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The Bismarck Model: Social Health Insurance

Comprehension Questions

Indicate whether the statement is true or false, and justify your answer. Be sure to cite evidence from the chapter and state any additional assumptions you may need.

1. Sickness funds in Bismarck health care systems are publicly administered and financed.

   FALSE. Sickness funds in a Bismarck model are private, non-profit entities.

2. Bismarck nations tend to have higher national health care expenditures than Beveridge countries.

   TRUE. Bismarck countries have around a 11% average health expenditure as a percentage of GDP, while Beveridge countries are around 9.5%.

3. Universal health care in Bismarck countries emphasizes equity of care for all individuals, regardless of social and economic circumstances. The sale of private supplemental insurance is prohibited.

   FALSE. Supplemental insurance and private insurance is offered to individuals who are willing to pay for it.

4. There is an emphasis on managed competition in the Bismarck model.

TRUE. Managed competition is one of the defining aspects of the Bismarck model.

5. Even though it is illegal for sickness funds to deny coverage to individuals, insurers still often engage in risk selection.

   TRUE. Bismarck countries are continually making policies to combat risk selection.

6. Physicians have no say in what prices to charge their patients.

   FALSE. Even though many countries have government controlled prices, physicians can still lobby and negotiate with public entities each year to determine medical prices for each year.

7. Patients in France typically pay all their health fees directly to the doctor and are later reimbursed by their insurance fund.

   TRUE. One distinction between France and other Bismarck countries is that patients pay all costs upfront and then are reimbursed by their insurance fund. This helps ensure patient choice and physician autonomy.

8. One way that Bismarck nations control costs is through government-set prices for care.

   TRUE. Uniform prices for care throughout the country helps control costs each year from skyrocketing.

9. Every Bismarck country has over a hundred sickness funds for patients to choose from, which distinguishes them from Beveridge countries.

   FALSE. Although there are countries with over a hundred sickness funds, Israel has only four. It is true that Beveridge countries typically only have a single national plan.

10. Health insurance coverage is primarily financed through payroll and other taxes.

    TRUE. Individuals pay a percentage of their income to finance sickness funds.

11. People in Bismarck countries tend to visit the doctor and receive more CT and MRI scans than people who live in Beveridge countries.

    TRUE. Patients in Bismarck tend to use more medical technology than those in Beveridge countries.

12. Even though health insurance is universal, citizens can choose whether or not they are insured.

    FALSE. Insurance is required of all citizens. Individuals may only opt out of public insurance if they buy private insurance as a replacement.

13. Like the Beveridge model, there are no real cost controls, therefore long queues are a problem.

    FALSE. There are fewer queues in the Bismarck model because there are cost controls that Beveridge patients do not have to worry about (i.e. some co-payments).

14. Bismarck countries have all had universal insurance for at least 40 years.

    FALSE. Israel and Switzerland have only had their universal insurance systems since the 1990s.

15. Patients in Bismarck model countries are able to choose which health care provider they see.

    TRUE. If patients do not like care given by one provider, they are free to see a different one.

16. Patients are charged premiums based on their risk rating.

    FALSE. Sickness funds are prohibited from charging premiums based on risk rating. Instead they can charge community rated plans.

17. Like NICE in the U.K., Germany has an entity that advises sickness funds on the cost-effectiveness of new technologies.

    TRUE. The Institute for Quality and Efficiency in Health Care is able to use cost-effectiveness on new medical technologies to advise firms. However, they do not conduct analyses themselves, nor do they have the authority to enforce their findings on a national level, but their findings can help inform sickness funds of procedures that may or may not be cost-effective.