Abderrahmane MIRA University of Bejaia
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Module

" Health, Society and Humanity (SSH) "

COURSE

"HEALTH ECONOMICS"

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COURSE 2 : Health Systems in the World and in Algeria

1. EDUCATIONAL OBJECTIVES

At the end of this course, the student will be able to:

- Understanding the different **approaches to organizing and financing** health systems around the world
- Identify the **strengths** and **weaknesses** of each model.
- Situating the **Algerian health system** in its contemporary developments

2. PROGRAM/CONTENT

The course is structured around four themes addressed successively:

1. What is a health system?

2. Key characteristics of health systems

3. Interest in studying large models of health systems

4. The three major models of health systems

4.1. The liberal (decentralized) model

4.2. The planned (Beveridgian) model

4.3. The socialized (Bismarckian) model and its application in Algeria

1. WHAT IS A HEALTH SYSTEM?

A health system is a **complex and dynamic whole** that plays a crucial role in managing the health of a population. Here are its main components:

a) Organizations, Institutions and Resources:

- Includes **hospitals, clinics,** and **healthcare professionals.**
- Also includes **insurance, patients,** and various **ministries** (health, labor, higher education, etc.), because health problems are often *multidimensional* and require *intersectoral coordination.* For example, the ministry of transport may be involved in the management of road accidents.

b) Health activities:

- Aims to **improve, maintain** or **restore** the health of individuals and communities.
- This may include preventing disease, treating illnesses and health conditions, or promoting healthy lifestyles.

c) Interactions between components:

- Health systems do not operate in isolation. They are characterized by many interactions between their different parts.
- For example, the **geographical distribution of health professionals** influences access to care and can affect health inequalities. Poor distribution can lead to limited access to services in some areas, exacerbating regional disparities.

IN SUMMARY, a health system is an **integrated structure** that requires close collaboration between various entities to function effectively and meet the health needs of a population.

2. KEY CHARACTERISTICS OF HEALTH SYSTEMS

Health systems are **complex structures** that play a crucial role in the well-being of populations. Here are the main characteristics that define them:

a) Multidimensional

- **economic**, **social,** and **political** dimensions.
- For example, health care financing is a major economic issue and an important political choice. It involves decisions about the distribution of resources and access to health services, reflecting a society's priorities.

b) Adaptive

- These systems are designed to be **flexible** and evolve according to the **context** and changing **needs** of the population.
- A striking example is the rapid adaptation of health systems around the world to the COVID-19 pandemic, where they had to adjust their resources and strategies to respond effectively to the health crisis.
- This **adaptability** is crucial to maintaining the effectiveness of care in the face of unforeseen challenges.

c) Goal oriented

- Health systems aim to achieve several key objectives:
  - ✓ **Improving health** : By increasing life expectancy and reducing disease.
  - ✓ **Equity** : Ensuring equitable access to care for all, regardless of socio-economic status.
  - ✓ **Efficiency** : Optimizing the use of available resources to provide the best possible care without waste.

IN SUMMARY, health systems are designed to respond to a multitude of challenges while adapting to the specific needs of the populations they serve. Their effectiveness depends on their ability to integrate various aspects while pursuing clear and measurable objectives.

3. INTEREST IN STUDYING MAJOR MODELS OF HEALTH SYSTEMS

Analyzing different models of health systems around the world is essential for several reasons:

a) Understanding of Organizational and Financing Approaches

- Each country has developed a unique model based on its **history, culture,** and **values.**
- Studying these models helps us understand how health care is organized and financed differently across the globe.

b) Identification of Strengths and Weaknesses

- By comparing systems, we can identify what works well and what could be improved.

- This comparative analysis, known as **international health benchmarking,** allows us to draw inspiration from best practices to optimize our own system.

c) Anticipation of Future Challenges and Emerging Trends

- Studying different models helps predict future challenges, such as the impact of an **aging population** or the increase in **chronic diseases.**
- Understanding how other systems address these issues helps us **develop more effective strategies** for our own system. By analyzing their approaches, we can identify innovative solutions that are tailored to our future needs.

d) Promotion of Critical Reflection on Health Policies

- This study encourages critical reflection on health **policy choices.**
- She stresses that there is no perfect model, each system being the result of **compromises** and **societal choices.**
- This opens the way for **constructive discussions** on improvements.

