Technische Universität Berlin

Health insurance in Europe: Social health insurance - in Germany, western Europe, CEE

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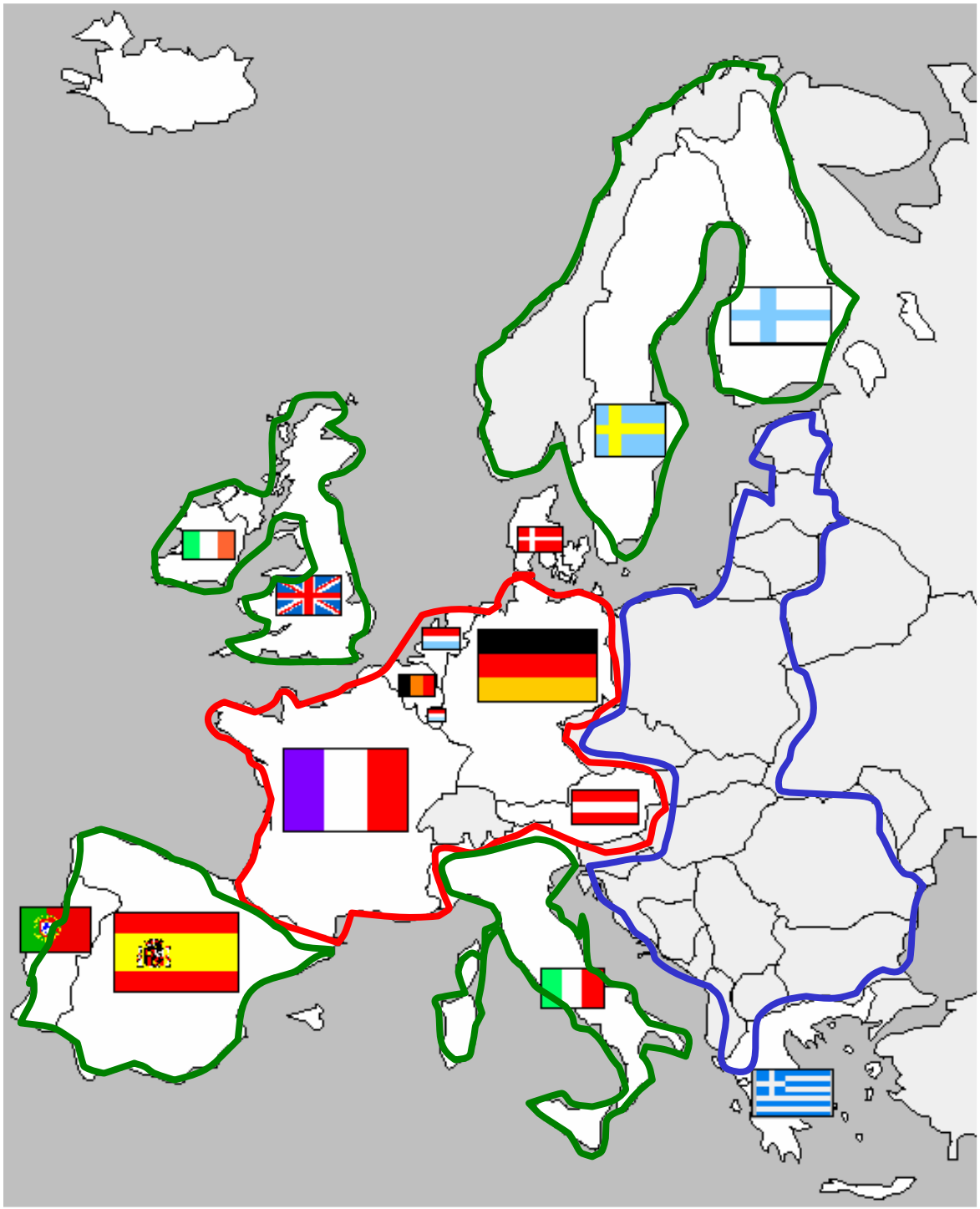
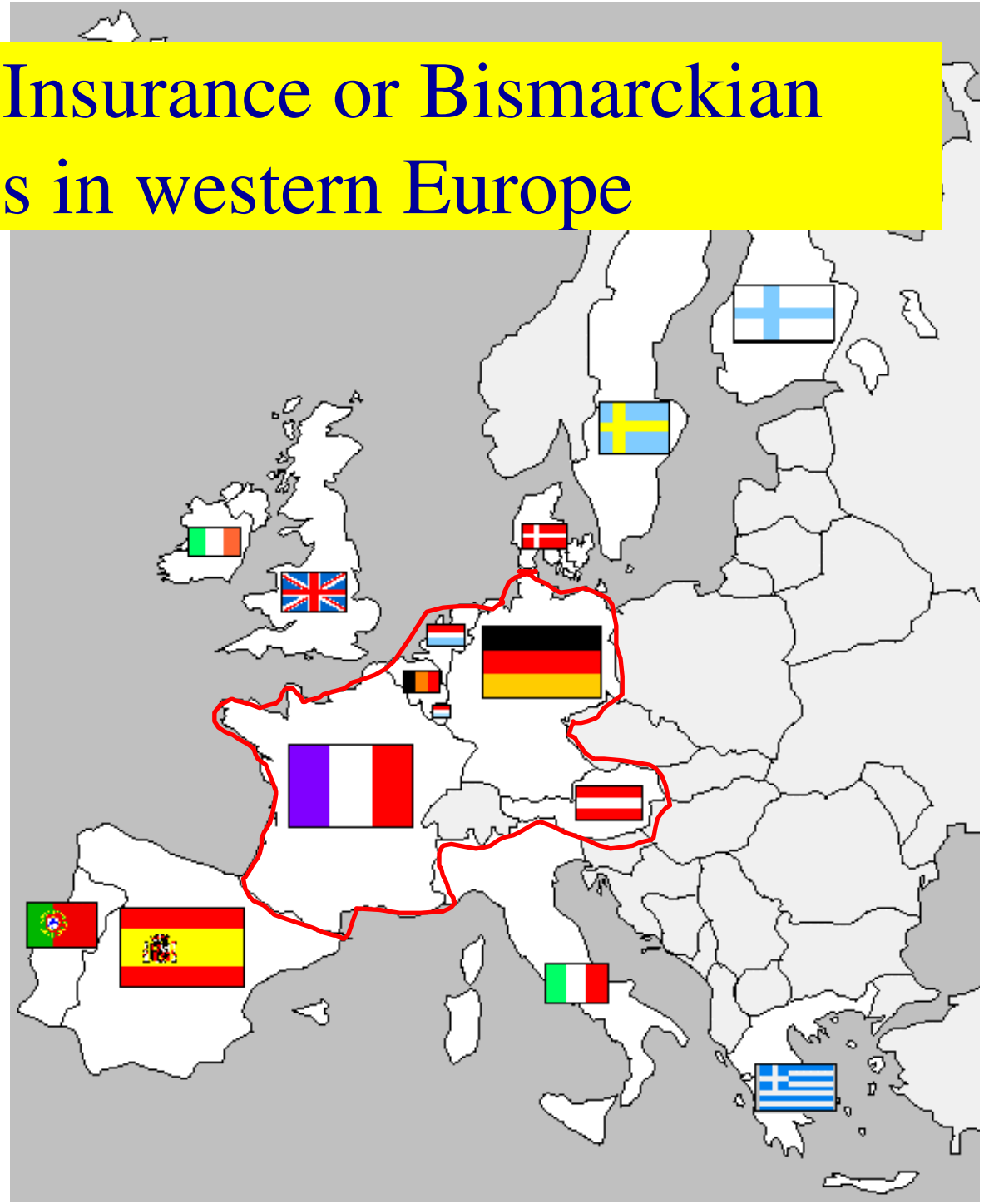
- Social health insurance countries in western Europe
- Central and eastern Europe (Semashko to SHI)
- Tax-based systems in western Europe



