Technische Universität Berlin

Social health insurance – an introduction

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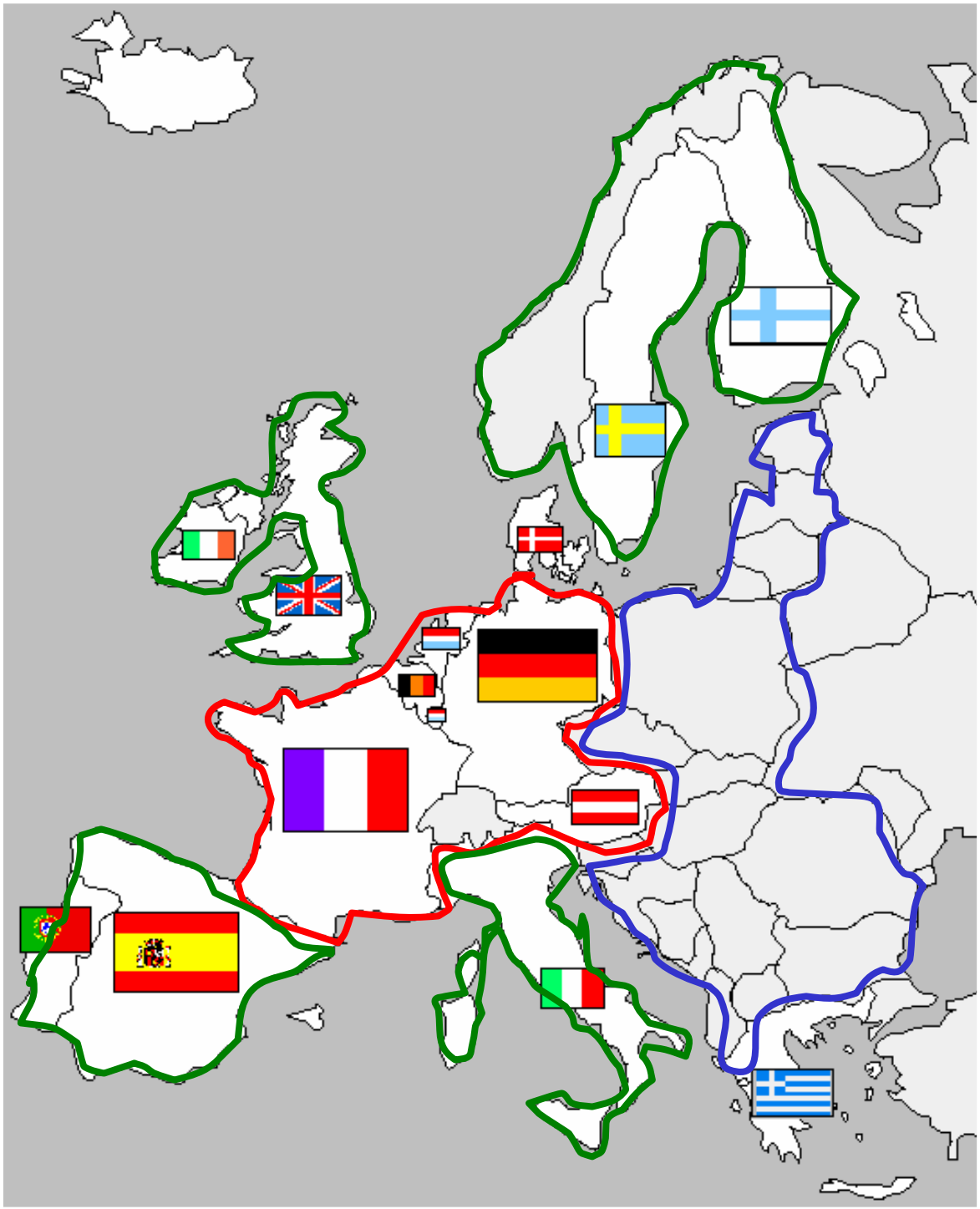
- Social health insurance countries in western Europe
- Central and eastern Europe (Semashko to SHI)
- Tax-based systems in western Europe

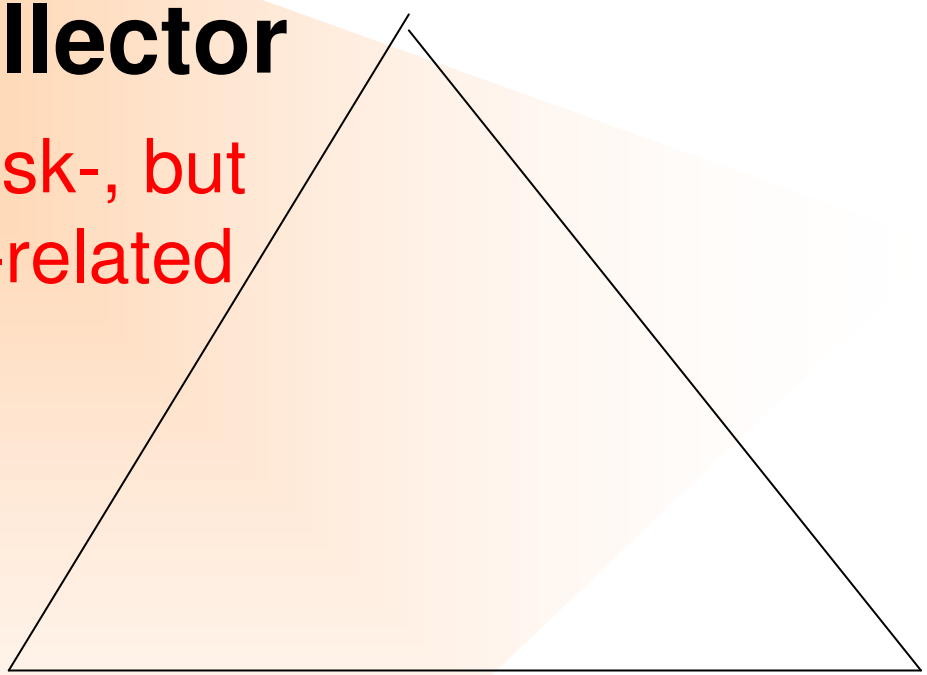


What makes a health system a SHI system?

Contribution collector

Third-party payer

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



Population

Providers

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Different ways to fund health care

- Taxes on income (usually progressive) and on goods and services (VAT; proportional):
  not earmarked, no link to benefits = NHS
- Contributions on income (proportional; often only on wages, sometimes capped = regressive):
  earmarked, weak/ no link to benefits = SHI
    - *Fixed premium per head: „community rating“*
- Premiums depending on age, sex, pre-existing illness etc. (usually regressive): earmarked, link to individual benefits = PHI
    - *Out-of-pocket*

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What makes a health system a SHI system?

