Between Beveridge and Bismarck – options for health care financing in central and eastern Europe

Michael Cichon & Charles Normand

A government-run national health service (the Beveridge model) can provide care for all at a reasonable cost but cannot avoid the dangers of poor quality. An insurance-based system (the Bismarck model) can achieve high quality but cannot ensure care for all at an affordable cost. The best chance of achieving a reliable financial base for health services is to use a combination of both these approaches.

Reform of health care financing is high on the political agenda both in the former planned economies of central and eastern Europe, and in the market economies of western Europe, North America and many parts of the developing world are also considering reforms. International experts have been quick to point out the disadvantages of the various options for health services financing, but reluctant to be specific about what is the best system, and what characteristics it should have.

Countries of central and eastern Europe have an urgent need to reform their health care financing. As countries in economic and political transition they also have the greatest opportunities to design a system which draws on the strengths and avoids the pitfalls of existing systems. It is worth remembering that no-one has any real experience of this type of transition. No models of reform of centrally planned economies exist, and all those involved are having to invent procedures and start new traditions.

In the summer of 1992 the International Labour Office held a summer school in Turin (Italy) on health insurance management and financing for officials from central and eastern Europe. Participants asked the authors to “get off the fence”, and state what system or combination of systems they would recommend. In attempting to do so, we sought to identify the advantages and drawbacks of the different options, freeing ourselves as much as possible from preconceptions derived from our historical and cultural inheritance. Both of us have been actively involved in discussions about reforms in many countries and we are well aware that no one model is suited to all national circumstances. However, it could be useful to offer some analytical thoughts on an alternative approach.

The approach we have in mind combines tried and tested features of the two classic European models: the Beveridge National Health Service and the Bismarck social insurance model. Lord Beveridge’s mainly
state-funded plan to make “full preventive and curative treatment” available to every citizen without exception came into effect in the United Kingdom in 1948. Otto von Bismarck’s mainly insurance-funded plan protecting workers against accidents, sickness, invalidity and old age was introduced in Germany in 1881.

Health in central and eastern Europe

The formerly planned economies of central and eastern Europe have inherited large public health care delivery systems with high levels of poorly paid staff, decaying infrastructure, poor equipment, and problems with pharmaceutical supply. National economies have been in decline, inflation has been high and there has been a tight squeeze on government expenditure in real terms. Many of these countries have poor and declining health status.

Poor and worsening standards of health care have led to disenchantment among both patients and providers with the delivery systems now in use. There has therefore been a search for additional and secure sources of finance for the health care services. For the foreseeable future such financing is likely to come from outside the existing state budgets. Most countries are aiming to use some form of social insurance mechanism to finance health care, which can require quite complex structures and procedures to be put in place. The process of reform is expected to take several years, and problems that have arisen have sometimes been caused by over-optimistic timetables. Some details of progress on the reforms are given in the table.

Strengths of social insurance financing

The arguments typically cited in favour of social insurance financing of health services are as follows:

Earmarking of resources for health

As an independent body, a social insurance institution has clearly identified resources. It does not have to compete regularly against other spending priorities for government resources. The greater acceptability to insured people and third parties of a visible flow of funds specifically for health care means that earmarked resources tend to be a more stable source of funds.

Self-governance

The governance arrangements for social insurance for health should in principle allow direct control of the management of insurance funds by those who provide the resources. Contributors such as employers can influence health care policy, help to negotiate appropriate packages of care, and have a strong incentive to keep costs down. Health service priorities can be influenced directly by those financing and using services.

Defined entitlements

The language and principles of insurance carry over to social insurance for health. Benefits and access to health services are specified. It is normal for the income of the insurance schemes to be set so as to make available the defined benefits, rather than making budgetary constraints determine to some extent the access to care, as well as its quality and availability.
### Summary of the state of health financing reforms in countries of central and eastern Europe (December 1993)