Social Health Insurance or Bismarckian countries in western Europe

- SHI definition
- Commonalities and variations between countries
- In-depth description of Germany

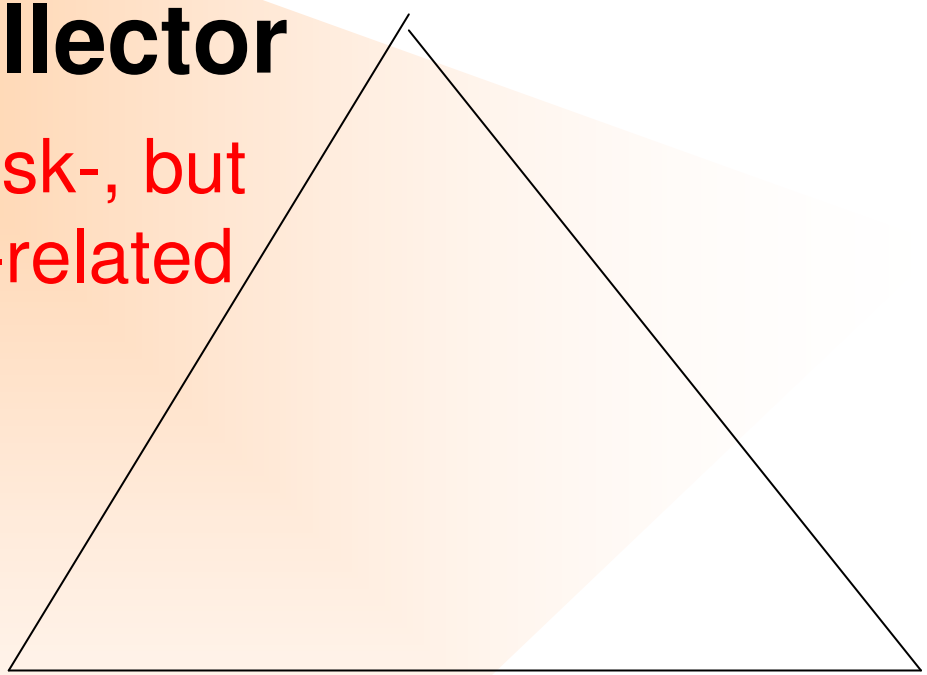


What makes a health system a SHI system?

Contribution collector

Third-party payer

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



Population

Providers

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A reminder to the session on funding 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*

What makes a health system a SHI system?

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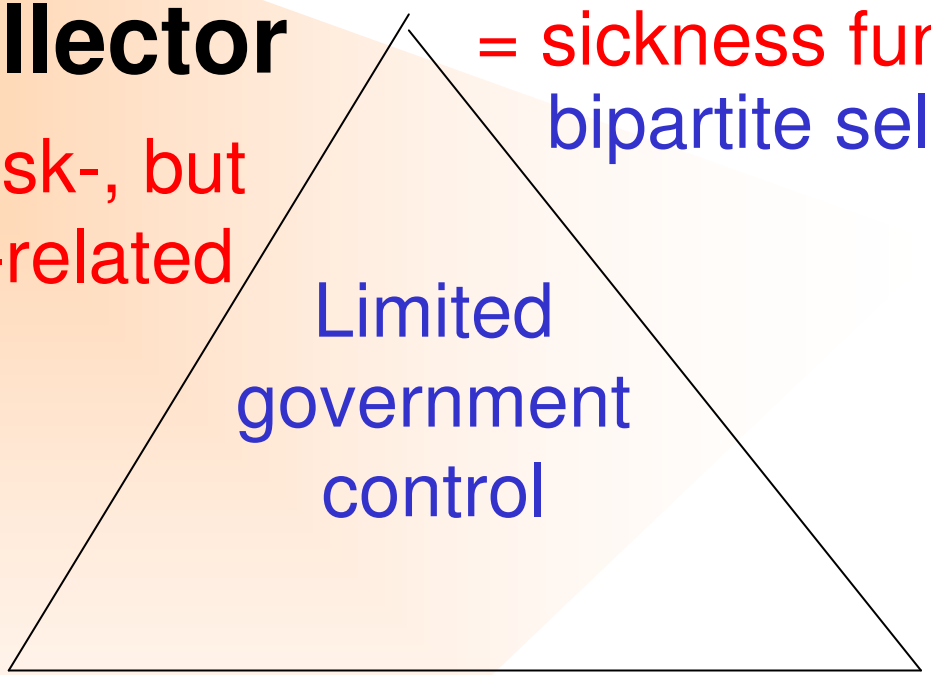
Third-party payer

= sickness funds

bipartite self-government



Population

Providers

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Principal organisational forms of sickness funds

- One national monopoly fund
- Several regional monopoly funds
- Several monopoly funds organised on other principles (e.g. occupation)
- Several funds in competition
    - *Bi-partite: self-government is shared between employers and employees – government supervises*

(tri-partite = government participates directly)