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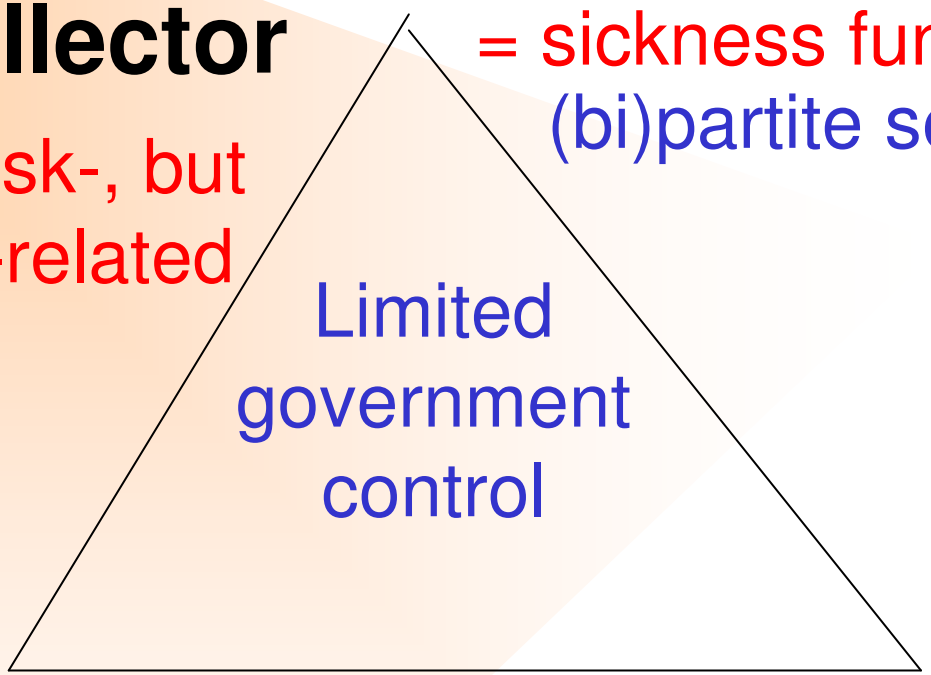
Not (health) risk-, but usually wage-related contribution

Third-party payer

= sickness funds

(bi)partite self-government



Population

Providers

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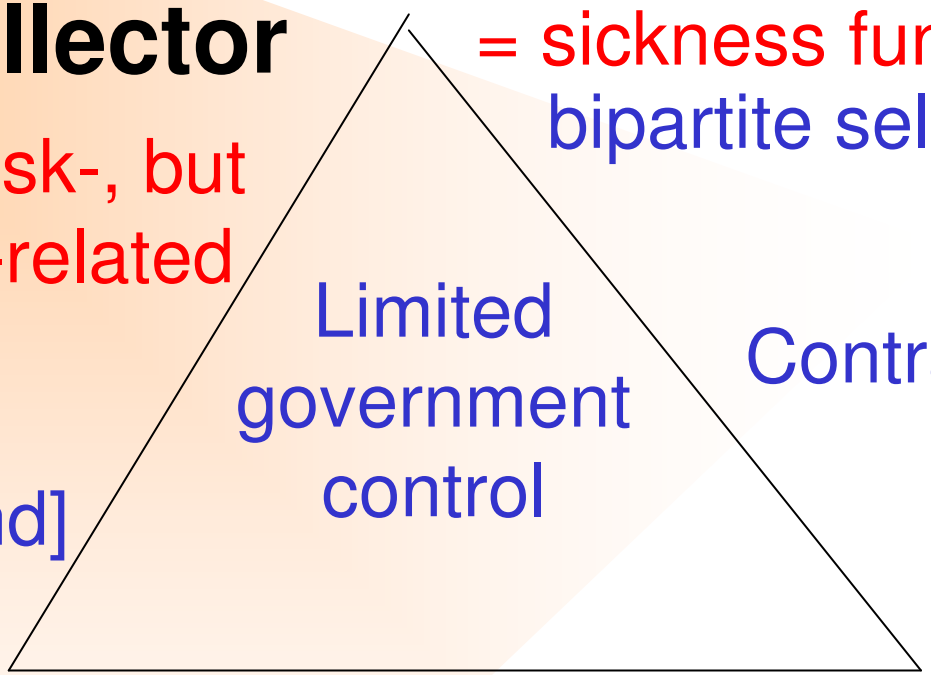
Principal organisational forms of sickness funds

- One national monopoly fund: e.g. Hungary
- Several regional monopoly funds: e.g. Bosnia
- Several monopoly funds organised on other principles (e.g. occupation): e.g. Austria, France, Luxembourg
- Several funds in competition: e.g. Belgium, Czech Republic, Germany, Netherlands, Switzerland
    - *Bi-partite: self-government is shared between employers and employees – government supervises (tri-partite = government participates directly)*

What makes a health system a SHI system?



Contribution collector

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

[Choice of fund]

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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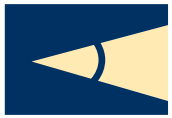
Other SHI system characteristics

- ***Solidarity:*** set of four cross-subsidies on the funding side (healthy to sick, well-off to less-well-off, young to old, and individuals to families) that provide equal benefits on the entitlements side.
- ***Pluralism:*** a complex mix of different public, quasi-public, not-for-profit, and sometimes for-profit actors.
- ***Participation:*** shared governance among these actors, sometimes described as "self-regulation".
- ***Choice:*** insurees' ability to select among contracted providers and, in some countries, among different sickness funds.

