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Social health insurance systems: Where are the incentives?

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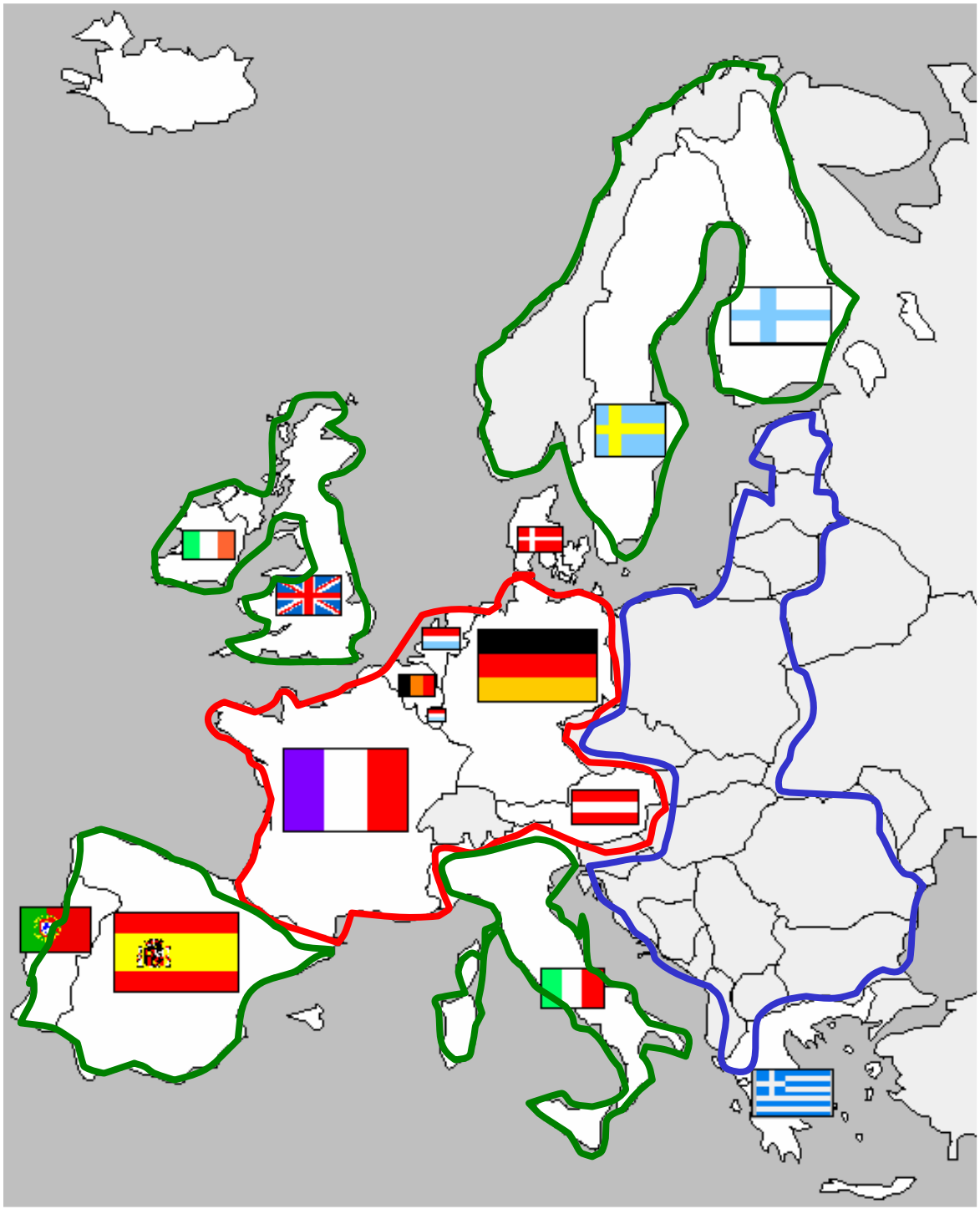
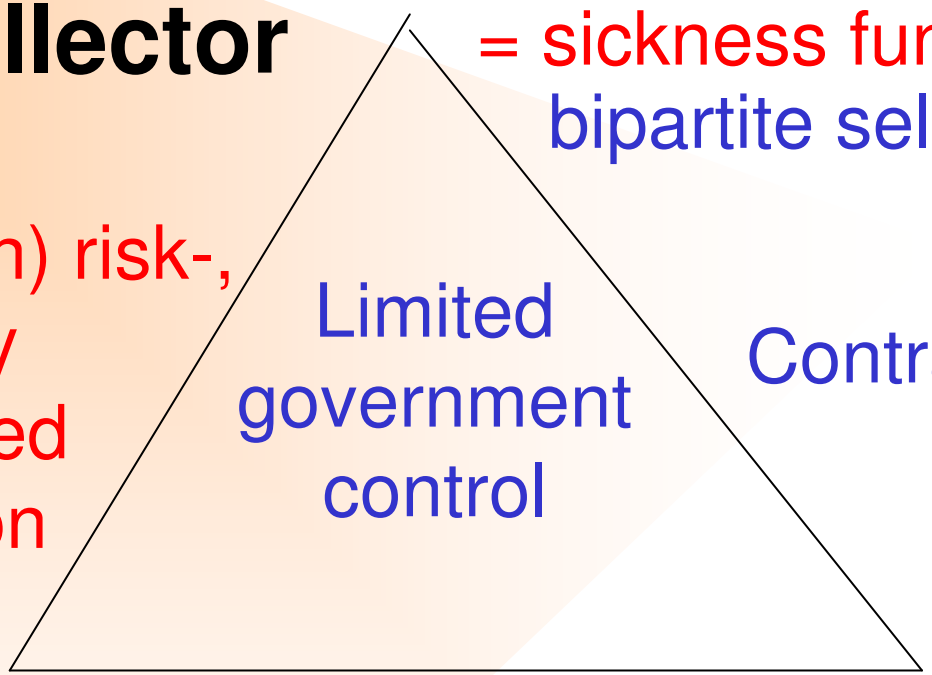
- Social health insurance countries in western Europe
- Central and eastern Europe (Semashko to SHI)
- Tax-based systems in western Europe



What makes a health system a SHI system?