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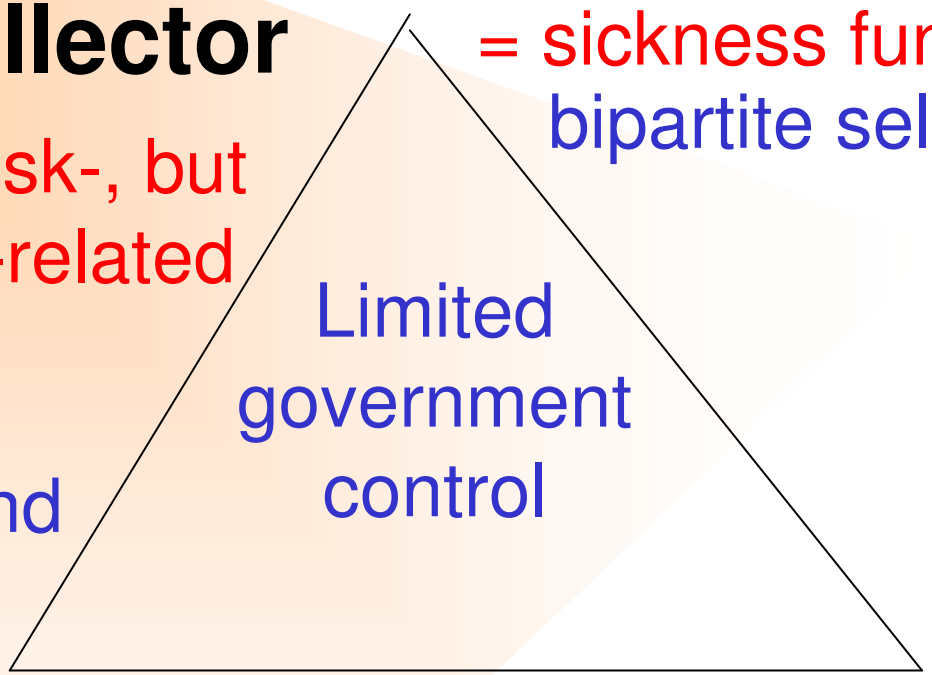
What makes a health system a SHI system?



Contribution collector

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

Choice of fund

Third-party payer

= sickness funds

bipartite self-government

Limited government control

Population

Mandatory insurance

Providers

Public-private mix

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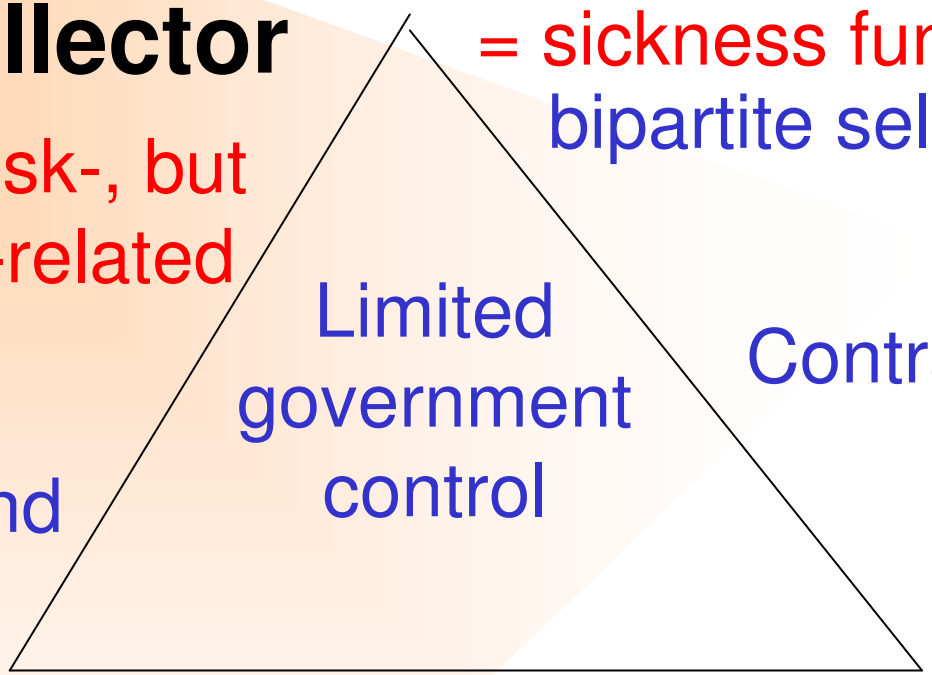
Public-private ownership in Bismarckian countries

	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%	

What makes a health system a SHI system?