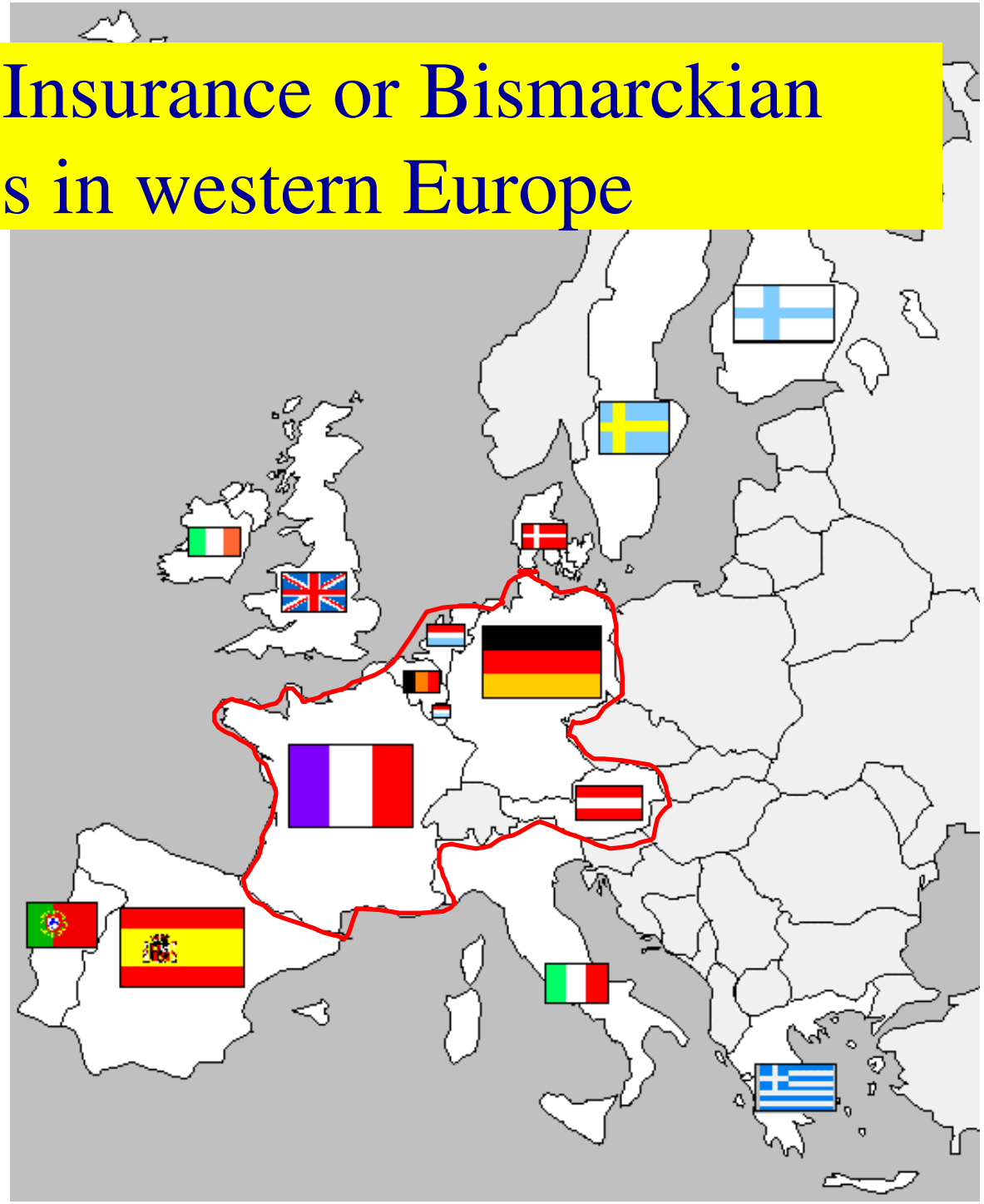


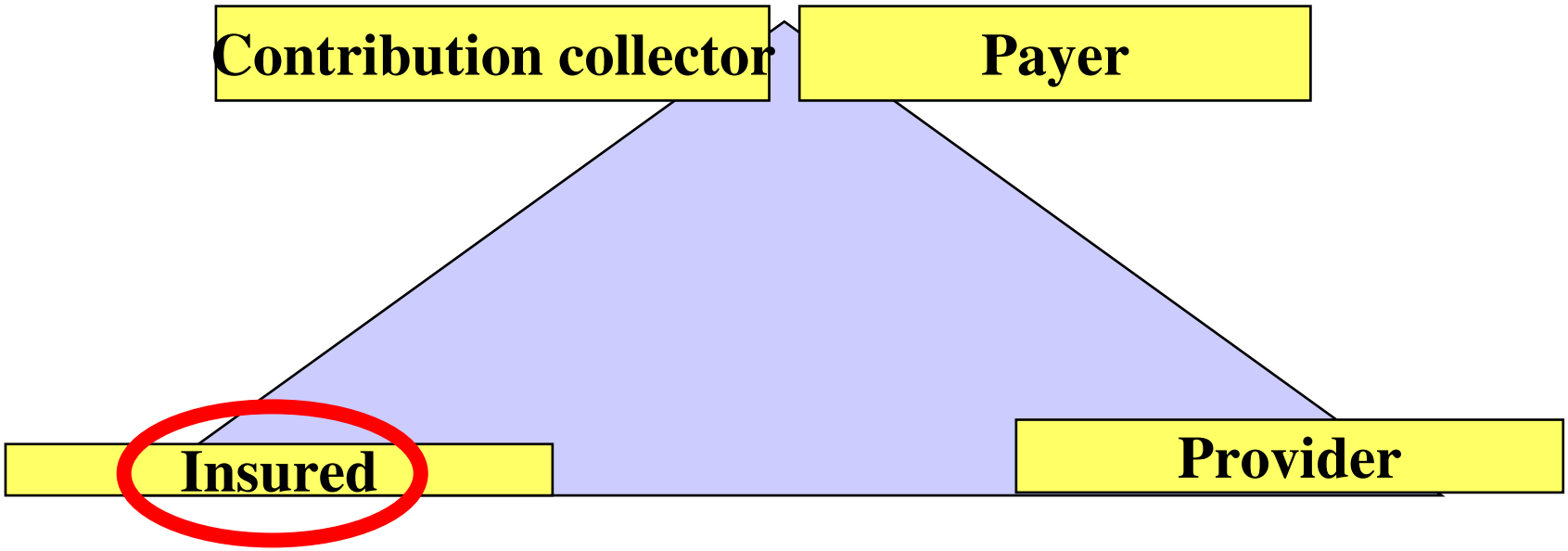
Stewardship and accountability

- Stewardship role for government complicated as major health care responsibilities are in the hands of sickness funds
- Sickness funds should be (and usually are) accountable, but only to their insured and regarding the benefits covered (i.e. no broad public health perspective)

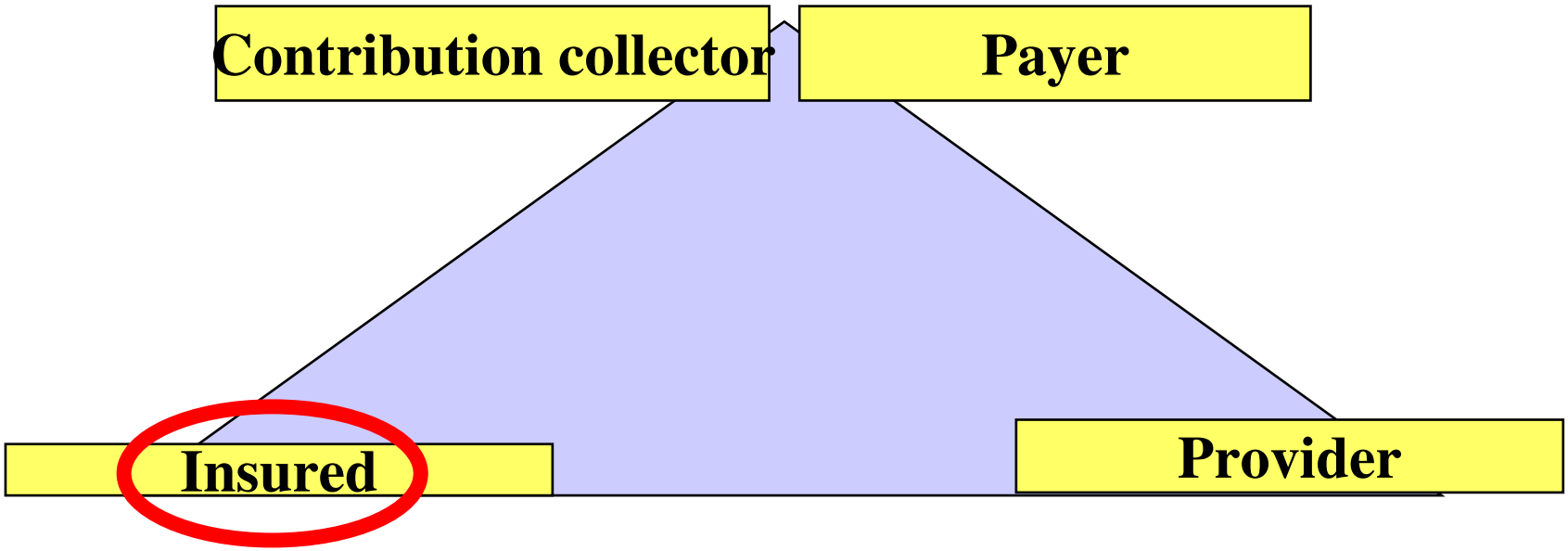
Social Health Insurance or Bismarckian countries in western Europe