Contribution collector

Not (health) risk-, but usually wage-based contribution

Third-party payer

= sickness funds

bipartite self-government

Limited government control

Contracts

Free access

Population

Mandatory insurance

Providers

Public-private mix

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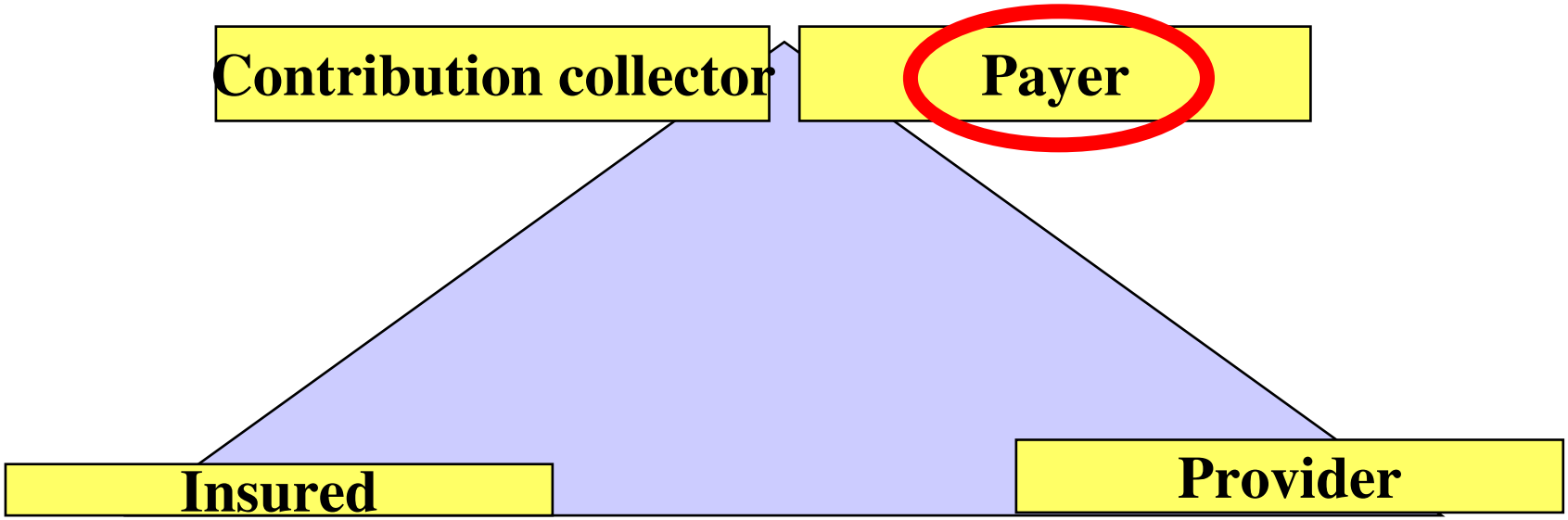
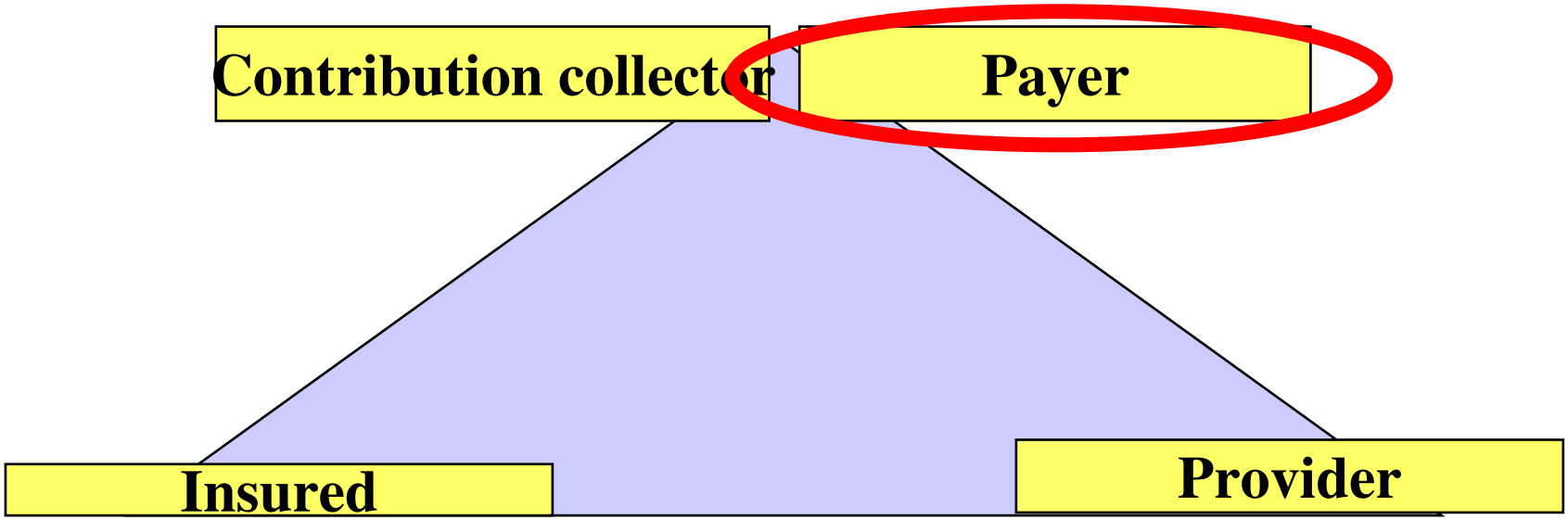


