



Sietse Wieringa, MD  
sietse.wieringa@nhs.net

## 29 – Do you Understand how Your Health System Works? From Beveridge to Bismarck; a Whistle-stop Tour of European Health Systems

*Sietse Wieringa, GP, MSc*  
*Co-authors*  
*Luisa Pettigrew, MB ChB, MRCGP, MSc*  
*Stephanie Kumpunen, MSc*  
*Greg Irving, BMedSci, BMBS, MSc, MPH, MRCGP*

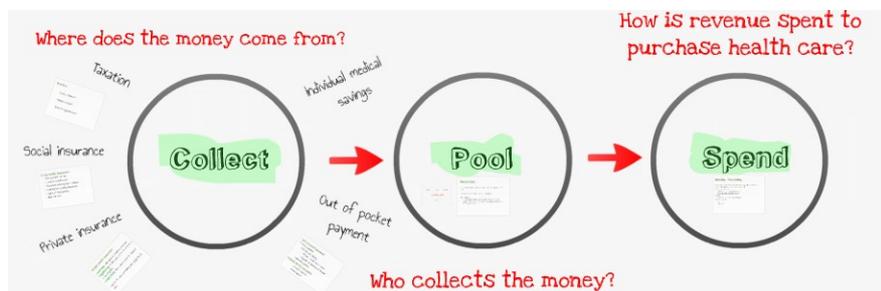
As family doctors we should be thinking about how our healthcare system works and how we can shape it. We share responsibility for the distribution of limited resources not only as healthcare professionals, but also as patients and taxpaying citizens. But how much do we know about how the system works, and in particular how it is financed?

### Healthcare Systems' Goals

In order to understand a healthcare system the first requirement is to think about its policy goals. The 'final' goals ultimately are; to improve the health of the population; to be responsive to the needs of healthcare service users and citizens; and to ensure protection among citizens from the burden of financial hardship due to healthcare payments.

There are also 'instrumental' goals; to be transparent and accountable; to deliver high quality healthcare services; to be efficient; and to ensure equity across the healthcare system. Equity exists in several forms, such as equity in access or use of the service, equity in coverage of the type of services provided to the local population, and equity in how financial risk is redistributed.

With the final and instrumental goals of a health system in mind, there are three key questions that help to determine the financing structure of a health system; (1) Where does the money come from? (2) Who collects the money? (3) How is the money spent?



### Where Does the Money Come From?

There are several ways to collect funds for healthcare. Options include taxation, compulsory social health insurance, voluntary private health insurance, individual medical savings accounts or out-of-pocket payments. In the case of lower income countries, funding can also come from international donations.

The archetypal European models to collect funds for healthcare are the tax model, named after the English economist William Beveridge (1879-1963), and the social health insurance model more commonly known as the Bismarck model, named after German Chancellor Otto von Bismarck (1815-1898). In 1942 Beveridge laid the foundations of the National Health Service (NHS) in the United Kingdom in which free healthcare at the point of delivery was paid through taxation collected by the government. Bismarck passed the sickness insurance law in 1883 in an effort to improve economic growth through employees' well-being in Germany. In his model employers contributed one-third and workers two-thirds into locally managed funds that paid for medical treatment and sick pay.



In general terms, taxation and social health insurance are considered the most 'progressive' methods of paying for healthcare, in other words, they enable the most equitable forms of collecting and pooling funds. On the other hand out of pocket payments are 'regressive' or the least equitable, hitting the sickest and poorest the hardest. Every method has of course its own variants, advantages and disadvantages, as well as its ethical, moral and ideological arguments. Thinking about taxes, for example, differences can arise in whether taxes are collected directly (e.g. income tax) or indirectly (e.g. tobacco tax) or whether those who earn more should contribute a higher proportion of their earnings.

