Department of Healthcare Management & Health Economics

ASSIGNMENT REPORT

ECONOMIC AREA MANAGEMENT: OPTION 1 - HEALTHCARE FINANCING MODELS AND RESOURCE ALLOCATION

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1. Abstract

This report evaluates how different healthcare financing models collect money, pool financial resources, and allocate funds to healthcare providers. Financing decisions play a direct role in determining patient access, cost containment, system efficiency, and overall social equity in healthcare delivery.

The paper compares major financing systems—tax-based systems (Beveridge model), social health insurance (Bismarck model), private health insurance, and out-of-pocket payments. It also analyses common provider payment methods, including fee-for-service, capitation, global budgets, and Diagnosis-Related Groups (DRGs), highlighting how each method influences doctor and manager behaviour. Through comparative case studies of the UK National Health Service and the United States healthcare system, the report examines real-world financial outcomes. Finally, a strategic resource allocation proposal is presented for a regional health system to maintain financial sustainability while ensuring fair and quick treatment access for patients.

2. Introduction

Healthcare systems across the world face rising financial costs due to aging populations, chronic illnesses, and expensive medical technologies. How a country finances its health sector determines who gets care, how much patients pay out of their own pockets, and whether health services remain financially sustainable over time (Mossialos et al., 2002).

Health economics focuses on three main financial functions: revenue collection, risk pooling, and provider purchasing (World Health Organization, 2010). When these functions are designed well, healthcare institutions can deliver high-quality care without causing financial hardship to citizens. However, different payment mechanisms create different incentives for hospitals and doctors. For instance, paying doctors for every service can lead to over-treatment, while fixed budgets may lead to long waiting lists. This report examines healthcare financing models, provider payment mechanisms, comparative international case studies, and practical resource allocation strategies for regional health system managers.

3. Literature Review

The literature in health economics categorizes healthcare financing into four major archetypes (Bohm et al., 2013). Each model relies on distinct funding mechanisms and administrative structures:

1. *Beveridge Model (Tax-based National Health Insurance):* Funded through general government taxes. Healthcare is provided as a public service, and most hospitals are publicly owned (e.g., UK NHS). It offers universal coverage with low administrative costs, but can suffer from budget constraints and long waiting lists (Beveridge, 1942).
2. *Bismarck Model (Social Health Insurance):* Funded jointly by employers and employees through payroll taxes collected into non-profit "sickness funds" (e.g., Germany). Providers can be public or private, ensuring universal access while maintaining competition.
3. *Private Health Insurance Model:* Funded by voluntary private insurance premiums (e.g., US market). It encourages rapid technology adoption, but often results in high total expenditure and leaves uninsured groups behind.
4. *Out-of-Pocket Payment (Direct Payment):* Patients pay directly at the point of service. Common in developing regions, this approach causes high financial risk and poverty due to medical bills.

Beyond collection mechanisms, provider purchasing methods dictate how funds flow from insurers to doctors and hospitals. According to Rice (2002), payment structures directly shape clinical decision-making, referral patterns, and service volume.

Payment Method	Financial Mechanism	Incentive Created for Providers	Impact on Cost & Access
Fee-for-Service (FFS)	Payment per specific procedure/visit	Incentive to increase volume and intensity of services	Risks cost inflation; good patient access if covered
Capitation	Fixed fee per registered patient per year	Incentive to keep patients healthy and control volume	Controls total costs; risk of under-servicing patients
Global Budget	Fixed total funding for a facility per year	Incentive to strictly manage hospital operational costs	Excellent cost containment; potential waiting lists
Diagnosis-Related Groups (DRGs)	Fixed payment per hospital admission by diagnosis	Incentive to reduce length of stay and inpatient cost	Improves hospital efficiency; risk of early discharge

4. Methodology

This report uses a qualitative secondary research method based on health economics literature, published case studies, and international health policy reports from the WHO, OECD, and World Bank.

The research evaluates four primary financing models and four provider payment methods. A comparative analysis is performed using two real-world case studies (United Kingdom vs. United States) to assess performance across four criteria: financial access, cost containment, operational efficiency, and equity. These findings are used to design an evidence-based resource allocation proposal for a regional health authority.

5. Findings: Healthcare Financing Models & Flow of Funds

The research findings confirm that no single financing model is perfect, but the flow of funds between population, purchaser, and provider determines system stability. Systems with high out-of-pocket expenses create severe equity gaps, while centralized single-payer systems achieve better cost control.