Commonalities and variations between countries

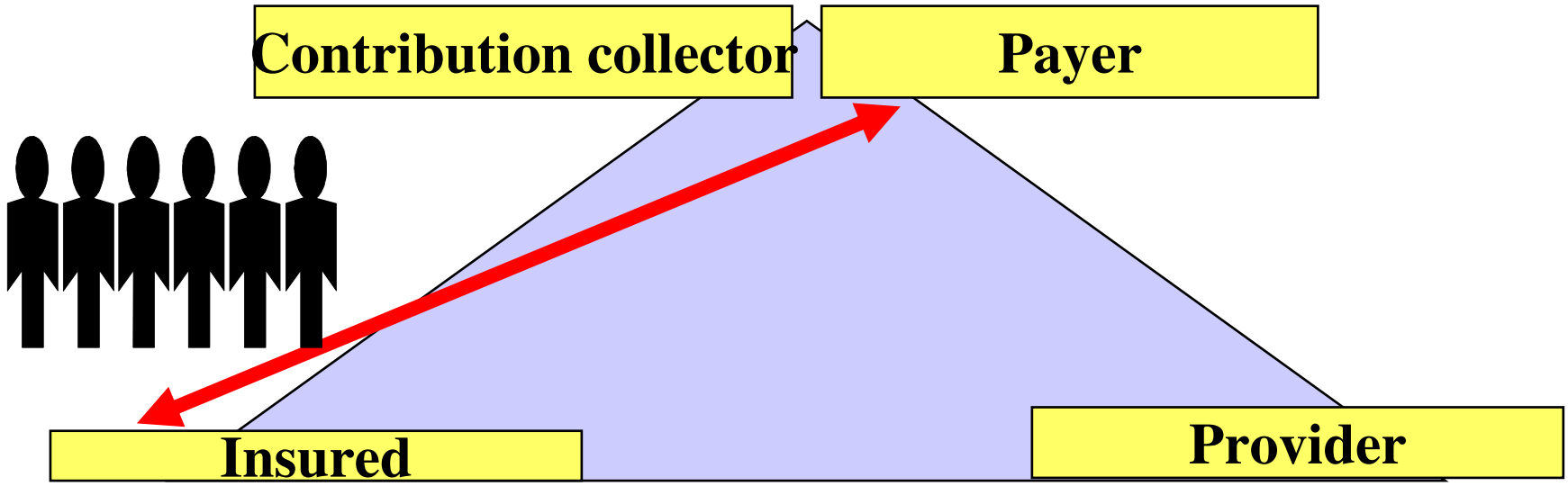




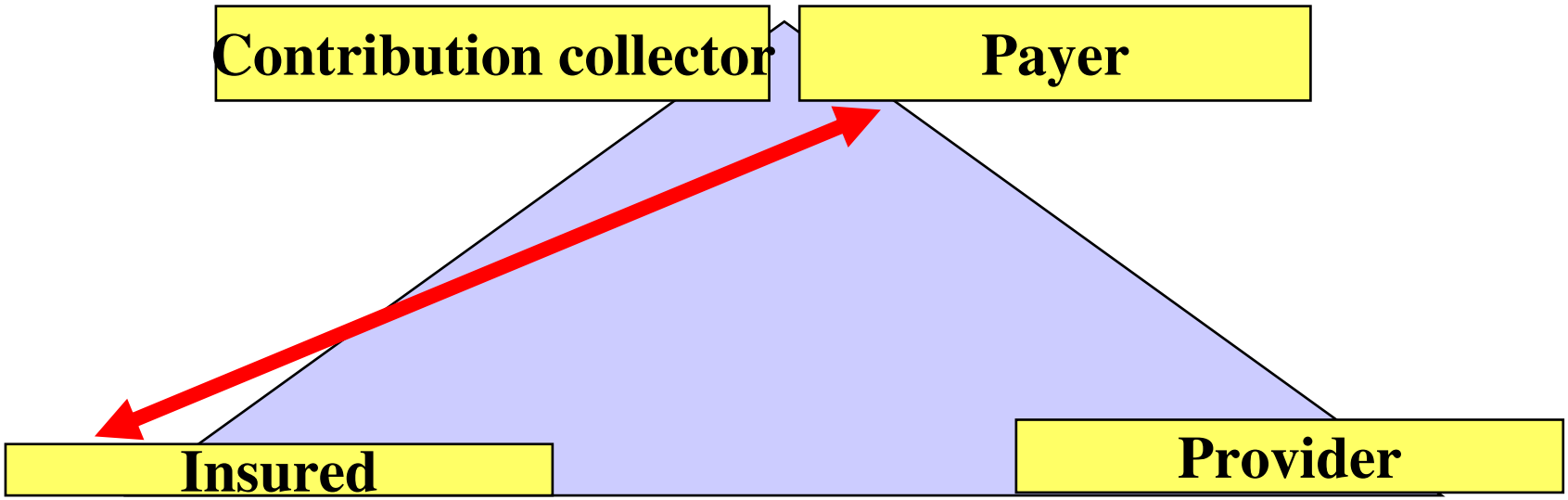
- SHI tradionally tied to employment
- later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- no exclusion due to health status, but
- notion of “universal coverage“
  = very recent phenomenon



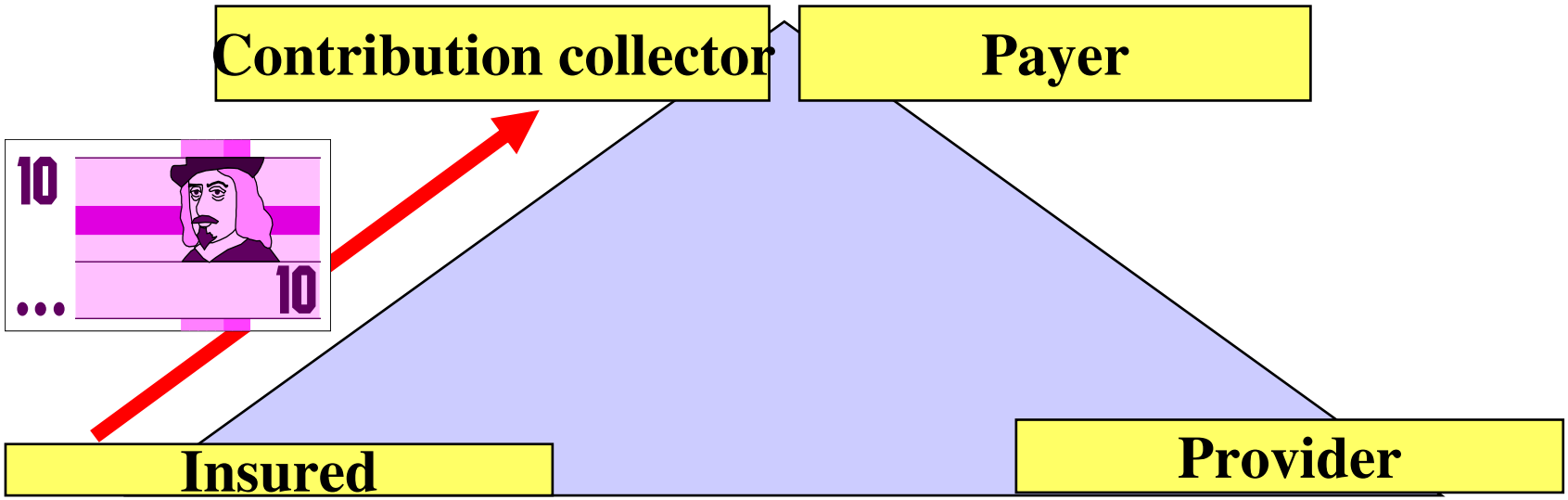
- 100% population coverage de facto in Austria and Luxembourg, legally in Belgium (since 1998), France (since 2000) and Switzerland (since 1996)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



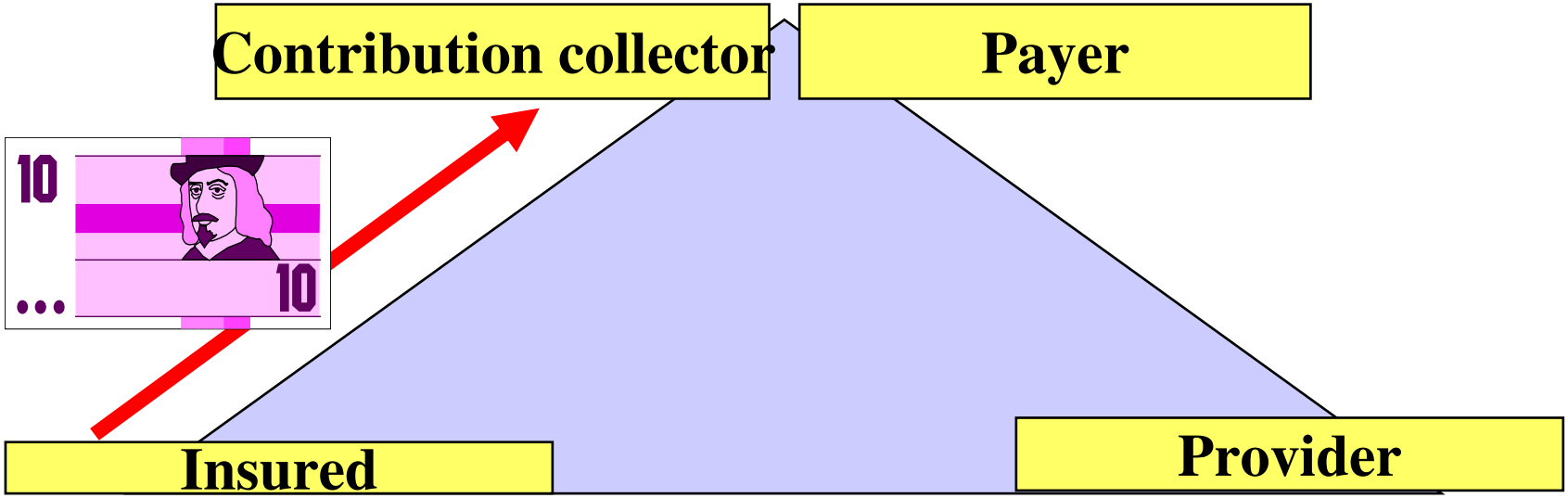
- Issue 1 – Choice: *pre-determined* membership in Austria, France and Luxembourg;
  free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland - *the young, well-educated and healthier are changing funds more often, i.e. risk-structure de-mixes!*