IN SUMMARY, the study of major models of health systems enriches our overall understanding and guides us in the continuous improvement of our own policies and practices.

4. THE THREE MAIN MODELS OF HEALTH SYSTEMS

Health systems around the world can be classified into three broad models, each with its own distinctive characteristics in terms of organization and financing:

- ✓ The liberal (decentralized) model
- ✓ The planned (Beveridgian) model
- ✓ The socialized (Bismarckian) model

4.1. THE LIBERAL (DECENTRALIZED) MODEL

The liberal health model embodies a fundamentally **decentralized approach,** where the *economic freedom* of health actors takes precedence over *state intervention.*

4.1.1. The Foundations of the Liberal Model

This system is based on three fundamental pillars which are articulated in a **logic of regulation by the market** :

a) Mainly Private Health Care Offer

- Most of the **healthcare infrastructure** (such as hospitals, clinics, and medical practices) are **owned and operated by private entities.**
- This privatization (predominance of the private sector) is supposed to stimulate **competition** and innovation **in** the health sector, because health care providers operate as independent companies.

b) Financing by the Patient and Private Insurance

- Funding is based on two sources:
  - ✓ contribution **from patients**
  - ✓ **Private insurance,** often linked to employment.
- So, individuals pay directly for their medical expenses, whether **using their own financial resources** OR **by subscribing to private insurance** that covers all or part of the costs of medical services.
- In the United States, for example, insurance is often provided by **employers** as part of the employment contract.
- This system can lead to **excessive costs** and **inequalities in access to care.**

c) Regulation by the Market

- Under the liberal model, regulation is conducted through **market mechanisms**, where the balance between supply and demand determines:
  - ✓ Prices of medical services and insurance premiums
  - ✓ Geographic distribution of services
  - ✓ The quality and nature of the care offered and provided.
- In the healthcare market, **providers** (hospitals, clinics, and medical practices) freely set their **prices** and **operating conditions.**

  ⇨ **EXAMPLES:**

  - ✓ **Variable Medical Fees:** In the United States, physicians are free to set their fees based on their specialty, experience, and location. For example, a cardiologist in New York City might charge more than a colleague in a rural area because of the cost of living and local demand for specialty services.
  - ✓ **Hospital Rates by Facility:** U.S. hospitals can charge very different rates for similar services, depending on their status (private or charitable) and geographic

location. For example, the cost of surgery at an urban hospital may be significantly higher than at a rural hospital.

- ✓ **Single Rooms with Extras:** Some hospitals offer single rooms with luxurious amenities for an additional cost. In the United States, these rooms may include additional services (such as concierge service, gourmet meals, or access to television, telephone, and Internet) and cost several hundred dollars extra per night.

- Similarly, in the health insurance market, **private insurers** determine insurance premiums based on the **risk associated with each insured.**

  ⇨ **EXAMPLES:**

  - ✓ **Age of Insured:** Younger adults, who are often considered to have a lower health risk, may be offered lower insurance premiums. On the other hand, older adults, who are more likely to require frequent medical care, may face higher premiums.
  - ✓ **Lifestyle Habits:** An individual who does not smoke, regularly exercises, and maintains a healthy weight may benefit from reduced premiums. Conversely, a smoker, a sedentary person or an overweight person may be subject to higher premiums due to the increased risk of health problems.
  - ✓ **Occupation:** People working in high-risk occupational environments, such as construction or mining, may pay higher insurance premiums compared to those in less hazardous occupations, such as office work.

- The idea is that competition between providers and insurers improves the quality of care and reduces costs (see Box 1 below).
- However, even in these liberal systems, some **public regulation** (state intervention) exists to ensure minimum quality standards and protect consumers (see Box 1 below).

Representative Countries

- The **United States** and **Switzerland** are the main examples of this model. Although they have different approaches, they share these fundamental characteristics.

In summary, the liberal model emphasizes **the autonomy of private actors coordinated by the market**, with a **limited role for the state**. This can lead to **rapid innovation**, but also to **disparities (inequalities) in access to care**.

