High Level Overview of Major International Models

| Specification | Beveridge Model | National Health Insurance Model | Bismarck Model | "Out of Pocket" |
|---|---|---|---|---|
| **Description** | **National health service** | **National health insurance** | **Social health insurance model** | **Market-driven health care** |
| **Country Examples** | The United Kingdom, Ireland, Denmark, Norway, Sweden, Finland, Iceland, Australia**, New Zealand, Cuba<br><br>*<u>Shifted from Bismarck Model in the 70s/80s to this model:</u>* Greece, Italy, Portugal, Spain, Italy; South Korea | Canada, Taiwan | Austria, Germany, Belgium, Japan, Switzerland, France, The Netherlands | Market-Based Plans: South Africa*, Uruguay, The Bahamas, Chile, Argentina<br><br>Minimal health plan structures: Rural areas of India; China, Sudan, Nigeria; Cambodia |
| **Similarities in the US** | Like the Veterans Health Administration; Indian Health Service | Like Medicare | Like employer-based health care plans and some aspects of Medicaid | Like US market-based health plans with options limited for uninsured or underinsured |
| **Historical Points** | Developed by Sir William Beveridge in 1948, started in the United Kingdom | Evolved as a mix of the Beveridge and Bismarck models | Developed at end of the 19th century by Otto von Bismarck in Germany | Has evolved in each country considering its wealth/structures |
| **General Structure** | Government acts as the single payer through the establishment of a central national health service that delivers the care | • Publicly run insurance program that every citizen pays into<br>• Uses private sector providers<br>• The universal insurance does not deny claims | • De-centralized<br>• Employers and employees fund "sickness funds" created by compulsory payroll deductions.<br>• Private insurance plans cover everyone regardless of pre-existing conditions | • Wealthier able to purchase commercially offered insurance<br>• If no insurance available or can't afford - patients must pay for their procedures out-of-pocket. |
| **Eligibility** | All legal citizens | All legal citizens | All legal citizens | NA |

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| **Benefits** | • Access to a standardized set of benefits available across the country<br>• Evidence-based decision-making in benefit selection | • Medically necessary defined federally, but local decisions vary on benefit package<br>• Evidence-based decision-making | • Set by a federal committee in collaboration with the regional "sickness funds"<br>• Use evidence in decision making | Varies |
| **Costs** | • Free at point of service; no out of pocket costs<br>• Government controls prices | • Government processes all claims; aims to reduce the amount of duplication of services<br>• Financial barriers to treatment are generally low<br>• Patients usually can choose their healthcare providers | • Some copays in Germany for nursing homes, pharmaceuticals, and medical aids<br>• Government tightly controls prices while insurers do not make a profit, even if more than one health plan option | No cost controls in place |
| **Administration** | Central/national government administration | Administered by provinces and territories in Canada | De-centralized regional administration with national role | NA |
| **Delivery System** | • The government owns majority of hospitals and clinics<br>• Most doctors are government employees | • Hospitals and providers remain private<br>• | • Health providers are generally private institutions<br>• Social health insurance funds are considered public | • Majority are private entities<br>• Some countries have some public investment in hospitals |
| **Health Plans** | Government run; eliminates competition in the market | In some countries, can purchase private insurance for additional needs or in substitution | Some with a single insurer (France, Korea); other countries may have multiple, competing insurers (Germany, Czech | More availability of health plans emerging; if can afford |

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| | | | Republic) or multiple, non-competing insurers (Japan). | |
| **Funding** | Income taxes | Income taxes | Payroll deductions | Predominately self-pay |
| **Additional information** | • Tighter cost controls than Bismarck Model<br>• Waiting lists for obtaining some services<br>• Overuse of services<br>• Maintain adequate tax funding; especially in an emergency crisis or rising costs<br>• Standardized population health-focused efforts on prevention<br>• Sweden has some features of a national health service such as hospitals run by county government; but other features of national health insurance such as physicians being paid on an FFS basis<br>• See notes below re Australia | • Waiting list to obtain elective services, but also for some subspecialty care<br>• Aging population issue<br>• Some note overuse of services | • Some countries have shifted to move to include elements of the Beveridge model (i.e. Germany and Hungary)<br>• Can substitute private insurance<br>• Higher rates of cost growth noted than Beveridge model<br>• Can see overuse of services<br>• Some evidence of increased satisfaction with de-centralized administration (by region)[i]<br>• Issue of increased retired population to employed citizens<br>• Payroll tax may impact interest by international companies to locate in the country | Poorer citizens unable to afford needed care<br><br>See notes below re South Africa |

**Notes:**

***** South Africa is developing a Social Health Insurance Scheme through which all South Africans will be covered; providers are a mix of public and private entities.

**Australia: The federal government funds Medicare, a universal public health insurance program providing free or subsidized access to care for Australian citizens, residents with a permanent visa, and New Zealand citizens following their enrollment in the program and confirmation of identity. Restricted access is provided to citizens of certain other countries through formal agreements. Other visitors to Australia do not have access to Medicare. Three levels of government are collectively responsible for providing universal health care: federal; state and territory; and local. The federal government mainly provides funding and indirect support to the states and health professions, subsidizing primary care providers through the Medicare Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) and providing funds for state services. It has only a limited role in direct service delivery. Australian states have most of the responsibility for public hospitals, ambulance services, public dental care, community health services, and mental health care. They contribute their own funding in addition to that provided by federal government. Local governments play a role in the delivery of community health and preventive health programs, such as immunization and the regulation of food standards.

**The table's content is from several sources, including the following;**

- Commonwealth Fund's detailed profiles of several industrialized countries are available at: https://international.commonwealthfund.org/
- John Hopkins overview of international models available at: http://web.jhu.edu/administration/provost/docs/101014%20Minor%20Speech%20PP.pdf
- Oregon's Universal Access to Care Work Group Meeting materials and Final Report December 2018 - Available at: https://www.oregonlegislature.gov/salinas/HealthCareDocuments/UAC%20Work%20Group%20Report%20%20FINAL%2012.10.18%20.pdf
- Princeton University article on the Four Models: available at: https://pphr.princeton.edu/2017/12/02/unhealthy-health-care-a-cursory-overview-of-major-health-care-systems/
    - Concluding notes from Princeton article: "Each country faces different concerns when attempting to construct a system for health care delivery. No health care system is completely alike, and none are completely free of problems; a method that works for one country is not likely to be completely transferrable to another due to different health concerns, priorities, and mindsets. Though complicated, considering the implications of various models is essential to implementing an American health care system that is fair and just to all citizens, not just the wealthiest. Its construction should emerge from the collaboration between policy experts, health providers, politicians, and other stakeholders to attempt to address the many complicated aspects of the health insurance market"