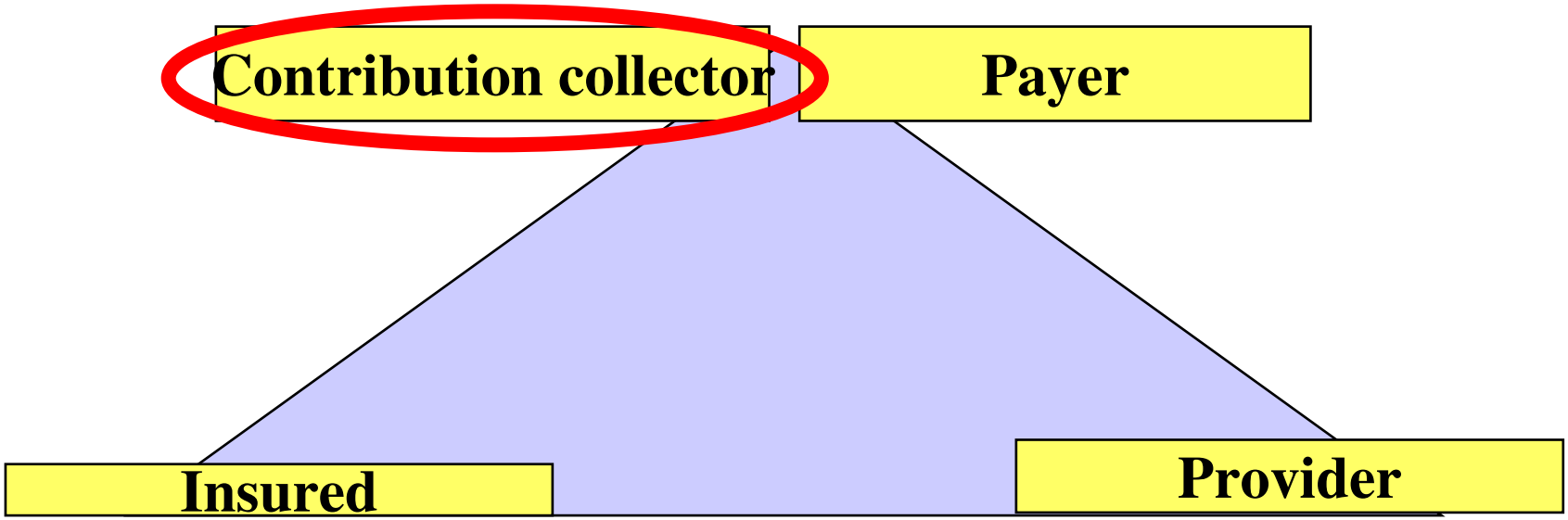
- Issue 2 – Benefits included: traditionally focused on acute care,
  partly extended to *preventive services* (mostly individual, problems with collective services!)
  and extension to *long-term care* e.g. in Germany from 1994 (through separate social insurance)



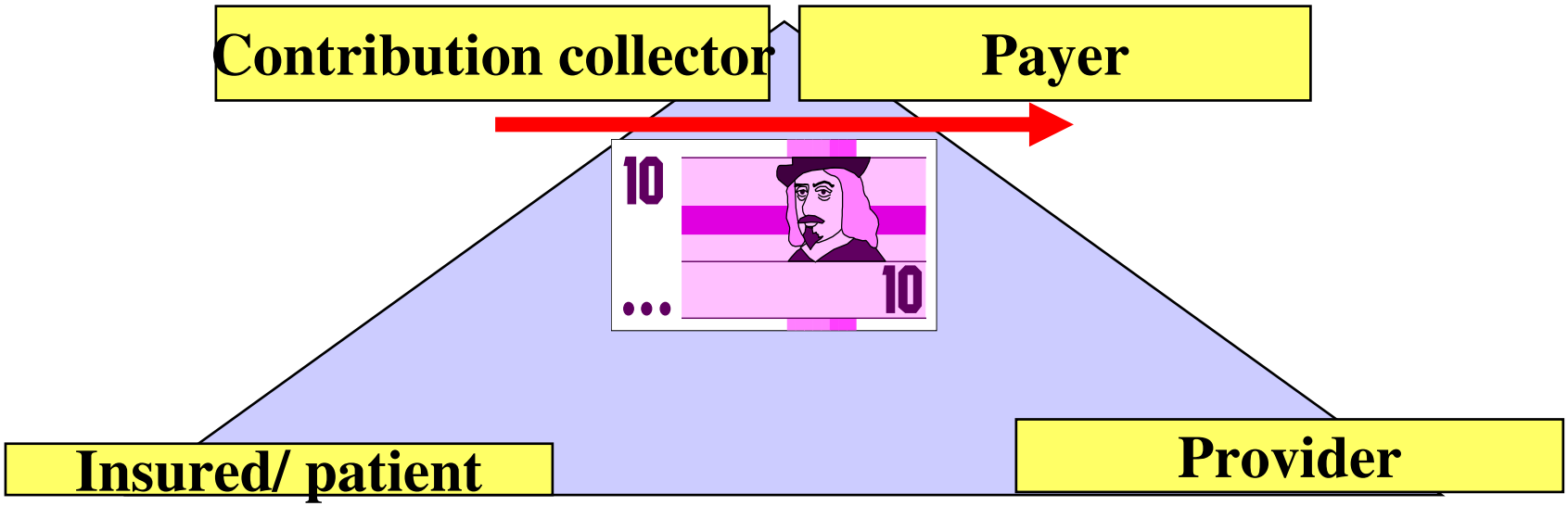
- Traditionally based on wages only (with an upper limit)
- Problem 1: increasing burden on labour costs as other income is rising faster
- Solution: broaden income base, e.g. by abolishing upper limit (Belgium, France)
- in France change from wage-based contribution of 8.9% to tax of 8.25% on all income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