BOX 1: Market Regulation and its implications

In the liberal model, market regulation is based on the interaction between supply and demand to govern the health system. This approach is divided into three main aspects:

a) **Central Role of the Market**

- The market acts as the main regulator, creating a competitive environment among healthcare providers (healthcare market) and private insurers (health insurance market). Thus, both **healthcare providers** (such as hospitals and doctors) and **private insurers** compete to attract patients. This competition aims to stimulate innovation and optimize the value for money of healthcare services.

b) **Improving Quality and Reducing Costs**

- Competition pushes providers to improve the efficiency and quality of their services to stand out. Healthcare institutions and insurers compete with each other to attract customers. For example, a hospital might invest in advanced medical technologies or offer specialized services to attract more patients. Similarly, insurers may offer more attractive plans with lower premiums or broader coverage to remain competitive.

c) **State regulation**

- Despite the dominance of the market, the state retains a supervisory role by imposing minimum standards of quality and safety. This may include regulations on the training and certification of health professionals, the accreditation of medical institutions, and the protection of patients' rights. These regulations aim to protect consumers from abusive or unsafe practices, and to ensure an acceptable level of care for all.

In summary, although the market is the main driver of the system in the liberal model, state intervention remains essential to maintain an ethical and secure framework in which health care providers and health insurers operate.

4.1.2. The Advantages of the Liberal Model

a) Innovation and Competition

- The liberal model encourages **medical and technological innovation.**
- Competition and emulation **between** healthcare providers stimulates the **search for innovative solutions** and the **continuous improvement of practices.**

b) High Income for Practitioners

- Practitioners benefit from **attractive income prospects,** which can attract **top talent** (globally) and encourage **medical excellence.**

c) Freedom of Choice for Patients

- Patients have the freedom to **choose** their healthcare providers and insurance, which can lead to greater **satisfaction** with the care they receive.

d) Quality and Diversity of Services

- The free market promotes a **diversified supply** of medical services, often of **high quality** due to competition between providers.
- Providers seeking to stand out, are developing specialized and innovative services to **meet the varied expectations** of their patients. This dynamic is manifested through:
  - ✓ A diversified range of care meeting the different expectations of patients.
  - ✓ Personalized and high-quality services
  - ✓ Increased responsiveness to patient needs

Despite its advantages, the liberal model has several major drawbacks which are often linked to the underlying market logic.

4.1.3. The Disadvantages of the Liberal Model

a) Medical overconsumption

- Competition between providers can lead to **overconsumption of medical care,** because certain economic incentives encourage the multiplication of medical procedures (consultations, examinations, etc.).
- Physicians may be tempted to **offer more services than necessary** to increase their revenue, while patients may be **induced to consume more** because of generous or poorly structured insurance coverage.

b) High cost of care

- The liberal model is often associated with an excessive cost **of care** for the entire system.
- Fragmentation between different actors (**private** hospitals, specialized clinics, insurance companies) leads to a **multiplication of administrative costs** and a lack of economies of scale. In addition, the search for profit by some providers can push to **increase the prices of medical services.**

c) Significant remaining charge (RAC) for patients

- In this type of system, a massive portion of medical costs can be left to the direct charge of patients in the form of **excess charges (RAC)**.
- This means that even after insurance reimbursement, patients must **pay a massive portion of medical costs themselves**. This can lead some individuals to **forgo care** because it is too expensive or to go into debt to cover their medical costs.

d) Inequalities in access to care

- Finally, the liberal model tends to accentuate **inequalities in access to care**. People with fewer financial resources or living in remote geographical areas may have **more difficulty accessing necessary medical services**.
- Because private insurance is expensive, **certain social groups** may be **excluded from the system** or find themselves **underinsured,** which limits their access to adequate treatment.