- One national monopoly fund
- Several regional monopoly funds
- Several monopoly funds organised on other principles (e.g. occupation): Austria, France, Luxembourg, Germany (-1995) and the Netherlands (-1992)
- Several funds in competition: Belgium, Germany, Netherlands, Switzerland

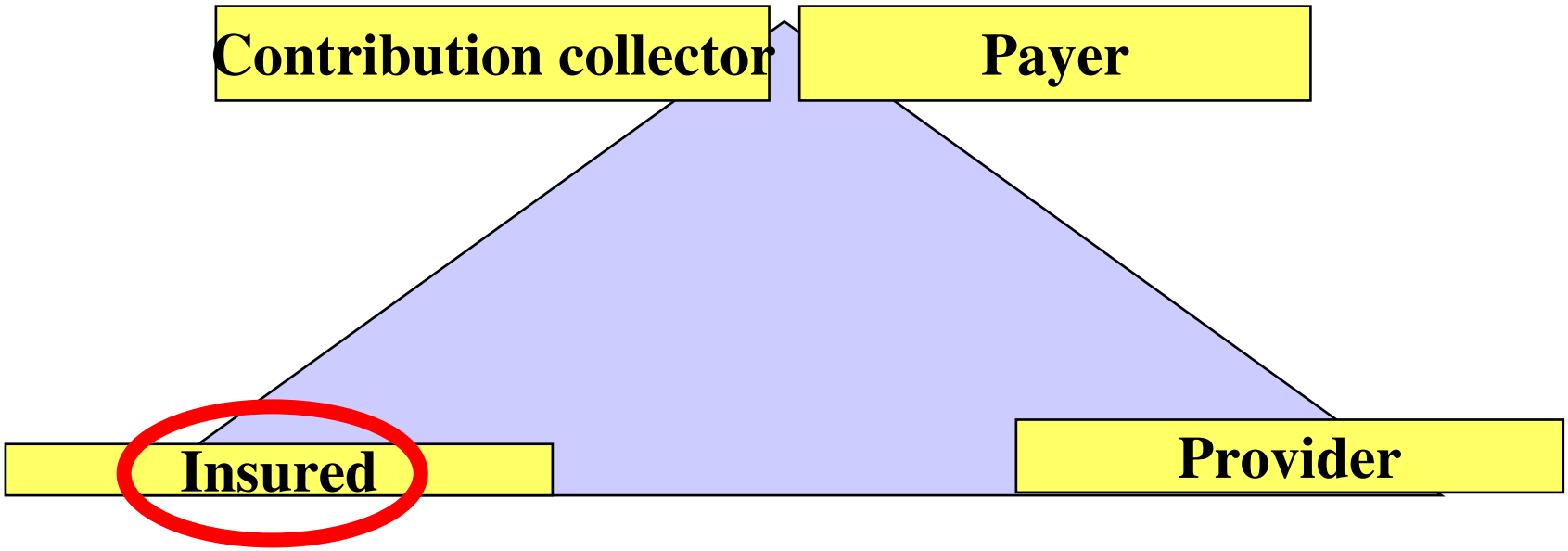


Number of sickness funds

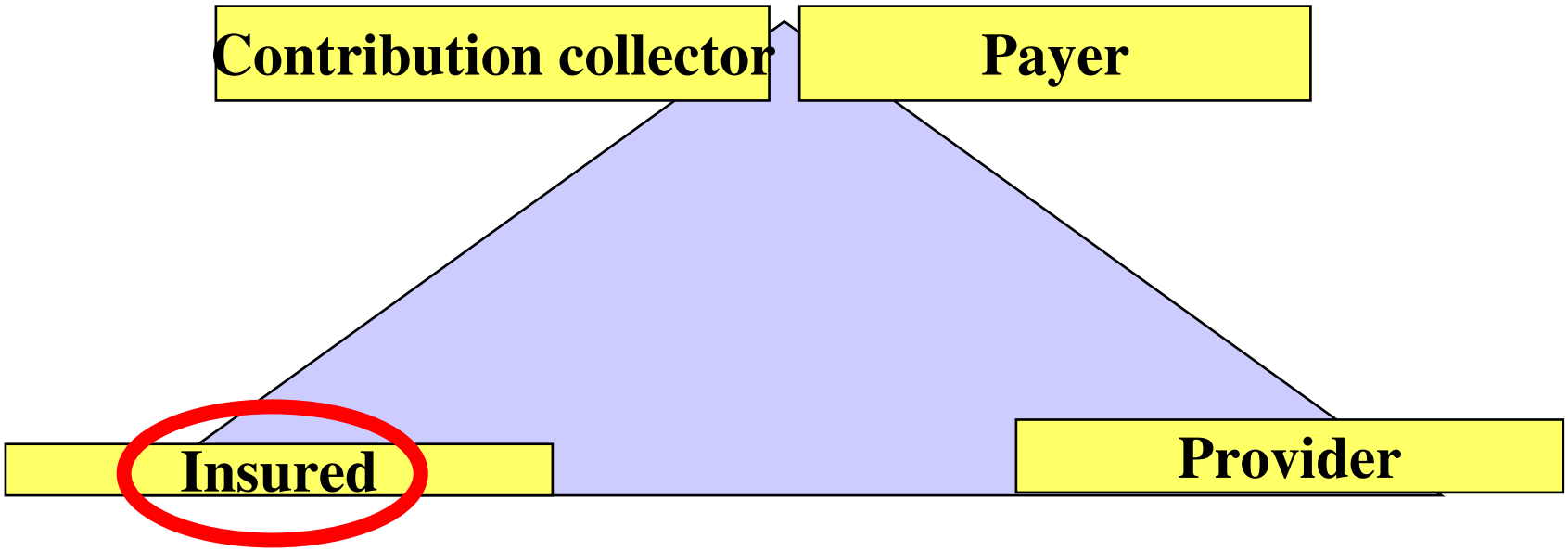
In no country complete responsibility for geographical areas = no incentive for population health!

