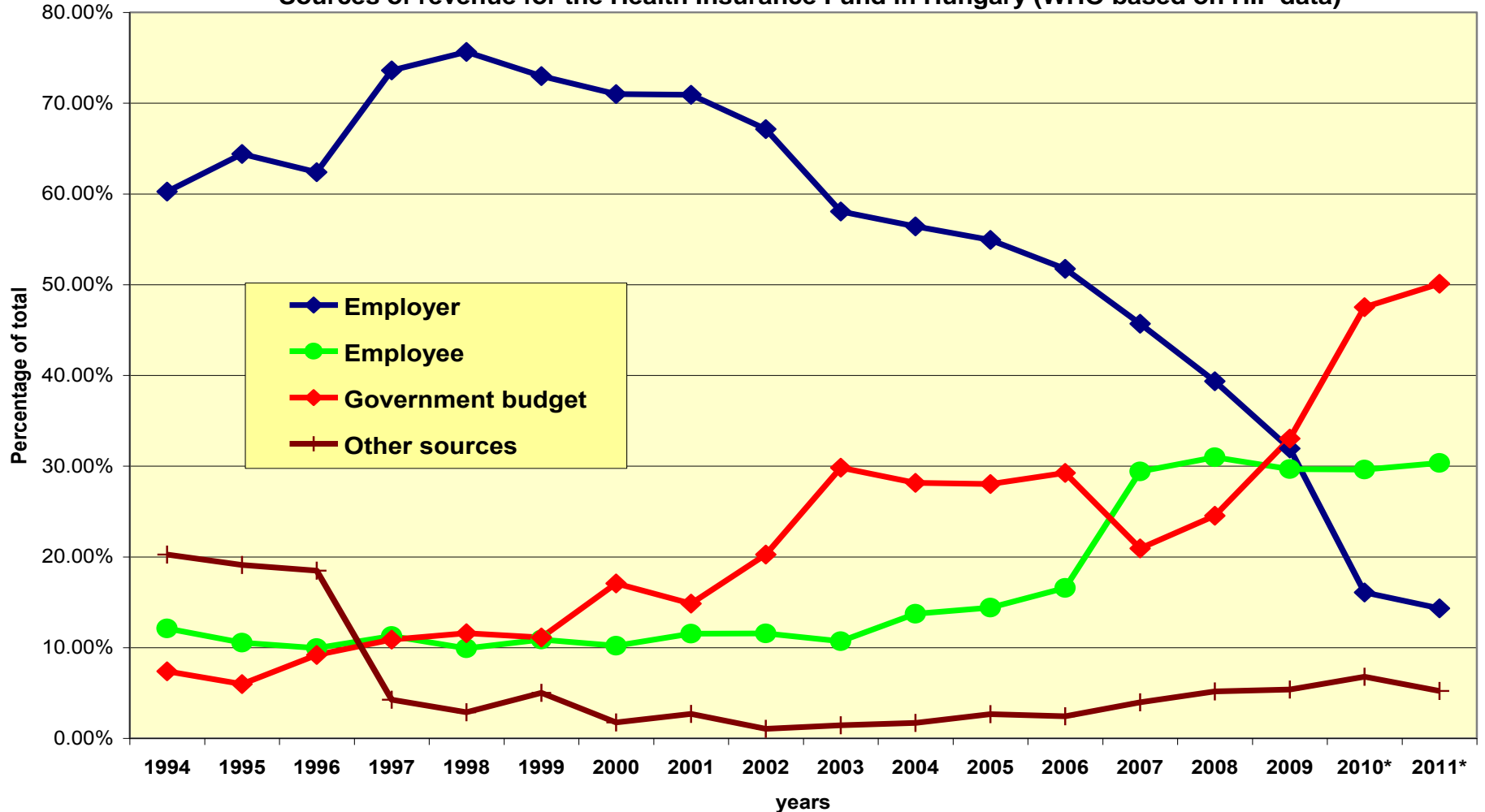
Germany's response

- 2007 law increased budget transfers to the insurance funds
- After crisis in 2009, Government injected general revenues into health insurance system in order to reduce payroll tax rate by 1% due to concerns about unemployment (later reversed)
- This was just an adjustment of sources, but did not imply any fundamental change in the German health financing system



Hungary also changed its funding sources in response to the crisis

Sources of revenue for the Health Insurance Fund in Hungary (WHO based on HIF data)



Source: Szabolcs Szigeti, WHO based on HIF data

Towards the Bev-marck or Bis-eridge model?