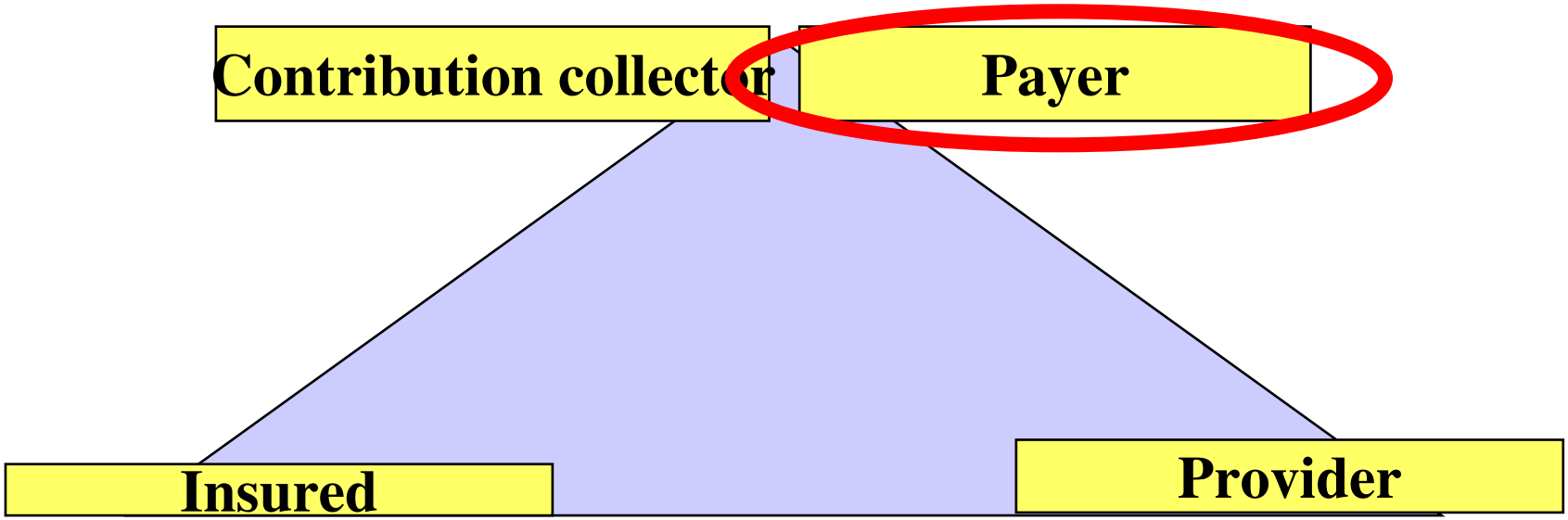
- Problem 2: inequity of contributions as risk profiles differ between funds
- Traditional approach: complete pooling of contributions, i.e. funds are reimbursed from pool according to expenditure
- = conflict with efficiency goal and instrument “competition“
- Currently: *uniform* contribution rate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



- Governmental agencies (Belgium, France, Netherlands)
- Union of sickness funds (Luxembourg)
- Individual sickness funds (Austria, Germany, Switzerland)



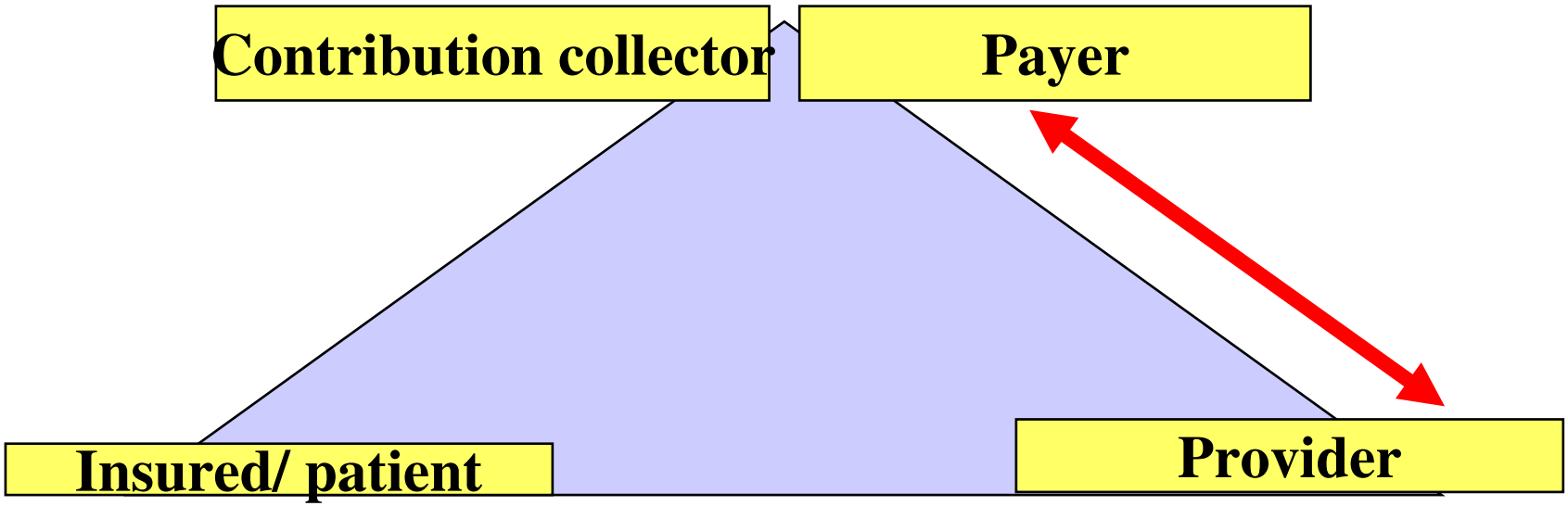
- new approach: prospective allocation of resources (Belgium, Netherlands) or re-allocation (Germany, Switzerland) – *the latter is more difficult as sickness funds view money as "theirs"*
- differences in: area of allocation - nation vs. region (Switzerland), degree of retrospective compensation, factors in the formulas (e.g. region in NL), types of expenditure included, use of high-risk pool