4.1.4. United States: A Fragmented System

The American health care system is often cited as the archetype of the liberal model, characterized by **high fragmentation** and a **predominance of the private sector**. Here are the main characteristics and implications of this system:

a) Limited Role of the Public Sector

- **Health Care Provision:** The majority of health care services are provided by private entities, such as hospitals, clinics and independent medical practices.
- **Financing:** Financing is based primarily on **private insurance** and **out-of-pocket payments,** with a limited role for the public sector.
- **Health Insurance Coverage:**
  - ✓ In 2018, **68% of Americans had private insurance,** often tied to employment, while 34.1% were covered by public programs such as **Medicaid** (low-income people) and **Medicare** (elderly and seriously ill people).
  - ✓ Despite **Obamacare reform** (see Box 2), which reduced the uninsured rate from 15.5% in 2010 to 8% in 2018, approximately **30.4 million people remained without coverage**.[1]

[1]Finegold, K., Conmy, A., Chu, R.C., Bosworth, A., & Sommers, B.D. (2021). *Trends in the US uninsured population, 2010-2020.* Office of the Assistant Secretary for Planning and Evaluation (ASPE). Retrieved from https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf

b) Fragmentation and Complexity

- The U.S. healthcare system is characterized by the presence of **more than 1,300 different insurers,** which increases complexity and fragmentation.
- Overlapping **coverage** is common, especially for seniors who may have both Medicare and private supplemental insurance.

c) High Health Expenditures

- Because of this complex and fragmented structure, the United States spends an **exceptionally high share of its GDP on health care** (17.8% in 2021), raising questions about the efficiency and equity of the system.
- This liberal model highlights the challenges of equitable access to care and cost control in an environment dominated by the private sector.

BOX 2: OBAMACARE Reform

Introduction: Obamacare is a key reform of the American health system signed in 2010 to improve access to health insurance.

Key Objectives:

1. **Coverage Expansion** :
   - ✓ **Expanded Medicaid** to all adults with incomes up to 138 percent of the federal poverty level.
   - ✓ **Income-Based Subsidies** for individuals with incomes above the federal poverty level but who lack access to affordable employer-based coverage.
2. **Consumer Protection** :
   - ✓ **Ban on refusals of coverage due to pre-existing medical conditions** (chronic illness, mental conditions, etc.), requiring insurers to accept all applicants regardless of their state of health.
   - ✓ **Removal of Caps on Essential Benefits:** There is now a set of **essential benefits** that must be **covered without limitation,** including services such as Hospitalization, Emergency Care, Maternity and Newborn Care, Mental Health and Substance Use Disorder Services, Prescription Drugs.
3. **Access to Preventive Care** : Mandatory coverage of preventive services at no additional cost. Examples: Cancer screenings, Services for Women and Children (preventive care visits for women, access to contraceptives, breast pumps for breastfeeding, etc.), Programs and advice to help quit smoking.

Impact: Obamacare reduced **uninsurance rates** and **improved access to care,** despite political controversy and attempts at repeal under President Trump.

4.1.5. Switzerland: A Supervised Liberal System

Switzerland offers a model of health system that combines liberal elements with strict regulation, ensuring a balance between **individual freedom of choice** and **state control**.

a) Main characteristics

- **Mandatory Health Insurance**
  - ✓ All Swiss residents must subscribe to **basic health insurance**. This obligation ensures that everyone has **access to essential care,** regardless of their personal or financial situation.
- **Free Choice of Insurer**
  - ✓ Residents can choose their insurer from around **fifty recognized insurance funds**. This variety allows individuals to **select the coverage** that best suits their needs, while stimulating competition **between insurers**.
- **Administrative Decentralization**
  - ✓ Switzerland is distinguished by a **strong decentralization,** distributing responsibilities between the federal government and the cantons:
    - ⇨ **Federal Government:** It is responsible for **regulating prices** and defining **the services covered** by basic health insurance. This ensures **uniformity** in basic care accessible to all.
    - ⇨ **Cantons:** The cantons are responsible for **hospital care** and **prevention policies**. This structure allows for **adaptation to local needs,** offering **flexibility** that can respond more precisely to regional expectations and particularities.
- **Health Expenditure**
  - ✓ In 2021, healthcare spending accounted for **11.8% of Swiss GDP**. While this figure is high compared to other developed countries, it is still **far lower than that of the United States**.
  - ✓ This level of expenditure reflects the **quality** and **accessibility of care offered** in Switzerland, despite a **very largely decentralized organization**.