### **Who Collects and Redistributes the Money?**

The second question points to how the money is pooled and (re-)distributed. Fund pooling is the accumulation of prepaid healthcare revenues on behalf of a population and facilitates the pooling of financial risk across the population. Collection agents can either be public or private, for profit or not-for-profit. The size of pools can vary (e.g. national versus regional). If multiple pools are available a risk-adjusted re-distribution of funds according to the risk profile of the population (e.g. age, sex, etc.) covered by each pool is preferable. This, in addition to regulation, is important to prevent cherry picking of patients in competitive health insurance systems, as well as to reduce the risk of healthcare funding bodies becoming insolvent.

### **How Is the Money Spent?**

The third question explores how money is used to purchase healthcare. The range or package of services can be agreed upon in several ways, for instance by decree in the Netherlands or by negotiation in Germany. A single organisation can undertake both the purchasing and provision functions, or these may be divided up between different organisations. In the English NHS in the 1990s for example, a purchaser-provider 'split' was introduced to encourage provider competition in healthcare markets.



How healthcare professionals are paid can vary and this can affect the healthcare system's ability to contain costs and deliver high quality care. Thinking specifically about primary care, for example, family doctors can be salaried, paid through fee-for-service or by capitation – or a blend of all three payment methods. In the most basic sense, salary and capitation payments are often less costly than fee-for-service and in particular in the case of capitation may promote preventive work. However they can lead to doctors over-delegating and under-providing services. Meanwhile fee-for-service places the financial risk on the payer and may potentially increase 'unnecessary' activities.

Performance-based pay is also often used, which involves paying doctors or groups of doctors for achieving targets on quality indicators. This may lead to improved attention to quality domains, but can also lead to surrogate end points, neglect of non-quality indicators and may disturb the doctor-patient relationship. There are, of course, more incentives than just money. Providers can be incentivised by professional development, clinical guidelines, utilisation reviews, targets, public disclosure, ethics and of course an intrinsic desire to do good! Payments can modify behaviour, but mechanisms to create more incentives generally have greater administrative costs. Their merits depend on the context in which they are made.

### ***Take Home Messages – Finding the Right 'Blend'***

- Archetypal models and methods generally ignore the complexity of healthcare system financing and conceal similarities and differences. It is unlikely to find a system that, for example, uses tax contributions solely to fund healthcare and reimburses providers using solely capitation-based payments. Most systems in Europe now blend methods to collect, pool and spend healthcare funds.
- In order to achieve the policy goals of any healthcare system blended methods of financing are needed to balance the drawbacks of purist methodologies and to align incentives. The input of family doctors as advocates for their patients and as front-line health professionals is important to help find the right blend in each context to meet the desired goals of their healthcare system.

### ***Original Abstract***

[www.woncaeurope.org/content/ws07-do-you-understand-how-your-health-system-works-beveridge-bismarck-whistle-stop-tour-2](http://www.woncaeurope.org/content/ws07-do-you-understand-how-your-health-system-works-beveridge-bismarck-whistle-stop-tour-2)

### ***WONCA Europe Vienna 2012***



In a packed room during the 2012 WONCA Europe conference in Vienna, this workshop set out to provide participants with a framework to compare their own healthcare systems. It was picked up in a column by RCGP chair at the time, Prof Claire Gerada (1), reported in a blog for the London School of Economics and Political Science (2), and the full presentation (available on Prezi) has over 3000 views (3).

### ***References***

1. [http://email.rcgp.org.uk/rp/440/process.clsp?EmailId=139125&Token=29A76D1D621057493A98ECFE1394744DC&utm\\_campaign=RCGP\\_Update\\_|\\_4\\_November\\_2011&utm\\_medium=Email&utm\\_source=CM\\_RCGP](http://email.rcgp.org.uk/rp/440/process.clsp?EmailId=139125&Token=29A76D1D621057493A98ECFE1394744DC&utm_campaign=RCGP_Update_|_4_November_2011&utm_medium=Email&utm_source=CM_RCGP)
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