EDITORIAL

Health System Financing
Social Health Insurance vs Tax-Financed Health Systems

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Not Only Is A Healthy Society Possible; It Is Inevitable

All people are entitled to quality essential health services, without suffering financial hardship to pay for health expenses. This simple but powerful belief undergirds the growing movement towards universal health coverage (UHC), now a global commitment under the Sustainable Development Goals (SDGs).

The 17 Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly (UNGA) consists of targets that primarily focus health.[1] Target 3.8 of SDG 3 - achieving universal health coverage (UHC), including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all – is the key to attaining the entire goal as well as the health-related targets of other SDGs.[2]

Strong, financially sustainable health systems create healthy citizens, who can then get the education and skills they need to thrive in a dynamic global economy. Health does indeed produce wealth (Figure 1).[3]

Figure 1: Health in SDG ERA[3]

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HEALTH SYSTEM FINANCING SPECTRUM

Traditionally, health care systems have been compared in terms of tax-financed Beveridge-type and contribution-financed Bismarck-type alternatives. The world is in the midst of a debate about the relative merits of social health insurance and tax-financed health systems. Most systems are hybrid of the two types and most have unique caveats embedded within.[4]

A ***tax-financed Beveridge-type,***[5] named after William Beveridge (1879-1963)[6] an economist and social reformer in the UK, detailed five "giant evils" in need of being addressed: want, disease, ignorance, squalor, and idleness. This model is funded by means of general taxation. Responsibility for the budget is in the hands of and under strong influence of the government. The organisation is often part of a pyramid shaped hierarchical bureaucracy with primary health care at the bottom and tertiary care teaching hospitals at the top and are geopolitically organised. Access to specialized care is dependent on a referral from a primary health care: the so-called gate-keeping system.[7]

A ***contribution-financed Bismarck-type,***[5] named in honour of Prussian Chancellor Otto von Bismarck, is funded by earmarked premiums, mainly from salaried population. The system is more loosely organised, with less state influence and more pluralistic, with a strong influence of health care providers and (social) insurers. There is often parallel access to primary and specialised care and no strict geographic distribution. Care is provided by profit/non-profit hospitals and individual practitioners.[8]

A ***National Health Insurance*** (NHI) system is a form of the Bismarck model and should be seen as a sub-category or variant of that group. While both NHI and Bismarck models are insurance-based, the main difference is that NHI models are single payer systems, as opposed to having multiple payers (insurance funds) like the pure Bismarck models.[5]

Most classifications of health systems do not discuss ***Out-of-Pocket (OOP)*** models as a separate category. However, since the majority of countries in the world are too poor and the governments too weak to institute a public health system of any kind, and as a result have OOP systems.[5] The comparison of different healthcare models are described in figure 2.[9]

No one system is entirely capable of delivering a comprehensive health coverage and most of the countries build their own models combining different aspects of each. Strictly speaking the Social Health Insurance and National Health Insurance frameworks do edge out the others in merits and demerits.[5]

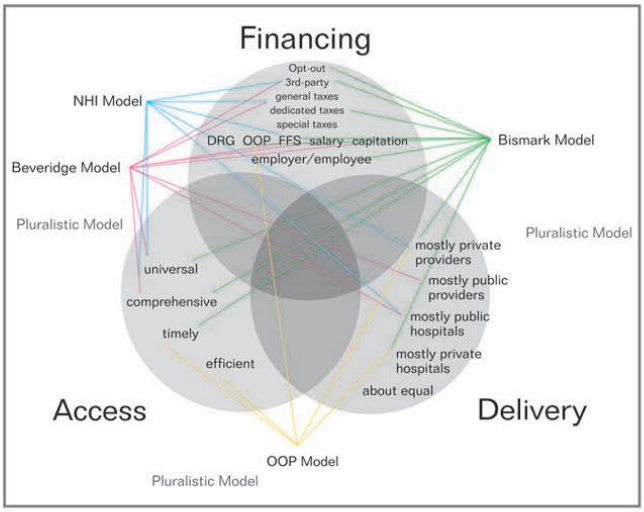

Figure 2: Comparison of Healthcare Models[9]