IN CONCLUSION, the Swiss system illustrates how a liberal model can be framed by state regulations to **guarantee universal access to care,** while allowing a certain **individual freedom in choices**. Decentralization also allows **management to adapt to local specificities,** contributing to the overall efficiency of the system.

4.2. THE PLANNED (BEVERIDGIAN) MODEL

The Beveridge model, or planned model, is a **centralized and state-run approach** to organizing health systems. It takes its name from William Beveridge, a British economist who influenced the creation of the *National Health Service* (NHS) in the United Kingdom, which is the emblematic example of this model. This system is based on three main characteristics: the ***provision of care mainly public, financing by taxes,*** and ***strict regulation by the State.***

4.2.1. Main characteristics

a) Mainly public healthcare provision

- ✓ In the Beveridge model, the provision of care is mainly provided by **public health services.**
- ✓ This means that **hospitals** and **clinics** are often **state-run** and the **majority of healthcare professionals** work for the **public sector.**
- ✓ The aim is to guarantee **universal access to care,** regardless of individuals' income or social status.

b) Financing by taxes

- ✓ The system is largely financed by taxes, which allows for **risk pooling on a national scale.**
- ✓ All citizens contribute through their **taxes,** and in return they have access to health services **at no direct cost** or at extremely low costs.
- ✓ **Advantage :** This method of financing allows for **universal health coverage,** where access to care does not depend on individual income.

(c) Strict regulation by the State

- ✓ In this model, the state plays a central role in **planning,** organizing **and** managing **health** services. The aim is to ensure a **fair distribution of resources** and **improve the efficiency of the system.**
- ✓ The state decides **on public health priorities,** allocates **financial and human resources,** and ensures that **all citizens have access to quality care.**

4.2.2. Representative countries

- The Beveridge model is particularly widespread in Europe and in certain countries outside Europe:
  - ✓ **United Kingdom:** The *National Health Service* (NHS) is the most iconic example. It provides **free care** at the point of use, funded by **taxes.**
  - ✓ **Scandinavian countries:** Sweden and Denmark have adopted similar systems with strong state involvement.
  - ✓ **Mediterranean countries:** Italy, Spain, Greece, and Portugal have also implemented systems inspired by the Beveridge model.
  - ✓ **Canada:** Although located outside Europe, Canada has adopted a system inspired by the Beveridge model, with universal coverage financed by taxes.
- Although these countries share the basic principles of the planned model, there are **significant variations** in their practical implementation. These differences often reflect the **historical, political, and social contexts** specific to each nation.
- Thus, some countries may allow greater **private sector participation** in health care delivery, while others maintain **strict public management**.
- In the UK for example, there are **additional insurances** which offer:
  - ✓ **Additional services:** Private insurance in the UK often offers additional services, such as private rooms in hospitals, consultations with specialists of your choice, and treatment in private facilities.
  - ✓ **Faster access:** One of the main attractions of these insurances is the **reduction in waiting times** for certain elective or specialist procedures (non-urgent cardiovascular surgery, cosmetic surgery, etc.) via private establishments, which can be a determining factor for those wishing to avoid NHS delays.
  - ✓ **Cover for innovative treatments in private settings:** They may also cover some innovative therapies or medicines (new medical technologies) that are not available through the NHS, such as some cancer medicines.

In conclusion, the Beveridge model embodies an approach where **the state plays a central role in the management of the health system**. It aims to guarantee **equal access** to care for all citizens through **tax-based financing** and **strict state regulation**. Although it is widely adopted in Europe and Canada, each country adapts this model according to its **specific needs** and **socio-political realities**.

4.2.3. Advantages of the Beveridge Model

a) Controlled costs

- ✓ **Public financing:** The Beveridge model is based on public financing through taxes, which allows for a **mutualization (pooling) of resources.** This helps to keep health costs under control, as the state can **negotiate directly with service and drug providers** to obtain advantageous prices.
- ✓ **Centralized management:** Centralized management allows for efficient allocation of resources, **avoiding duplication of services** and focusing efforts on **priority public health needs.**

b) Equity in access to care

- ✓ **Universal coverage:** This model ensures that **all citizens have access to necessary care,** regardless of their socio-economic status. This universal coverage is a fundamental pillar of the Beveridge system, ensuring that health is not a privilege but a **right accessible to all.**
- ✓ **Reducing inequalities:** By providing equal access to health services, the model helps to **reduce health disparities** between different sections of the population.