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albania</td>
<td>First steps towards the introduction of social health insurance are being taken. An interministerial working group has been established to draft a health insurance law.</td>
</tr>
<tr>
<td>Armenia</td>
<td>A draft law on a health insurance system combining compulsory and voluntary participation has been published. The compulsory part provides for universal coverage but insurance schemes might be non-statutory. Further details are still under discussion.</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>A national centre for health insurance was established in 1991. A draft law on social health insurance, envisaging compulsory universal insurance consisting of 28 local branches, was approved in principle by the Council of Ministers in October 1993. Parliamentary approval pending.</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>Compulsory social health insurance has formally been in operation since 1 January 1992 and initially embodied only administrative separation of the scheme from the government. The actual insurance structure and <em>modus operandi</em> of the scheme are being developed.</td>
</tr>
<tr>
<td>Lithuania</td>
<td>Draft enabling legislation on the introduction of compulsory social health insurance is being discussed in Parliament.</td>
</tr>
<tr>
<td>Poland</td>
<td>Government is pursuing plans to introduce a social health insurance system. Various models are still being debated within the government and with the social partners and political parties.</td>
</tr>
<tr>
<td>Romania</td>
<td>Some form of co-financing of health services by earmarked funds is being discussed.</td>
</tr>
<tr>
<td>Russia</td>
<td>Combination of compulsory social insurance with voluntary insurance should have been legally effective as of 1 January 1993. However, implementation of autonomous health insurance schemes in 89 <em>oblasts</em> (provinces) with a national financial risk policy has had a slow start. Concrete <em>modus operandi</em> still to be determined.</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>Responsibility for the financing of health services was transferred to a system of social security health insurance funds in 1993. <em>Modus operandi</em> of the system still to be finalized.</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Government plans the introduction of social health insurance. The National Institute for Health has drafted the first law which merges a social health insurance scheme with universal coverage.</td>
</tr>
</tbody>
</table>

### Quality of care

Under insurance, all patients expect a customer relationship with providers, and can choose among providers. Open access to different providers leads to a competitive supply of most health services, with generally positive effects on the quality of care.

### High labour costs

Social insurance contributions (by both employers and employees) are a charge on the payroll, and can increase the costs to employers of hiring staff. This may conflict with full employment policies. It can also foster informal employment arrangements that reduce or avoid the obligation to pay contributions.

### Weaknesses of social insurance financing

The arguments most commonly cited against using insurance to finance health care are as follows:
their nature, insurance-based systems require management staff for registration of contributors and dependants, collecting contributions, processing claims, contracting with providers of care and paying for services. This is likely to involve higher overall costs than a state-managed universal system.

**Problems in cost control**

The provision of services at low prices or free of charge at the point of use generates incentives to providers and patients to increase the volume of care. Governments can use fixed budgets to control overall costs. Private individuals are deterred by high prices, which helps to contain overall expenditure. Social insurance systems, on the other hand, can in principle just increase contribution rates to cover additional costs.

**Increasing convergence**

It is worth taking a closer look at some of these arguments. To economists, earmarking taxes or contributions is normally seen as a bad thing, since it reduces the scope for resources to be allocated to maximize welfare. However, this is probably less important than the greater public acceptability of the clearly visible flow of funds to health. Self-governing institutions cannot be controlled directly by governments and health care policy-makers.

---

**Diversity is a particular virtue in organizing sources of funds for health care, since it helps to avoid perverse incentives, and tends to spread the burden more evenly.**

This has the disadvantage of not being so easy to use in the pursuit of health policy, but it also has the advantage of insulating health services from arbitrary political manipulation. In addition, an element of independence contributes to the quality of service and consumer satisfaction.

Defined entitlements give important rights to insured people, but also reduce the scope for flexibility. The key issue is the mechanism for defining the rights. If this is independent of decision-making about financing, then there is no strong mechanism to control the overall cost of health care. In practice, existing social insurance schemes in Europe take costs into account when setting entitlements.

The effects of social insurance on labour costs is complex. In economists' terms, the crucial question is how the payroll charge is effected, that is, who actually bears the burden. It could be all borne by the worker, all by the employer, or shared between them. In a competitive labour market the total cost of employing a worker is constrained by the need to produce goods at a cost below the market price. In the short run, money available for staff emoluments is therefore fixed, and any increase in insurance contributions must reduce the take-home pay of staff. If, on the other hand, the firm operates in a labour market with little competition, and if the firm has profits, these can be the source of the additional contributions. The key point is that the effects of the introduction of health insurance contributions on labour costs depends on the degree of competition in the labour market.