- Convergence on sources
 - Growing, explicit role for general revenues in SHI
 - Some de-linkage of coverage from the labor market
- Irrespective of the source of funds, we observe variations and innovations across "models" in organization of pooling, mechanisms for purchasing of services, and ways that the entitlements and obligations of the population
- So labelling a system as Beveridge or Bismarck is not especially useful. But what are some important questions and issues of concern?

Health finance and public finance: some important issues for sustaining performance



1. Crisis and the need for counter-cyclic fiscal policies for health expenditure

- Need for health care during the crisis increases, but public revenues decline
- If public spending on health falls, burden shifted to patients, who may either forego needed care or run greater risk of incurring potentially catastrophic spending
- Major cuts in public expenditure may result in disruption of continuity of care and deterioration of quality of care
- **Bad combination: Utilization and quality of services and can decline despite increased needs**

Where policies protected people against the costs of seeking care, the reduction of utilization was lower

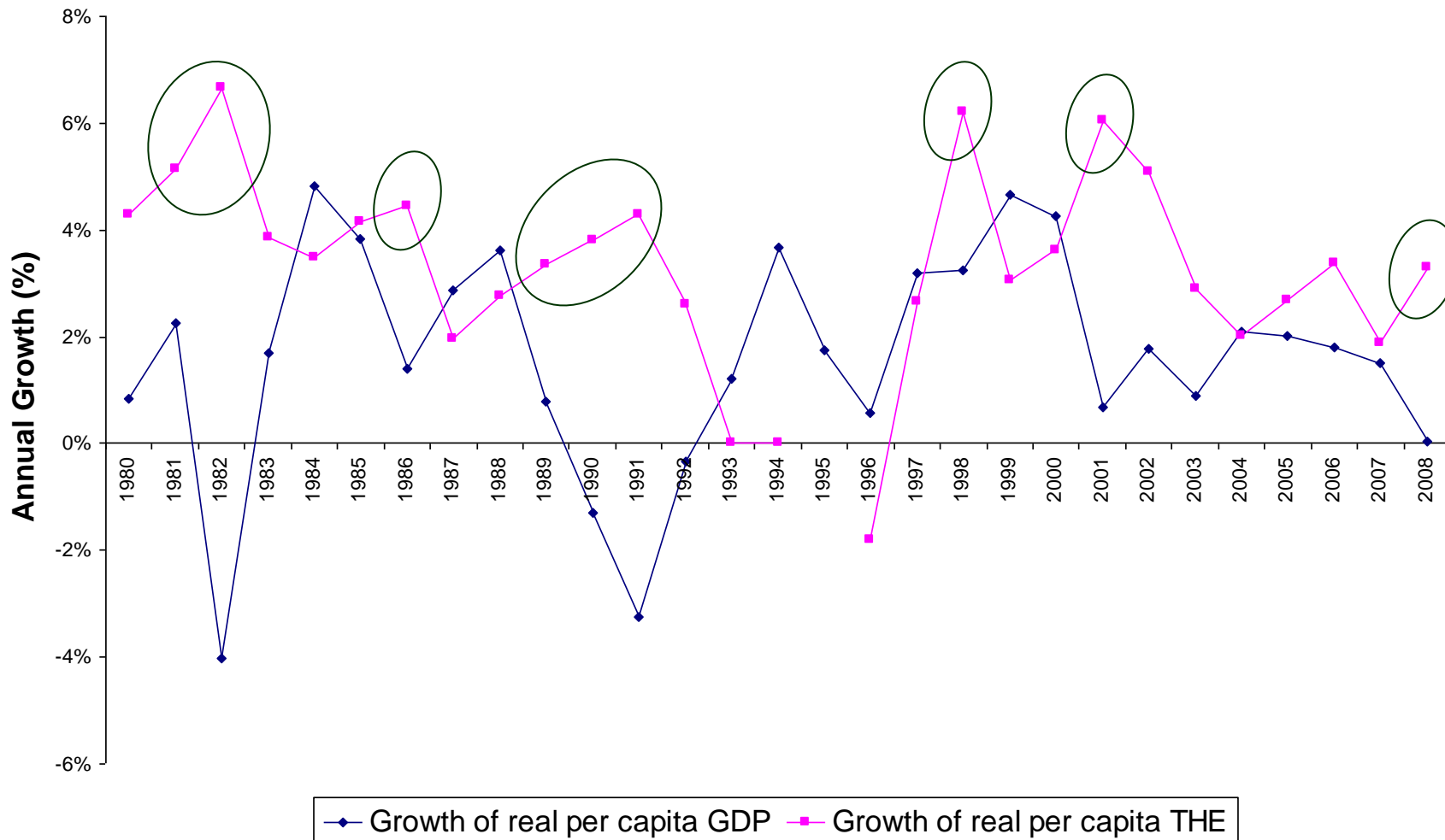
Changes in Utilization of Routine Health Care Since the Crisis					
Country	Reduce	Same	Increase	Net Change (Reduce - Increase)	N
United States	26.5	66.5	7.0	19.5	1901
France	12.0	82.7	5.4	6.6	868
Germany	10.3	83.0	6.7	3.6	879
Canada	5.3	89.3	5.4	0.0	1032
Great Britain	7.6	84.4	7.9	-0.3	757
5 Country Avg	15.2	78.3	6.6	5.9	5437