	A	B	CH	D	F	L	NL
1992	26	127	191	1223	19	9	27
2002	24	100	93	355	18	9	24

Incentive to merge in competitive environments!

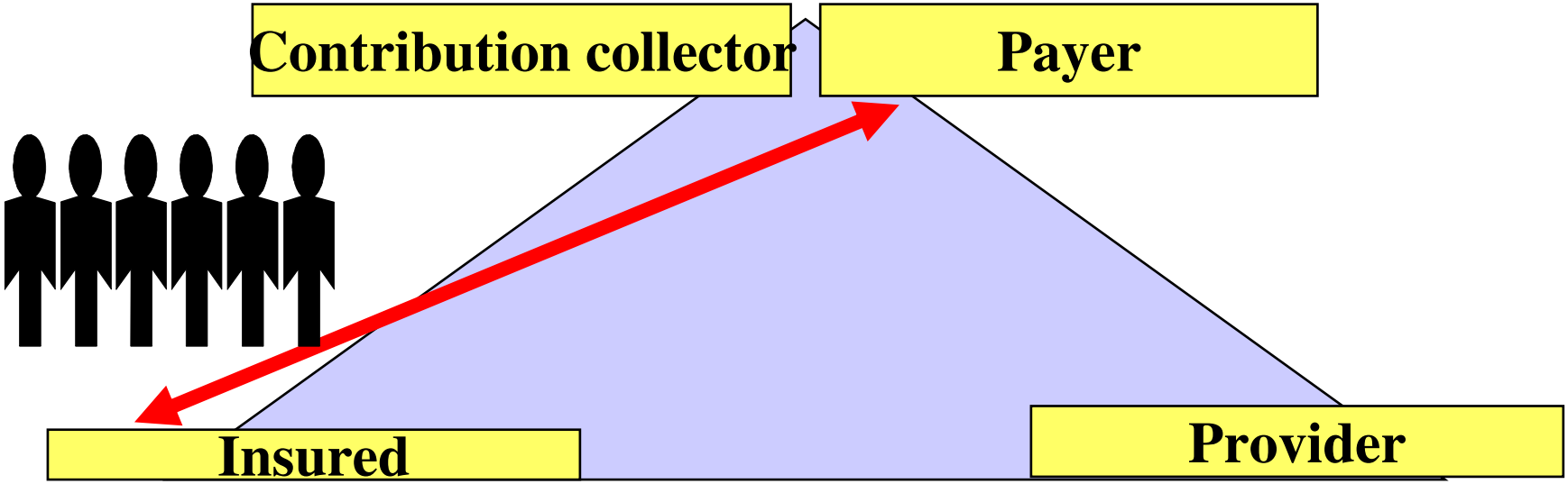


- SHI tradionally tied to employment
- later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- notion of “universal coverage“
  = very recent phenomenon

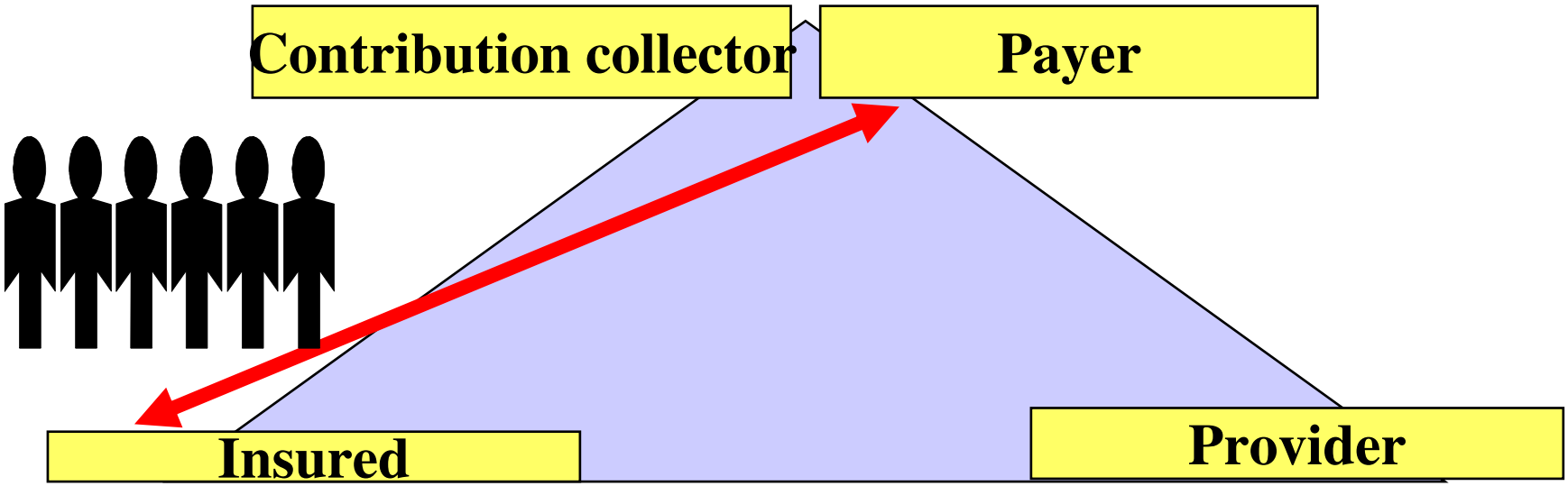


- 100% population coverage de facto in Austria and Luxembourg, legally in Belgium (since 1998), France (since 2000) and Switzerland (since 1996)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)