MERITS - DEMERITS

Contribution-Financed Bismarck-Type Financing Model

Healthcare insurance presents uncountable benefits. Numerous studies in developing and under developed countries have proven its potential. Health insurance reduces catastrophic health expenditures and out of pocket payments, it increases utilization of health services, and it improves health and well-being.[10]

It's a technically feasible and financially viable system providing equitable healthcare, stable financing, choice of services, and strong support of the population leading to infrastructure development. Health insurance has a way of mobilizing additional domestic resources for health, allowing organizational change for improved health system quality and efficiency which is easier to introduce through purchaser-provider splits and/or new provider payment mechanisms. It also extends financial risk protection to more people, or provide greater levels of protection to those already with coverage by replacing out-of-pocket spending with some form of prepayment and facilitates switching from private health insurance to social insurance. This additional financial protection is seen as a way of allowing more people to use needed services without incurring high out-of-pocket payments, effectively moving closer to universal coverage.[10]

Tax-Financed Beveridge-Type Financing Model

The establishment and performance of Tax-Based Systems depends on what politics makes possible in a particular country. Political instability and sensitivity to political pressures leads to irrational and inefficient decisions. People's expectations of the health service are unrealistic and underfunding due to small tax base and weaker institutional power effects the healthcare outcomes adversely.[11]

Tax-based systems are popularly known as "a poor system for poor people". Quality of care and efficiency is challenged with potential inefficiency in health care delivery. This primarily results from aging infrastructure, unresponsive staff, inability to downsize or reorient priorities, abuse of monopoly power, obsolete medical technology compared with the private sector, and waiting lists for nonemergency treatments. There's also varied access to medical care / health facilities because of geographical disparity.[12] Figure 3 showed the single-payer tornado as the single-payer healthcare which would force patients to wait for care, destroy million of jobs, hike taxes, ration prescription drugs and restrict research and development.[13]