Contribution collector

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

Third-party payer

= sickness funds

bipartite self-government

Limited government control

Contracts

Choice of fund

Free access

Population

Mandatory insurance

Providers

Public-private mix

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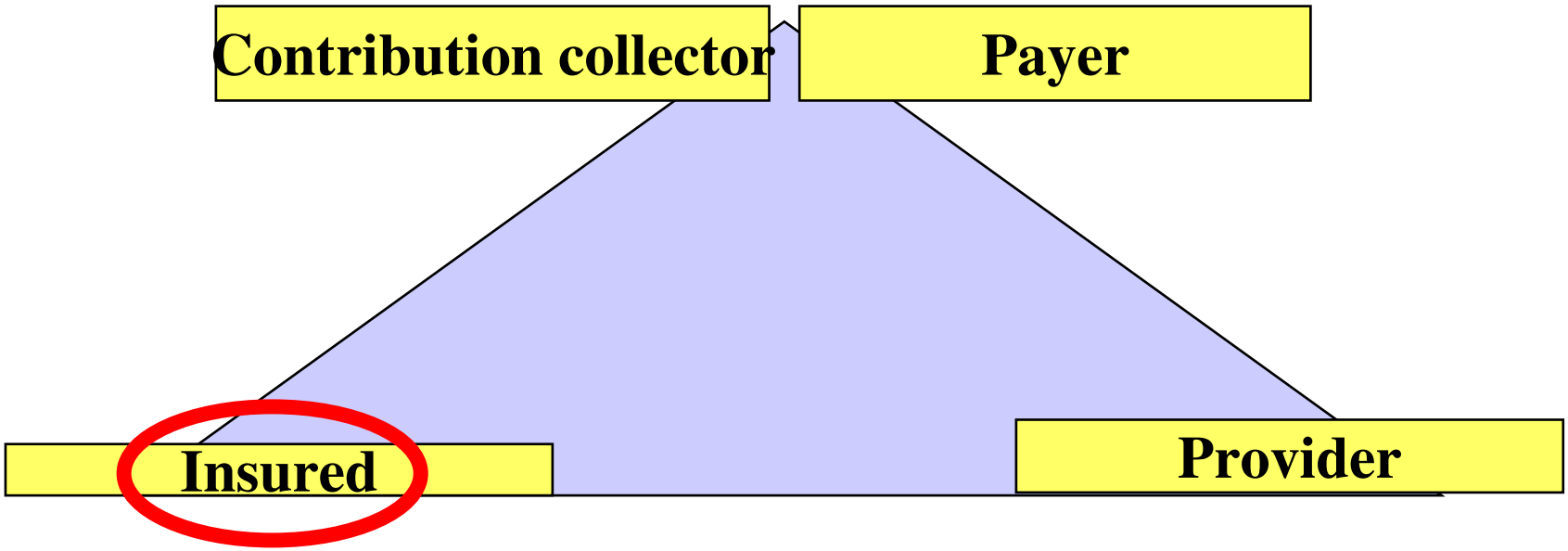
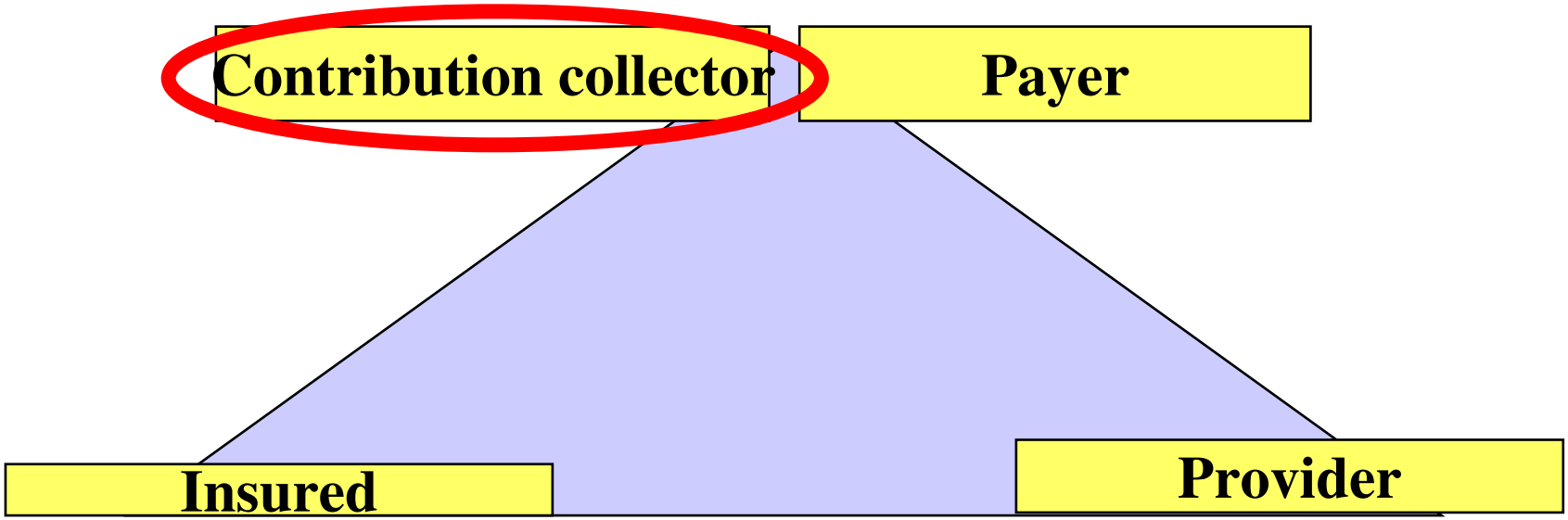
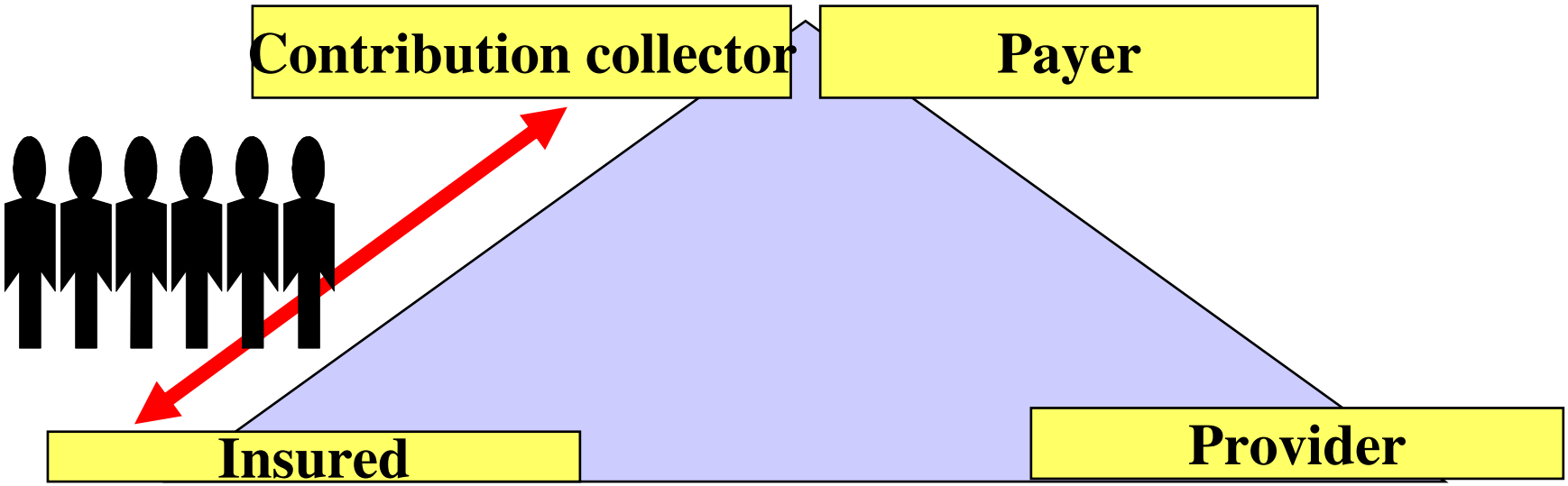