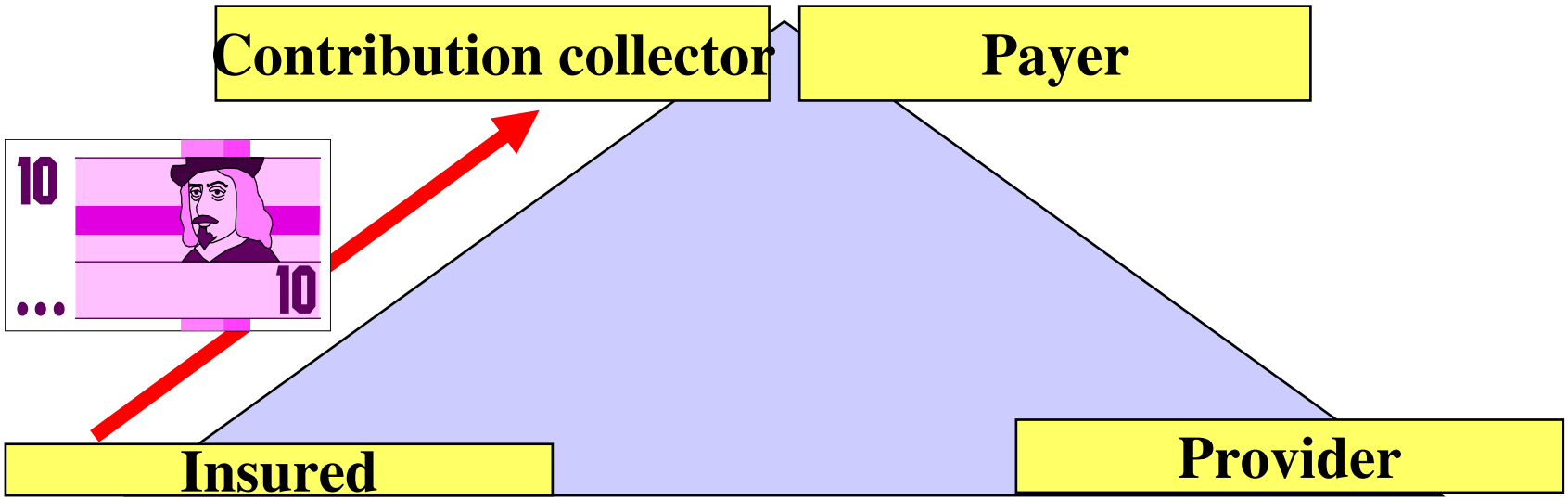
← **Clear incentives: well-earning young healthy singles = PHI; others = SHI**



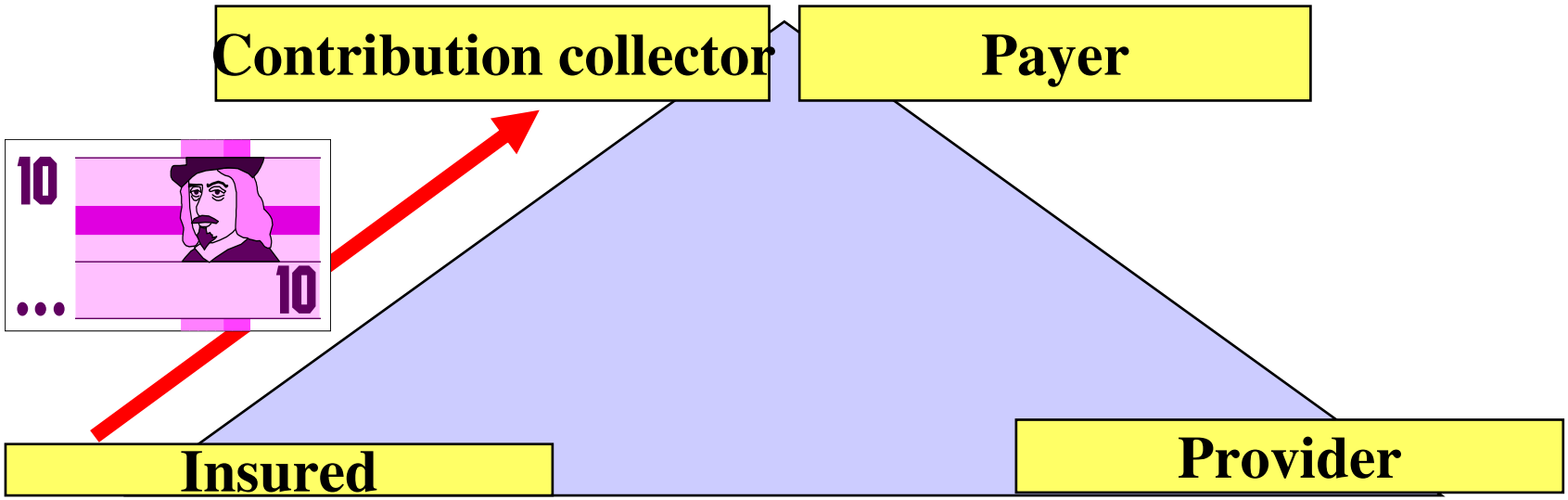
- Choice:
  pre-determined membership in Austria, France and Luxembourg = *inequity in risk-structure*;
  free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland - *the young, well-educated and healthier are changing funds more often = risk-structure de-mixes further*