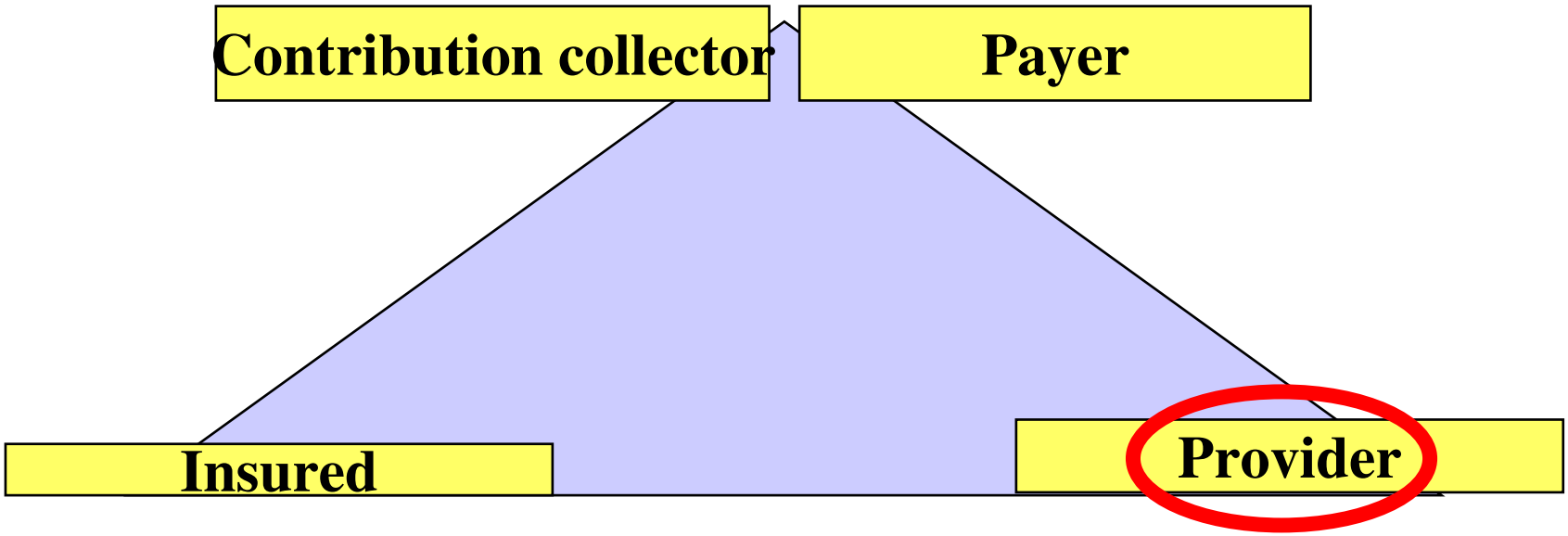
Number of sickness funds

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

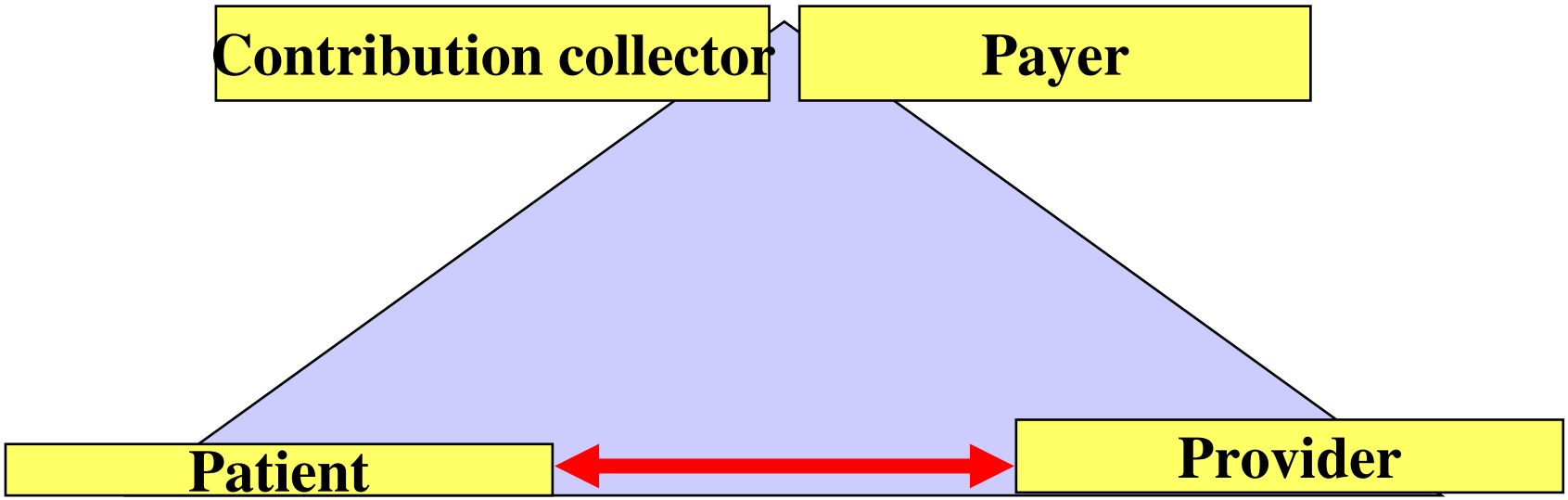
* typical bi-partite government



- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts will be illegal – but: funds hardly use selective contracts and reimbursement at lower than maximum rates

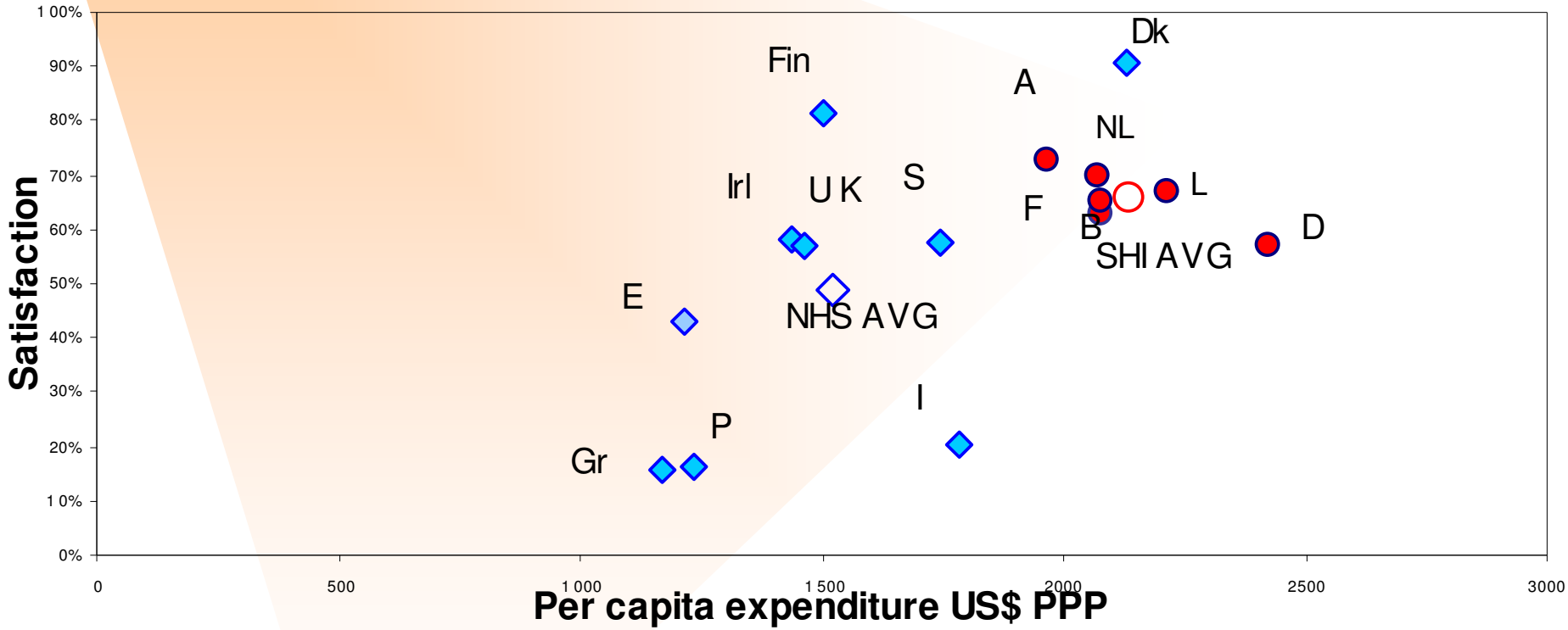


	Public	Not-for-profit	For profit
Austria	69%	26%	5%
Belgium	60%	40%	
France	65%	15%	20%
Germany	55%	38%	7%
Luxembourg	50%	50%	
Netherlands		100%	



- Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular (also in NL)
- Attempts in the Netherlands to separate “core” benefits from others (to be paid for privately) has failed: dental care was partly re-introduced; not covered services make up only 3% of expenditure

Health care spending and population satisfaction with health care system



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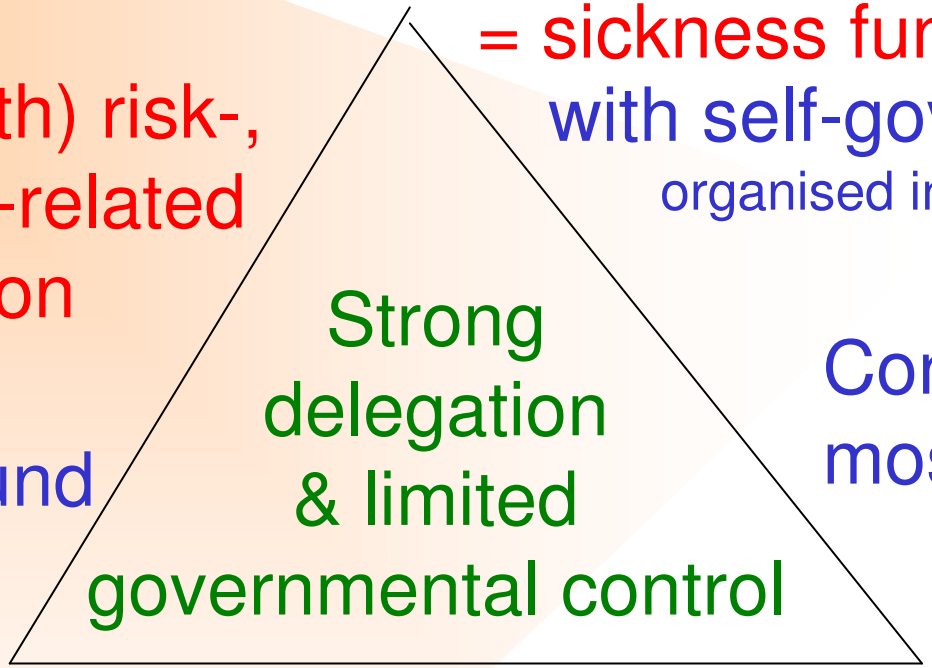
Reallocation in Germany