- The Beveridge model, or planned model, is recognized for its **centralized management** of health systems, which aims to ensure equity **and** cost **control.** However, like any system, it also has drawbacks.

4.2.4. Disadvantages of the Beveridge Model

a) Waiting times

- ✓ Due to the need to prioritize limited resources, some non-urgent care may experience **longer waiting times.** This is often the case for elective or specialist procedures where demand exceeds the available supply in the public sector.

b) Bureaucracy

- ✓ Centralized management can lead to heavy bureaucracy, which can **slow down decision-making,** the implementation of new policies, or **the introduction of innovative treatments and new medical technologies.** This administrative

burden can sometimes **hamper the responsiveness of the system** to changing or emerging needs of the population.

IN CONCLUSION, despite these challenges, the Beveridge model remains valued for its **egalitarian approach** and its ability to provide **quality care to the entire population** while **effectively controlling health spending**. It embodies a vision where health is a **universally accessible public good,** supported by **state management** that seeks to balance ***equity*** and ***economic efficiency***.

4.3. THE SOCIALISED (BISMARCKIAN) MODEL AND ITS APPLICATION IN ALGERIA

The socialized model, or Bismarckian model, is a **social protection system** based on **social contributions,** with **regulation shared** between the State and social partners. This model, inspired by the reforms of Otto von Bismarck in Germany at the end of the 19th century, has influenced many countries, particularly in Europe, but also countries such as Algeria. In this context, Algeria has adapted this model to its socio-economic particularities while retaining the fundamental principles of the Bismarckian system.

4.3.1. Main characteristics

a) Publicly dominated healthcare provision

- One of the pillars of the Bismarckian model is the predominantly public provision of health care. This means that **hospitals, clinics,** and **other health infrastructure** are mainly **managed by public entities,** thus ensuring **broad accessibility of care for the entire population**. This feature aims to ensure that **all citizens,** regardless of their economic status, can **access essential health services**.

- **ALGERIAN EXAMPLE:**
  - ⇨ In Algeria, this characteristic is manifested by a **network of public hospitals** managed by the Ministry of Health, Population and Hospital Reform (MSPRH). These establishments guarantee **broad accessibility of care** for the population.

- ⇨ Algerian public hospitals also offer **almost free care to citizens,** including medical consultations and hospitalizations. This free service ensures **universal access** to health services, even in rural areas with the network of Public Proximity Health Establishments (EPSP) made up of polyclinics, health centers and treatment rooms.
- ⇨ In the context of **financing public hospitals** by social security via the **"hospital package",** it is social contributions that finance part of hospital care (in addition to the direct state budget). This mechanism has helped to ease pressure on the public budget in times of economic crisis, especially from the end of the 1980s.

b) Financing by social contributions

- The financing of the Bismarckian system is based on social contributions, which is to say that it is the **employers** and **employees** who finance the system through **deductions from salaries.**
- This method of financing, which directly links the ***health system*** to the ***labor market,*** is based on the principle of **professional solidarity** ; contributions are calculated according to income, which allows for a **redistribution of solidarity** between those who work and those who temporarily do not have access to employment or who are ill.
- **ALGERIAN EXAMPLE:** The Algerian social security system is mainly financed by **contributions from salaried workers.** However, a **reform in 1983** expanded social security coverage to include almost the entire population, with the notable exception of unemployed adults.
  - In 1983, the system was thus modified to include **non-salaried workers** (farmers, artisans, traders, and other independent professions) within the framework of the National Social Security Fund for Non-Salaried Workers (CASNOS), allowing them to access benefits such as health insurance and retirement.
  - In addition to the self-employed, the reform has made it possible to include other vulnerable social groups such as **students** and **people with disabilities.** These groups now benefit from social benefits without necessarily contributing to the financing through contributions.
  - For a long time, unemployed adults were practically the only ones excluded from the social protection system. However, the recent introduction (March 2022) of an **unemployment benefit** now allows **unemployed young people** (19 to 40 years old) to obtain minimal protection in terms of health

and social benefits. This system aims to fill (in part) a significant gap in the Algerian social system that previously discriminated against this category of the population.