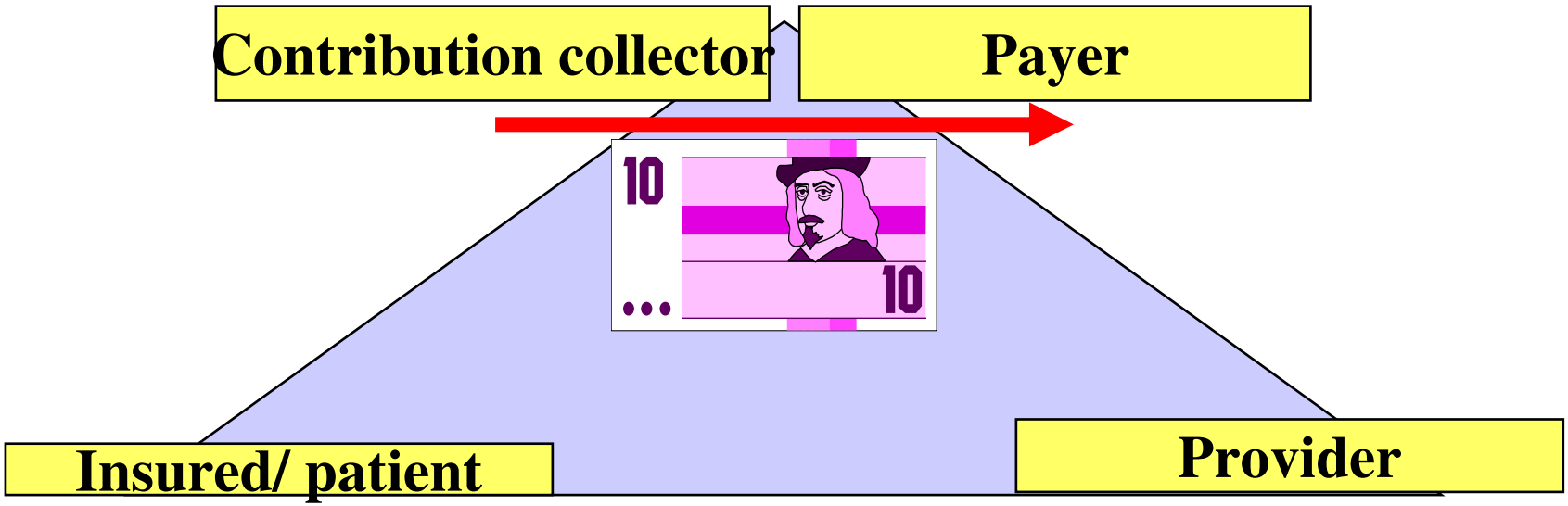
Experience has shown that sickness funds have an incentive to offer disputed services to attract (healthy) customers – not extra services for chronically ill.



- Traditionally based on wages only (and with an upper limit)
- Problem 1: increasing burden on labour costs as other income is rising faster
- Solution: broaden income base, i.e. abolish upper limit, in France change from wage-based contribution of 8.9% to tax of 8.25% on all income of insured + taxing of pharamaceutical advertising ...



- Problem 2: inequity of contributions as risk profiles differ between funds
- Traditional approach: complete pooling of contributions, i.e. funds are reimbursed from pool according to expenditure = *conflict with efficiency goal and instrument "competition"*
- Currently: *uniform* contribution rate in Austria, Belgium, France, Luxembourg and Netherlands (but differing per-capita premium on top); *differing* rate in Germany; *differing* per-capita premium in Switzerland



- New approach: prospective *allocation* of resources (Belgium, Netherlands) or *re-allocation* (Germany, Switzerland) = *incentive for sickness funds to be efficient*
- *Re-allocation is more difficult than allocation as sickness funds view money as "theirs"!*

The “risk structure compensation“ (RSC) - How does it work?

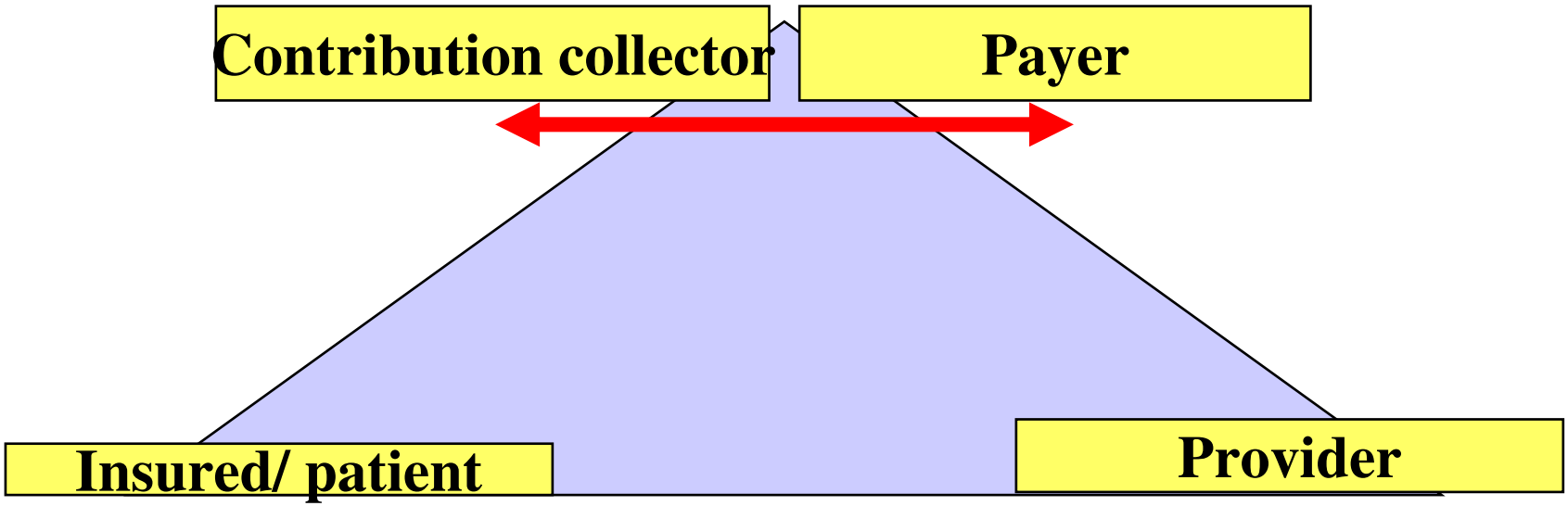
- Income-side: all wages liable to contributions are summed up across all sickness funds
- Expenditure side: “standardised“ (= average) expenditure is calculated per group of same sex, age and (in)capacity to work; total expenditure is calculated across all groups
- Total expenditure/ total income base = calculated contribution rate for RSC
- Responsible: the Federal Insurance Office