“Reductions in routine care today might lead to undetected illness tomorrow and reduced individual health and well-being in the more distant future.”

Source: Lusardi et al. The economic crisis and medical care usage 2010. Harvard Business School



Counter-cyclical health financing policy in Canada: An example to follow



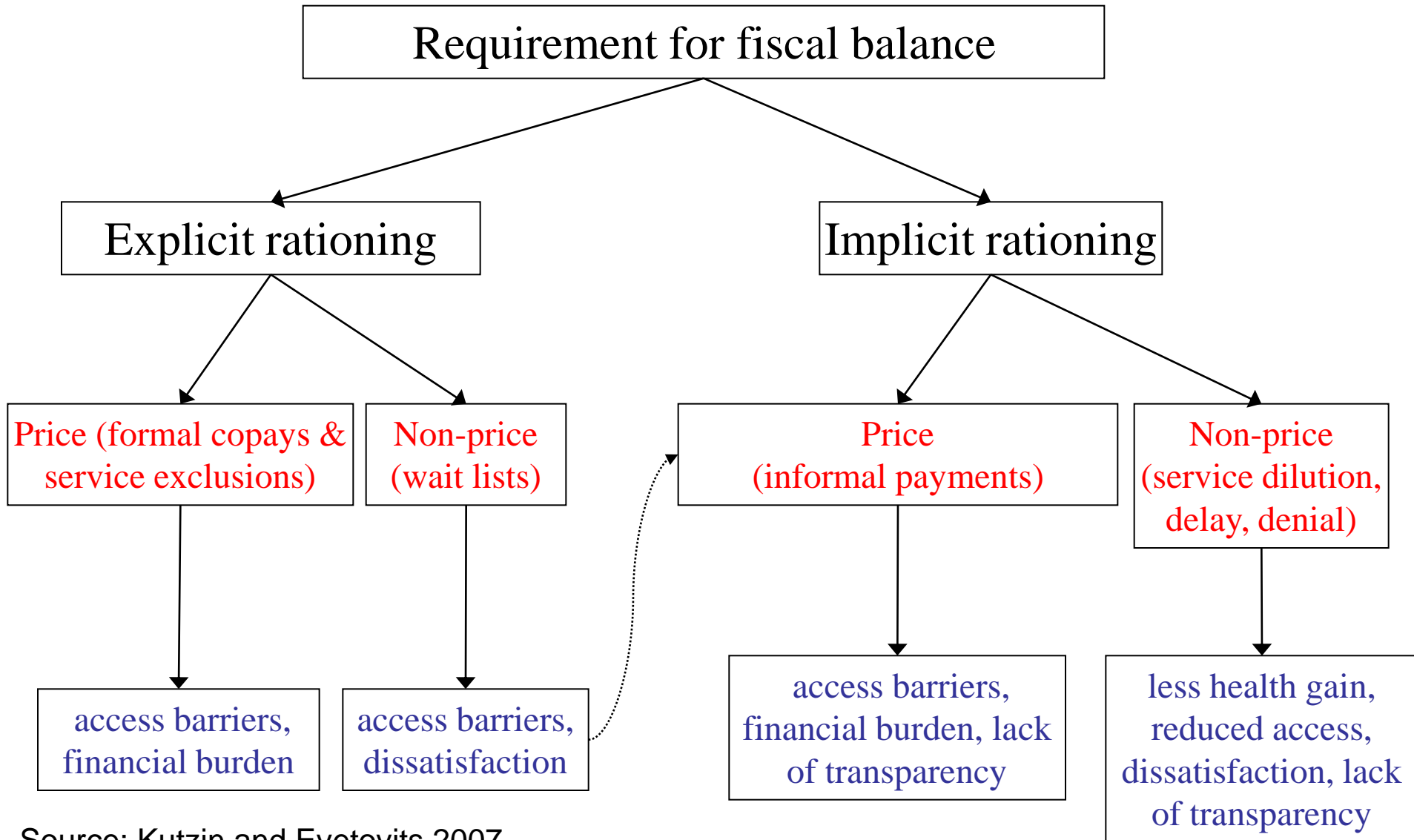
Counter-cyclical health expenditure strategies requires sound fiscal policies