c) Mixed regulation (State and social partners)

- The regulation of the Bismarckian system is mixed, involving both the **State** and the **social partners** (workers' unions and employers' representatives). This collaboration allows for **management that is closer to economic and social realities,** because it takes into account the needs of workers while integrating economic considerations.
- **ALGERIAN EXAMPLE:** In Algeria, although the State plays a central role in the management of the social protection system, there is also an **indirect (but extremely limited) involvement of social partners** (workers' unions and employers' representatives) in some reforms aimed at improving the efficiency of the system. However, the involvement of the latter in the management of the system remains limited to **occasional consultations** or discussions **during tripartite meetings.** Unlike in other Bismarckian countries where unions and employers play a direct role in the management of health insurance or pension funds (as in Germany), in Algeria, these actors do not have significant decision-making power, and **the State retains a strong hold on the system.**

4.3.2. Representative countries

- The Bismarckian model is adopted in several European countries: **Germany, Belgium, France, Luxembourg, Netherlands,** etc.
- Algeria has also adopted this model to structure its health and social protection system. However, the Algerian system is distinguished by **strong state intervention.** Although social contributions finance part of the system, the State plays a central role in **the management and financing of public health institutions.** Since the 1970s (with the policy of free care introduced in 1974) and especially with the major reform of 1983, the country has also undertaken a series of adjustments to **extend social coverage to a larger part of the population** : self-employed workers, students, disabled people, etc. and, most recently, to unemployed young people receiving unemployment benefits. These successive adjustments aim to fill the intrinsic limits of the system in order to **ensure universal access to care.** Indeed, the Bismarckian socialized model was mainly intended for salaried workers, and thus

only covered a limited part of the active population, excluding many social categories, notably non-salaried workers and the unemployed.

- All these countries have **adapted the model to their national contexts** while retaining its fundamental principles: financing by social contributions, public provision of care and regulation more or less shared between the State and social partners.
- The **Bismarckian socialized model** has distinctive features that bring considerable benefits in terms of social protection, but also structural challenges, particularly in terms of financial sustainability.

4.3.3. Advantages of the Bismarckian Model

a) Equity in access to care

- One of the main strengths of the Bismarckian model is its commitment to equity. Through a financing system based on **income-related social contributions,** it guarantees access to care for the entire population, regardless of income or employment status.
- **Solidarity principle** : Contributions are calculated based on income, allowing the wealthiest to contribute more while ensuring that the most vulnerable benefit from comprehensive coverage.
- **ALGERIAN EXAMPLE:**
  - ✓ In Algeria, contributions are levied on workers' salaries, allowing the health system to be financed. Although the system is historically linked to salaried work, the Algerian state has **expanded coverage** to include almost the entire population today.
  - ✓ This ensures that even those who are not directly affiliated to the labor market benefit from social protection, thereby guaranteeing access **to basic care for its entire population,** regardless of income or professional status.
  - ✓ Thus, a series of reforms allowed an **extension of social coverage** to other social groups beyond the classic Bismarckian model, ensuring that even those who did not contribute (such as students, people with disabilities and the young unemployed) could benefit from medical care.
  - ✓ In addition, Algerian public hospitals provide **free healthcare to all citizens,** which allows for a certain basic universal coverage. For example, informal workers – who do not contribute – benefit from medical care at the level of hospitals and EPSPs, and can thus receive treatment without having to pay directly for consultations or medications.