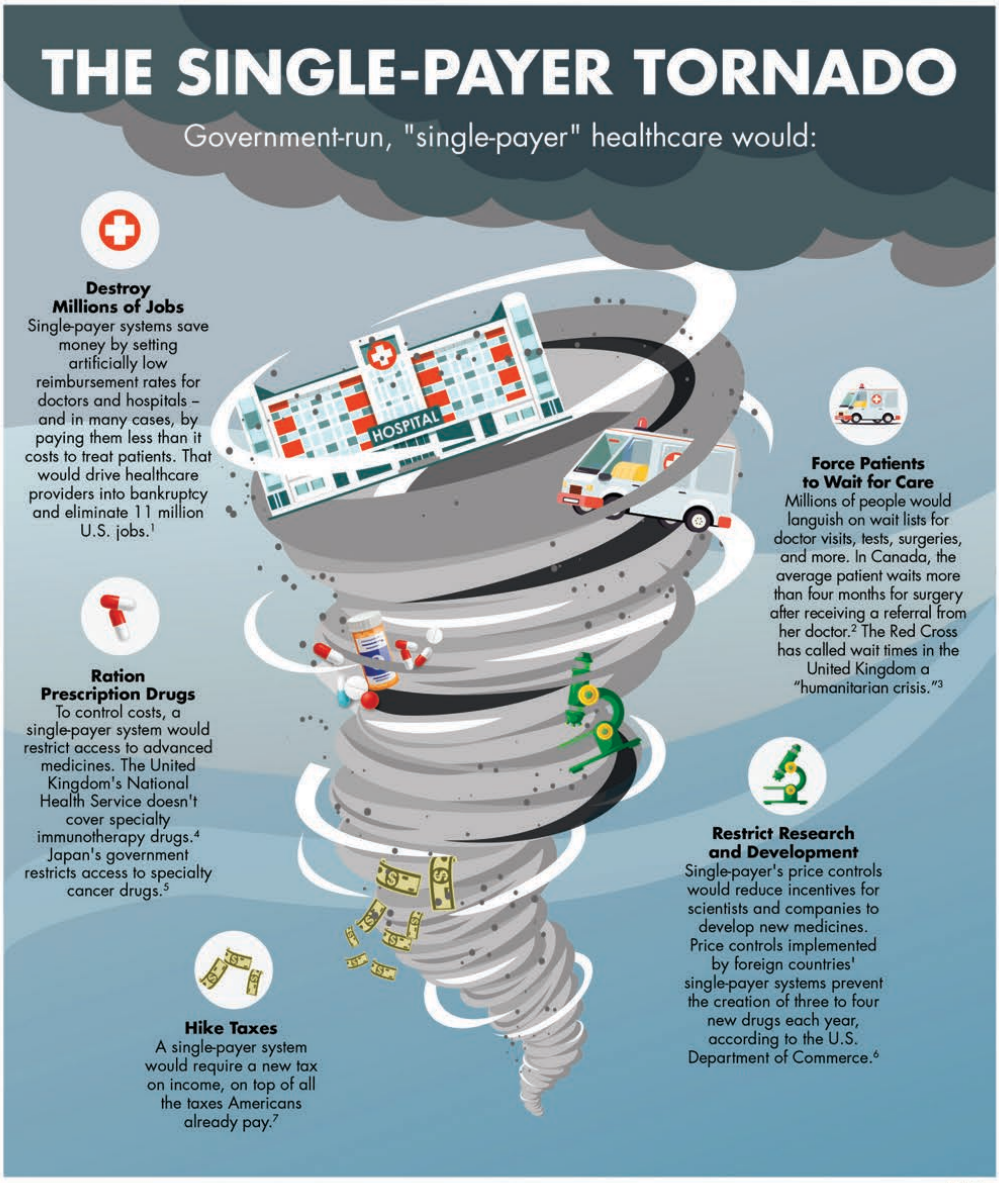

Figure 3: The Single Payer Tornado[13]

BISMARCK OR BEVERIDGE: A BEAUTY CONTEST BETWEEN DINOSAURS

Towards the Bev-Marck or Bis-Eridge Model?

The debate on 'which system is best', depending on health outcome indicators (*overall mortality rate, infant mortality rate & life expectancy*), healthcare expenditure indicators (*Health expenditure per capita, Health care expenditure as percentage of GDP)* and satisfaction with the healthcare system is challenging and widely points towards a hybrid system tailor made for a population. There are major differences for higher-income and middle or lower-income countries for an ideal setup to achieve universality.[14]

BISMARCK BEATS BEVERIDGE!

Bismarck systems dominate the top of EHCI ranking as reported in Euro Health Consumer Index 2016 (Figure 4).[15]

Beveridge systems offer conflicts between loyalty to citizens and loyalty to healthcare system/organisation. There's lack of business acumen in Beveridge systems; efficiency gains and cutbacks are mostly not differentiated.

Moreover, "Bismarck" systems do better than centrally planned "Beveridge" systems. Multiple professionals at multiple levels take better decisions and drive development better than central bodies where incentives driving quality and productivity are essential.[15]

EuroHealth Consumer Index 2016

Sub-discipline	Indicator	Albania	Austria	Belgium	Bulgaria	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	FYR Macedonia	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Lithuania	Luxembourg
1. Patient rights and information	1.1 Healthcare law based on Patients' Rights																					
	1.2 Patient organisations involved in decision making																					
	1.3 No-fault malpractice insurance																					
	1.4 Right to second opinion																					
	1.5 Access to own medical record																					
	1.6 Registry of *bona fide* doctors																					
	1.7 Web or 24/7 telephone HC info with interactivity																					
	1.8 Cross-border care seeking financed from home	n.ap.										n.a.	n.ap.							n.a.	n.a.	
	1.9 Provider catalogue with quality ranking																n.ap.					
	1.10 EPR penetration																					
	1.11 Patients' access to on-line booking of appointments?																					
	1.12 e-prescriptions																					
	Subdiscipline weighted score	73	108	104	66	108	73	87	111	108	108	90	118	104	63	73	115	80	83	87	97	101
2. Accessibility (waiting times for treatment)	2.1 Family doctor same day access																					
	2.2 Direct access to specialist																					
	2.3 Major elective surgery <90 days																					
	2.4 Cancer therapy < 21 days																					
	2.5 CT scan < 7days																					
	2.6 A&E waiting times																					
	Subdiscipline weighted score	163	200	225	150	175	125	213	150	163	150	188	225	188	125	125	163	100	138	113	175	200

Figure 4: Results of 2016 Euro Heath Consumer Index[15]

Healthcare is the cornerstone of the socialist state. It is the crown jewel of the welfare state.
Monica Crowley

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