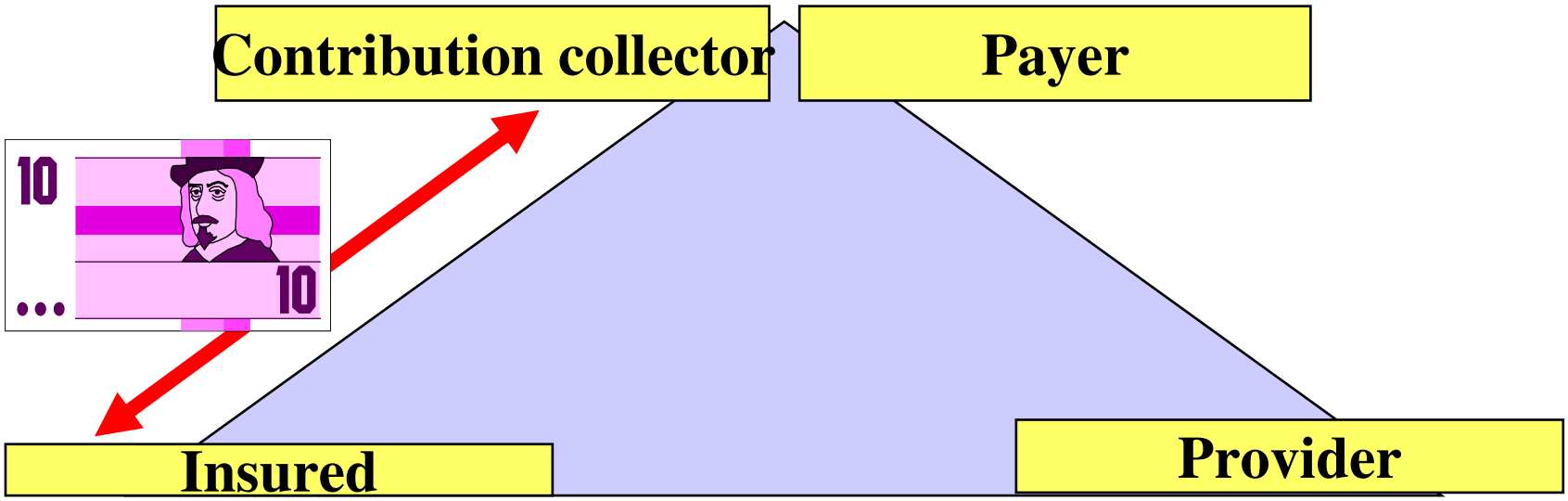
- 100% population coverage in Austria, Belgium, France, Luxembourg, Switzerland (since 1996!)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