b) Broad population coverage

- **The** Bismarckian model provides **extensive social protection,** covering a large part of the population, including salaried workers, the self-employed and sometimes even the unemployed. This broad coverage contributes to **social cohesion** and the overall improvement of public health.
- **Near-universal protection** : Although based on wage labor, the system has expanded in several countries to include other social categories, thus guaranteeing near-universal coverage.
- **ALGERIAN EXAMPLE:**
  - ✓ The Bismarckian model in Algeria ensures **extensive social protection,** covering not only salaried and self-employed workers, but also **certain vulnerable groups** (students, disabled people, young unemployed people). This broad coverage contributes to **social cohesion** and **the overall improvement of public health**.
  - ✓ The National Social Insurance Fund (CNAS) covers not only employees but also their **dependents (spouse and children),** thus ensuring protection for the whole family. In addition, the National Social Security Fund for the Self-Employed (CASNOS) allows **self-employed workers** (farmers, shopkeepers, craftsmen, etc.) to access similar coverage.

4.3.4. Disadvantages of the Bismarckian Model

a) Risk of social security deficit

- Despite its advantages, the Bismarckian model faces a major challenge: the **risk of a financial deficit** in the social security system. This risk is fueled by several structural factors:
  - ✓ **Aging population** : As the number of elderly people increases, pension and health care costs increase significantly. Retirees pay less into the system while requiring more care.
  - ✓ **Increase in chronic diseases** : Chronic diseases such as diabetes, cardiovascular diseases and cancers require lengthy and costly treatments, putting additional pressure on public finances.
  - ✓ **Costly technological advances** : Medical advances (innovative technologies, innovative drugs) improve the quality of care but also increase costs. These medical innovations can be very costly for the system, especially if they quickly become indispensable.

b) Dependence on the labor market

- The Bismarckian model is financed mainly by social security contributions directly deducted from workers' incomes. This structure leads to **considerable dependence on the labor market**. As a result, problems can arise in economies with **high unemployment** or when **a significant proportion of workers operate in the informal sector.**
- **ALGERIAN EXAMPLE:** In Algeria, a significant portion of the working population works in the **informal sector,** meaning that they do not contribute to the social security system. This **reduces the contributory base** and puts additional pressure on public finances to compensate for this shortfall.

IN CONCLUSION, the Bismarckian model embodies a **compromise between *collective solidarity* and *individual freedom of choice*.** However, it must constantly face **financial challenges** related to demographic aging, the increase in chronic diseases and the increasing costs related to technological advances. The central question remains that of the **long-term sustainability of the model,** which requires proactive management and regular reforms to avoid financial collapse while maintaining universal access to care.

The Bismarckian socialized model applied in Algeria presents several **specificities adapted to the local context.** Although based on the principle of social contributions as in other European countries, it has been **supplemented by public financing** that reflects the historical commitment of the Algerian state to vulnerable social categories. However, this model today faces several structural challenges such as:

- ⇨ inequalities **in access to care:** while large cities such as Algiers have well-equipped and accessible hospitals, some regions in the South still suffer from a lack of adequate medical infrastructure,
- ⇨ saturation **of public services** : public hospitals are often faced with overload due to high demand and a lack of human and material resources,
- ⇨ and the **financial sustainability of the social protection system** : the financing of the Algerian social protection system is mainly based on social contributions, but this model is under pressure from several factors. On the one hand, the **aging of the population** and the **increase in chronic diseases** lead to a constant increase in health expenditure. On the other hand, the high proportion of workers operating in the **informal sector** limits contributions to the social security system, as they do not contribute but still benefit from free services in hospitals and EPSP. In addition, the **dependence on oil revenues** to finance a large part of the social budget makes the system vulnerable to

international economic fluctuations. This situation poses a **risk to the financial sustainability** of the social protection system, which could become unsustainable if structural reforms are not put in place to **broaden the contributory base** and **rationalize expenditure**.

All these challenges highlight the need for Algeria to **continue its reforms** in order to avoid a lasting financial imbalance in the social protection system and **ensure its long-term financial sustainability**. Reforms are also necessary to **improve equity in access to care** and strengthen the **capacity of public services** to meet the growing needs of the population. In short, periodic adjustments are essential to adapt to demographic and economic changes in order to remain viable in the long term. Measures such as increasing **contribution rates, gradually integrating the informal sector** into the contributory system or **better management of hospital resources** could thus be considered to ensure the sustainability of the Algerian Bismarckian model.