The visible payment mechanism does not in itself determine the sharing of the financing burden. Workers may be indifferent as to whether they receive a total remuneration package consisting of free health care combined with low net pay, or higher net pay combined with employee contributions for health insurance. Given the high level of open or hidden unemployment in the countries of central and eastern Europe, there is little pres-
sure to offer competitive salaries and benefits, and it is therefore probable that the burden of health insurance contributions will in fact fall mainly on the employees.

The arguments about administrative complexity also need careful examination. Highly centralized administration of health care systems, even in those countries that have tax-financed national health services, is now considered to be inefficient. Reform in the United Kingdom has introduced new structures that in many ways resemble those needed for social insurance, since local health authorities are responsible for purchasing care from self-managed providers. At least some of the administrative complexity of social insurance systems is probably also necessary in well managed state health care systems. At the same time, there is an increasing use of global steering mechanisms to control cost and performance in autonomous social insurance systems such as that in Germany. Thus the two systems are gradually converging.

Health care financing models are full of myths about what works and what does not. Experience shows success and failure in all types. The only clear message is that unregulated, private actuarial insurance is a poor vehicle for producing universal access to basic health services. Examples exist of taxes financing private provision of services, private and insurance funding of government-operated hospitals, and fully public systems. All are compatible with liberal democratic political systems. In this respect, tradition and history are more important than technical arguments as determinants of suitable health care models. Within political constraints, countries should choose a model that allows them to achieve policy goals. This may be a model already in use in some countries, but is more likely to be a model that combines features of those used elsewhere.

**Combining the best features of Bismarck and Beveridge models**

Most of the national health care services currently being reformed start with a system financed mainly by taxes. In most instances, the question for health services in central and eastern Europe is likely to be: how far should they move through the spectrum from tax finance to insurance finance? It is possible to make a case for stopping at several points along the way.

Certain principles can be suggested that might guide the choice of mechanisms for health care financing. All of them should be prefaced with "where possible". They are as follows:

- Population coverage should be universal, with contributions provided on a tripartite basis by employers, employees and government, each providing clearly defined shares of the required income for health.

- The payroll should not be used as an exclusive funding base unless benefits are themselves income-related (e.g. certain cash benefits for people off work due to ill-health). Contributions from employers should be based on turnover, profit or some other criterion that minimizes effects on employment incentives.

- **Given the high level of unemployment in the countries of central and eastern Europe, there is little pressure to offer competitive salaries and benefits, and it is therefore probable that the burden of health insurance contributions will in fact fall mainly on the employees.**

- The flow of funds from individuals (employees or self-employed) and employers to the health services should be clearly visible. On behalf of people unable to pay
themselves, assessed contributions should be paid by pension schemes, unemployment funds or the government. There should be no government subsidies for personal health services outside the scheme (except for public health interventions and health promotion).

- Contributions by employed or self-employed individuals (or the earmarked health services tax) should be income-related, be based on gross income and provide cover for dependants.

- Taxes on health-damaging goods should be earmarked for health care. This may provide the income base for population-based and public health interventions.

- Management of the funds for health should be in the hands of a largely autonomous body, with control by contributors, but within an agreed policy framework, and with a clearly defined legal mandate.

- The main benefits packages should be defined, and available as a right. The whole system should be cash-limited to avoid cost escalation. There should be mechanisms to ration use of non-essential treatments or to reduce payments to providers in the event of the scheme being overspent.

- Increases in the contribution rate should be made only as part of government health and social policy, and in the framework of macroeconomic objectives and constraints.

- Provider organizations should be separate from those responsible for managing the collection and allocation of the health resources. Policy-makers should exercise no a priori preference for private for-profit, private not-for-profit, or public providers.

Relevant to all these considerations is the fact that diversity is a particular virtue in organizing sources of funds for health care, since it helps to avoid perverse incentives, and tends to spread the burden more evenly. For example, indirect taxes are paid even by those who evade or avoid income tax.

The pattern that is likely to fulfil these criteria best is a system financed by earmarked taxes, levied on a range of bases, and transferred into a health fund. This fund would contract with health care providers to make available a minimum entitlement to benefits. Coverage would be universal, thus eliminating equity problems and the costs of policing compliance. There would be an element of control by patients and governance by contributors, and a customer relationship could be created. Most of the advantages of the Bismarck system would be available without the cost of administration, the potentially damaging effects on work incentives, and uncontrollable costs. The benefits of the Beveridge type national health service system would be available without its benefit levels and quality being determined in the context of the competing demands for shares of the government budget.