The risk structure mechanism (1998): standardised expenditure/ day (DM)

	Men (West/ East)	Women (West/ East)	Incapacitated men (W/E)	Incapacitated women (W/E)
0 y.	17,34/ 20,08	15,33/ 16,90		
5 y.	3,72/ 4,07	3,01/ 3,26		
20 y.	3,44/ 3,26	5,21/ 4,80		
35 y.	4,59/ 3,98	7,31/ 5,53	53,60/ 23,92	52,32/ 22,13
50 y.	7,99/ 6,52	8,67/ 7,47	35,17/ 29,48	31,88/ 23,72
65 y.	16,78/ 13,88	13,42/ 13,00	32,73/ 30,04	30,25/ 24,48
75 y.	21,08/ 18,57	19,47/ 16,07	**Differences within age groups are larger than between age groups (and morbidity not captured)!**	
85 y.	25,46/ 20,21	24,05/ 18,71		
90+ y.	28,46/ 19,63	25,52/ 18,19		

x 12

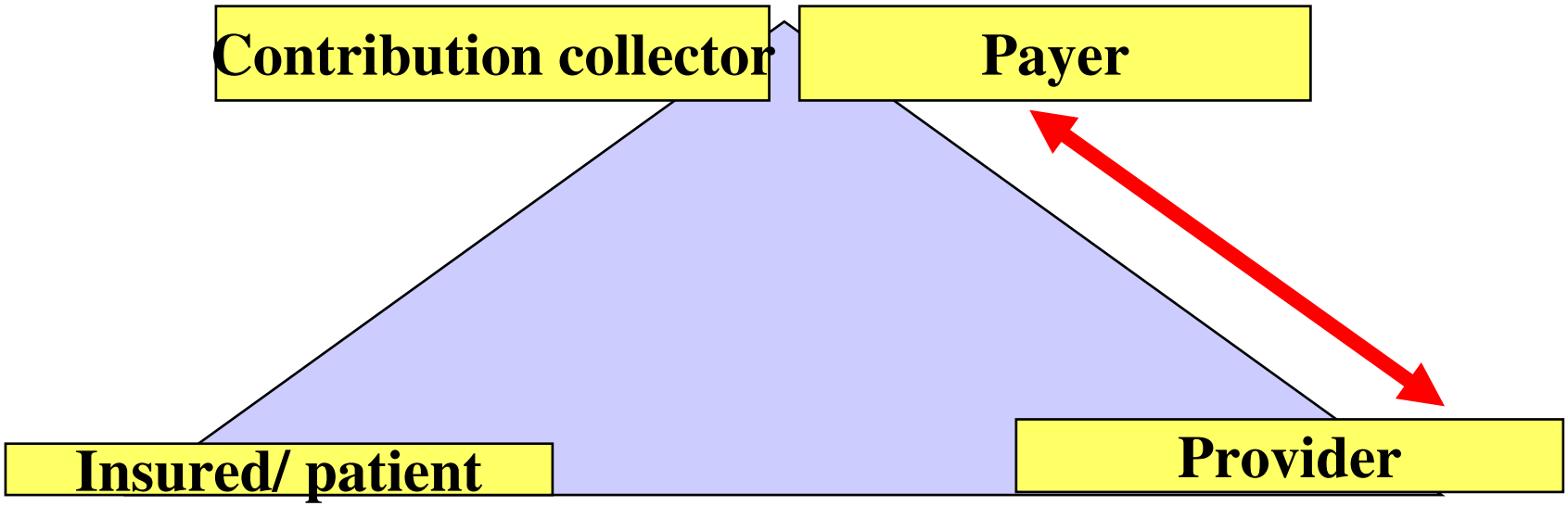
x 8



- Main problem with all risk adjustment formulae: included factors explain only a small part of variation as (costly) morbidity is not captured,