- Fiscal policy in countries with high public debt and high government deficits tends to be pro-cyclical, while countries that have low public debt and that have surpluses are more likely to conduct a counter-cyclical fiscal policy.

Source: Prof. Angelmar, INSEAD based on B. Egert, Fiscal Policy Reaction to the Cycle in the OECD: Pro- or Counter-cyclical? OECD Economics Department Working Papers, No. 763, May 2010

- A possible Bev-Bis difference in modality, but not in aim:
 - Sound policy on reserve accumulation in SHI funds (like Estonia)
 - Sufficiently sound long run fiscal policy to enable counter-cyclical health (and perhaps other social welfare) spending (like Canada)

2. How to deal with the “sustainability tradeoffs” in face of fiscal pressures



Improving efficiency (more health for the money) is essential to lessen severity of the tradeoffs



- eliminate ineffective and inappropriate services
- improve rational drug use (including volume control)
- allocate more to primary care and outpatient specialist care at the expense of hospitals
- invest in infrastructure that is less costly to run
- cut the volume of least cost-effective services
- Reduce unproductive administrative costs

Main health financing tool for this is strategic purchasing (pay for performance)

- Linking the allocation of resources to providers to measures of their performance and health needs of the population being served
- Changing the incentive environment through tailored use of markets and planning
- Strategic purchasing is happening in OECD countries (and elsewhere), irrespective of the label attached to the system



What can finance authorities do to facilitate better health purchasing?

- Most of all, the purchaser needs a stable, predictable flow of funds to have a basis for contracting with providers
 - Often thought of as an advantage of SHI, but dedicated revenues are more important than dedicated taxes
 - Balance the inherently political nature of the public choice of how much to allocate to health (and other sectors) with the needs of the purchaser for stability and predictability



Summary messages



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Beveridge vs Bismarck

- Historically interesting, but no longer conceptually relevant
 - Sources are not systems
- The shift from a right of labor to universal coverage marked the end of the "pure" Bismarckian era
 - Coverage of non-contributors
 - General revenue transfers
- Economic/demographic pressures will continue
 - De-link coverage from employment, broaden base to all income

Towards Bev-marck: implications of convergence

- More choices/options available for mixing different revenue sources
- Irrespective of the source of public funds, pay greater attention to use of purchasing instruments to promote provider efficiency
 - Effective purchasing required stability/predictability in the flow of public revenues as a basis for establishing contracts with providers



Is there an optimal model?

- A largely irrelevant question, given that the answer is context-dependent
- Each country has a different starting point and context, so the right "next steps" to improve efficiency and sustain performance will differ
- Regardless of model, sound fiscal policy is essential for enabling potential for counter-cyclical spending (to be better prepared for the next crisis)



Thank you



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