More information and full report available at: www.observatory.dk

Contribution collector + Third-party payer



Population

Mandatory SHI for 75%, open for others

Providers

Public-private mix,
organised in associations

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The “risk structure compensation“ (RSC)

- sickness funds = contribution collectors;
- therefore re-distribution of money is more difficult than in all other countries as
- 1. funds look at contributions as “theirs“
- 2. both income of funds and expenditure due to differences in sex, age, morbidity etc. vary.

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 J.	17,34/ 20,08	15,33/ 16,90		
5 J.	3,72/ 4,07	3,01/ 3,26		
20 J.	3,44/ 3,26	5,21/ 4,80		
35 J.	4,59/ 3,98	7,31/ 5,53	53,60/ 23,92	52,32/ 22,13
50 J.	7,99/ 6,52	8,67/ 7,47	35,17/ 29,48	31,88/ 23,72
65 J.	16,78/ 13,88	13,42/ 13,00	32,73/ 30,04	30,25/ 24,48
75 J.	21,08/ 18,57	19,47/ 16,07	**Differences within age groups are larger than between age groups!**	
85 J.	25,46/ 20,21	24,05/ 18,71		
90+ J.	28,46/ 19,63	25,52/ 18,19		

x 12

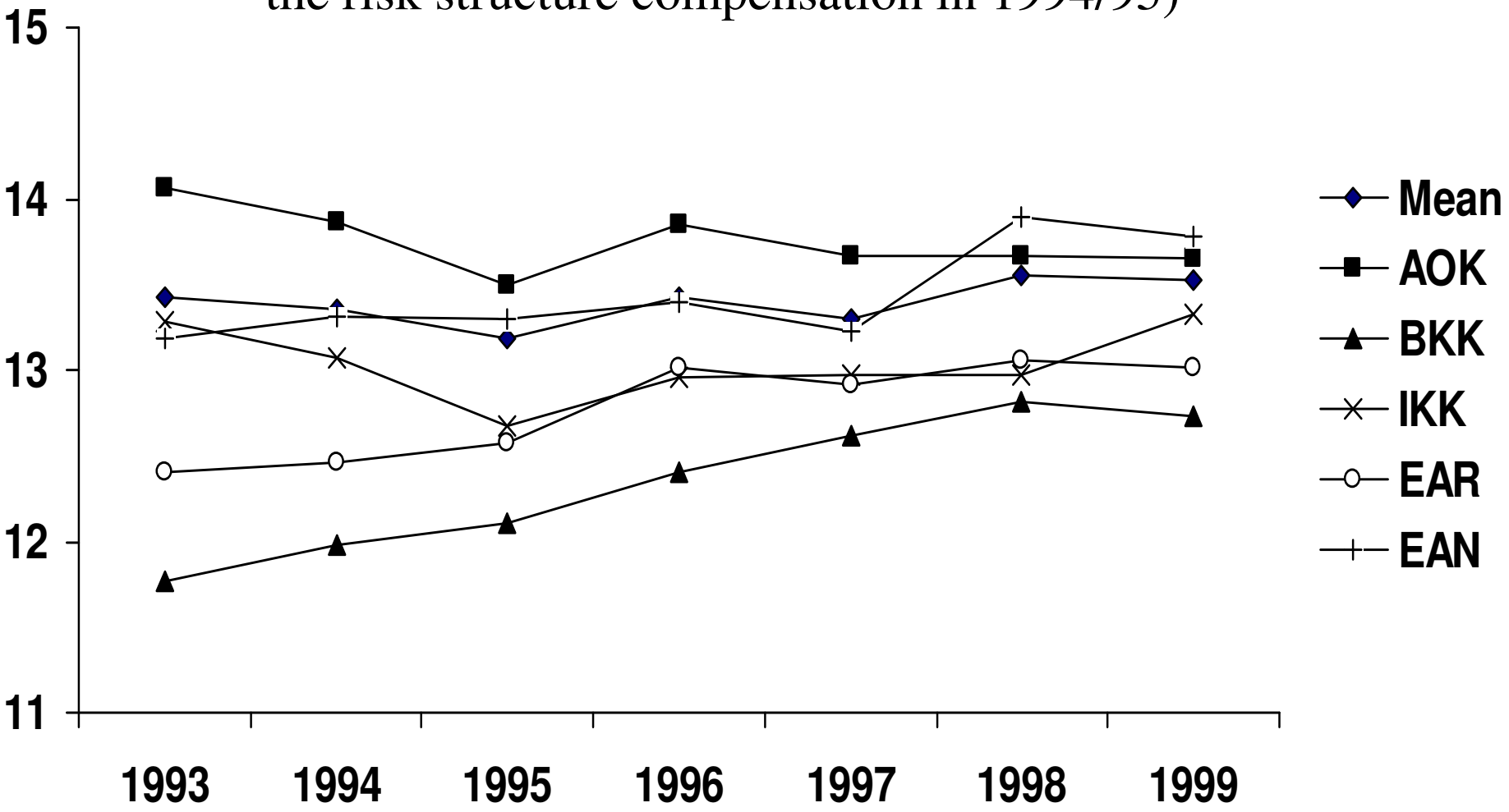
x 8

How does it affect the sickness funds?

- Funds have to pay money into RSC if their wage-basis is higher than average and/ or if their standardised expenditure is lower than average
- Funds receive money from RSC if their wage-basis is lower than average and/ or if their standardised expenditure is higher than average

Effect for sickness fund members: contribution rates have become more similar

(figures for the West in % before and after the introduction of the risk structure compensation in 1994/95)



Transferred money through "risk structure compensation"

	West		East		Germany	
	RSC[1]/ exp.[2] (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure
1995	13.49/ 190.29	7.1%	4.61/ 38.53	12.0%	18.05/ 228.82	7.9%
1996	14.22/ 196.39	7.2%	4.90/ 40.03	12.2%	19.12/ 236.42	8.1%
- 1 January 1997: First opportunity to change between funds -						
1997	15.07/ 192.13	7.8%	5.15/ 39.22	13.1%	20.22/ 231.35	8.7%
- 1 January 1998: Second opportunity to change between funds -						
1998	16.07/ 195.07	8.2%	5.47/ 39.06	14.0%	21.54/ 234.13	9.2%
- 1 January 1999: Third opportunity to change between funds -						
1999	16.24/ 200.83	8.1% (8.7%)*	6.44/ 40.14	16.0% (13.0%)*	22.68/ 240.97	9.4%
- 1 January 2000: Fourth opportunity to change between funds -						
2000	16.23/ 205.46	7.9% (9.2%)*	7.29/ 40.86	17.8% (11.1%)*	23.52/ 246.32	9.6%

Conclusions

- In all health insurance systems (except with one national funds), the income-base as well as the expenditure will vary between sickness funds.
- As much of this variation is not the “fault“ of the funds – but due to the economic situation and the demographic composition –, some of this variation should be taken away.
- While the German risk structure compensation does not even differences out, it has helped to increase equity in the system.