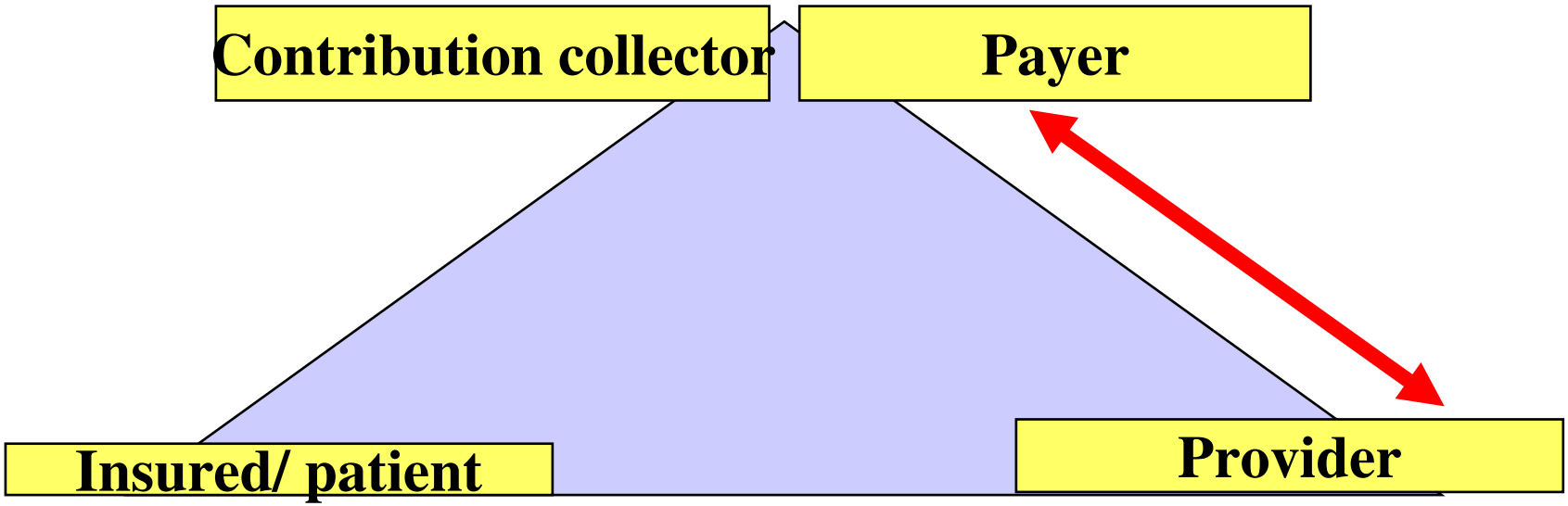
  i.e. sickness funds with a high share of chronically ill are disadvantaged - or:incentive to "cream-skim" is stronger ("be third best for chronically ill")

- Most innovative approach: to tie risk adjustment to inscription into disease management programmes *– but high administrative hurdles which make DMPs uniform*



- all SHI systems are traditionally multi-payer/ multi-provider systems – problem: weak cost-control
- traditional solution: collective contracts (Germany, Netherlands) – problem: contradicts competition
- new approach in the Netherlands (and Germany?): collective contracts are illegal –

  but: funds cannot apply selective conditions due to 24h-cover for GP care and scarcity of specialists



- new approach in Austria and France: hospital reimbursement is done jointly at regional level
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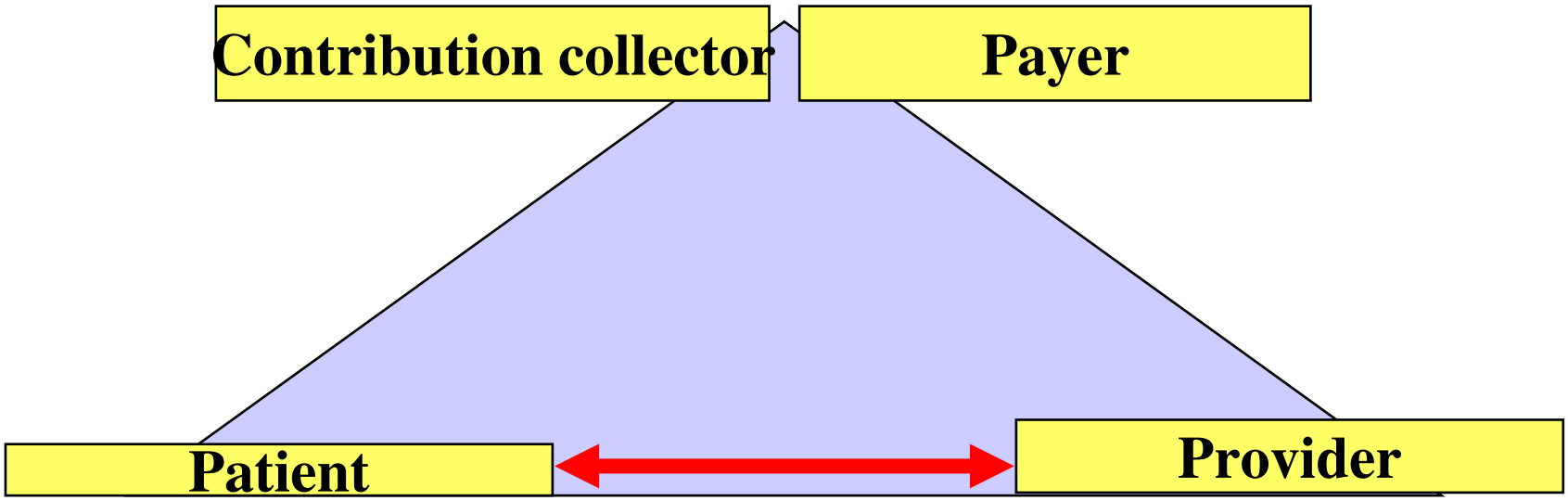
- disea *provi ctors!*

Contradicts logic of competition (at least in multi-payer systems without regional strongholds) – or leads to monopolies!



- Free access = feature of SHI systems (except NL); Gatekeeping: may be more effective and cheaper, but is also less popular: *in Switzerland, mainly healthy inscribed to GP-led care programmes (for premium rebate) – until the largest insurer, Helsana, terminated all contracts in June 2002!*

In conclusion,

- SHI systems have survived a long time incl. wars, mega-inflations, political transformations – and remain popular with the citizens.
- However, they are facing mounting problems, partly due to a imbalanced income/ expenditure base, partly due to the relatively weak steward-ship role for government.
- In this conflict, “more government“, “competition“ and “special focus to provide continuous care for chronically ill“ are used – but they two often contradict each other, i.e. provide very different incentives!

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Presentation available at:

http://mig.tu-berlin.de

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