Key Insights on Fund Flow Dynamics:

1. *Risk Pooling:* Broad risk pools (like general taxation or social insurance) spread financial risk across healthy and sick individuals, making care affordable for low-income citizens.
2. *Purchasing Power:* Single-payer purchasers (e.g., national health authorities) have stronger bargaining power to negotiate lower prices for medicines and medical equipment.
3. *Provider Alignment:* Blended payment systems (e.g., combining capitation with DRGs) perform better than pure fee-for-service systems by balancing volume and efficiency.



STRATEGIC IMPORTANCE OF RISK POOLING

Without financial pooling, health costs fall entirely on sick individuals. Effective risk pooling transfers resources from healthy to sick populations, ensuring equitable access to essential medical services regardless of personal income.

6. Discussion: Country Comparative Case Studies

To evaluate the impact of financing decisions on real outcomes, this section compares the tax-funded system of the United Kingdom with the multi-payer private/public system of the United States.

Case Study 1: United Kingdom (NHS) - Tax-Based Beveridge Model

The UK NHS is funded primarily through general taxation and provides universal health coverage free at the point of delivery. Primary care doctors (GPs) are paid largely through capitation, while acute public hospitals operate under global budgets and activity-adjusted block contracts (Mays, 2011). The main strength of the NHS is high financial equity and effective cost containment—spending roughly 11.3% of GDP on healthcare. However, the system faces challenges such as tight budget ceilings, long elective surgical waiting lists, and staff shortages during winter demand spikes.

Case Study 2: United States - Multi-Payer Private & Public System

The US relies on a mix of private employer-sponsored health insurance, government programs (Medicare and Medicaid), and individual out-of-pocket payments. Provider reimbursement historically favored fee-for-service, though DRGs and value-based purchasing are growing (Cutler, 2014). The US spends nearly 17.8% of GDP on health—the highest in the world—and excels in medical innovation and advanced diagnostic speed. However, it suffers from high administrative costs, medical debt, and millions of underinsured citizens, showing poor financial equity compared to other OECD nations.

Comparative Evaluation Summary:

The comparison highlights a fundamental economic trade-off: tax-funded single-payer systems achieve superior equity and cost control at the expense of potential wait times, whereas market-driven systems deliver high innovation and rapid access for covered patients at the expense of cost control and universal coverage.

7. Strategic Resource Allocation Proposal for Regional Health System

To maintain financial sustainability while ensuring fair and prompt care access, regional health managers must adopt a modern, risk-adjusted resource allocation strategy. Below is a practical implementation framework designed for a regional health authority managing a network of primary care centers and community hospitals.

REGIONAL RESOURCE ALLOCATION & SUSTAINABILITY FRAMEWORK

Pillar 1: Capitation-Based Primary Care Funding

Allocate 40% of the regional budget to primary care using a population risk-adjusted capitation formula (factoring in age, socio-economic deprivation, and chronic disease prevalence) to incentivize preventative care and reduce hospital admissions.

Pillar 2: Blended Hospital Reimbursement (DRG + Quality Bonus)

Pay acute hospitals using Diagnosis-Related Groups (DRGs) for inpatient stays to control length of stay, coupled with a 5% quality incentive pool linked to reduced 30-day readmission rates and emergency wait-time targets.

Pillar 3: Ring-Fenced Emergency & Equity Access Reserve

Establish a 10% contingency reserve dedicated to funding mobile clinics in underserved rural areas and managing unexpected seasonal winter capacity surges, ensuring prompt care access across all demographic groups.

8. Conclusion & Recommendations

In conclusion, healthcare financing decisions directly affect cost efficiency, clinical quality, and social equity. Transitioning from pure fee-for-service toward blended payment models (capitation combined with DRGs) provides the best path for health system sustainability.

Recommendations for Health System Managers:

1. Implement risk-adjusted capitation formulas for primary care funding to support preventative medicine.
2. Shift acute hospital payments from line-item budgets to activity-based DRG purchasing with strict quality indicators.
3. Review financial variances monthly to detect cost overruns early and protect emergency reserves.

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10. Appendices

Appendix A: Comparative Matrix of Healthcare Financing Models

Financing Model	Primary Funding Source	Risk Pooling Level	Cost Control Ability	Equity Index
Beveridge (Tax-Based)	General Income & Sales Tax	High (National Pool)	High (Global Budgeting)	Very High
Bismarck (Social Insurance)	Payroll Taxes (Employer/Employee)	High (Sickness Funds)	Moderate to High	High
Private Insurance	Voluntary Premiums	Fragmented Pools	Low (Market Driven)	Moderate / Low
Out-of-Pocket	Direct Individual Cash	None (Individual Risk)	Very Low	Very Low