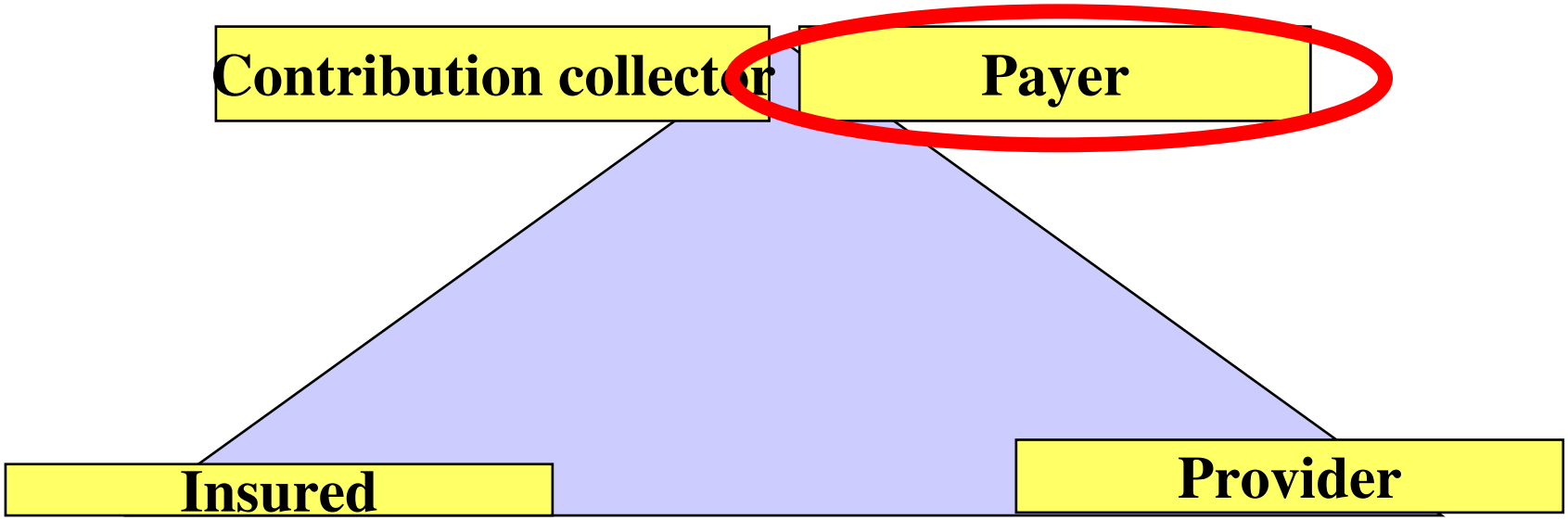
- Government (Belgium, France, Netherlands)
- Union of sickness funds (Luxembourg)
- Individual sickness funds (Austria, Germany, Switzerland)



- Pre-determined membership in Austria, France, Germany (until 1995) and Luxembourg
- Free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland



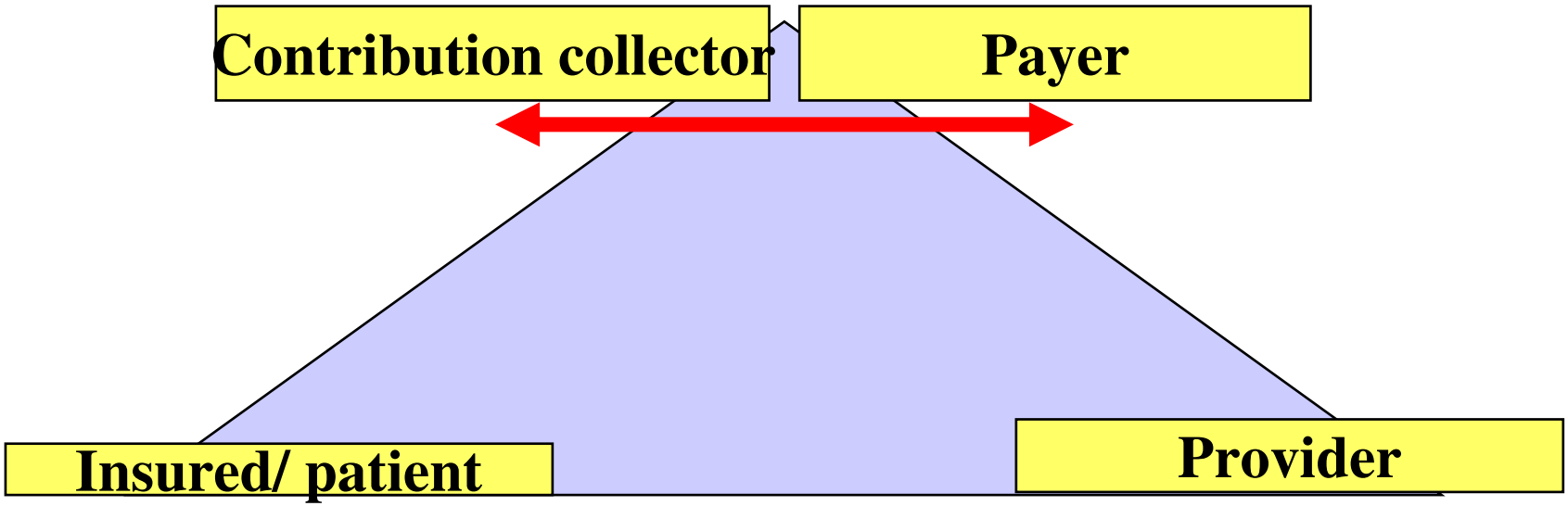
- Uniform rate in Austria, Belgium, France, Luxembourg and Netherlands (+ differing per-capita premium); differing rate in Germany; per-capita premium in Switzerland.
- Contribution cap in Austria and Germany but **not** in Belgium and France.
- France: in 1999 change from income-related contribution (8.9%) to tax on total income (8,25%)
- In the Netherlands, privately insured subsidise SHI, in Germany not.



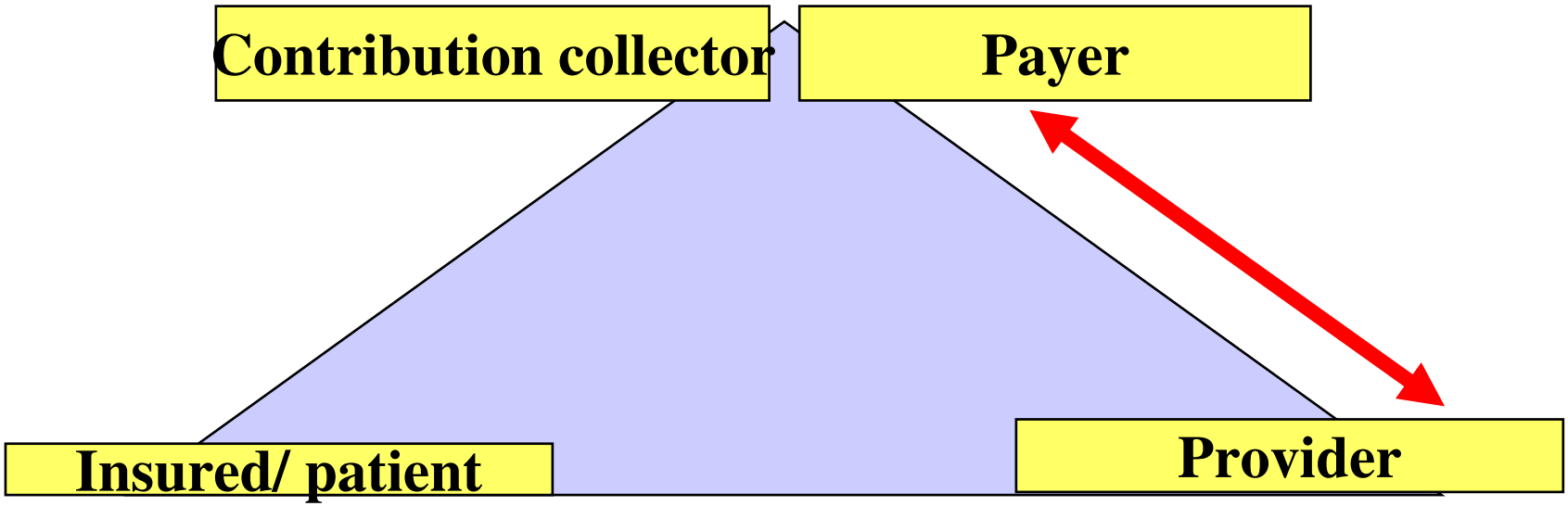
Number of sickness funds

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

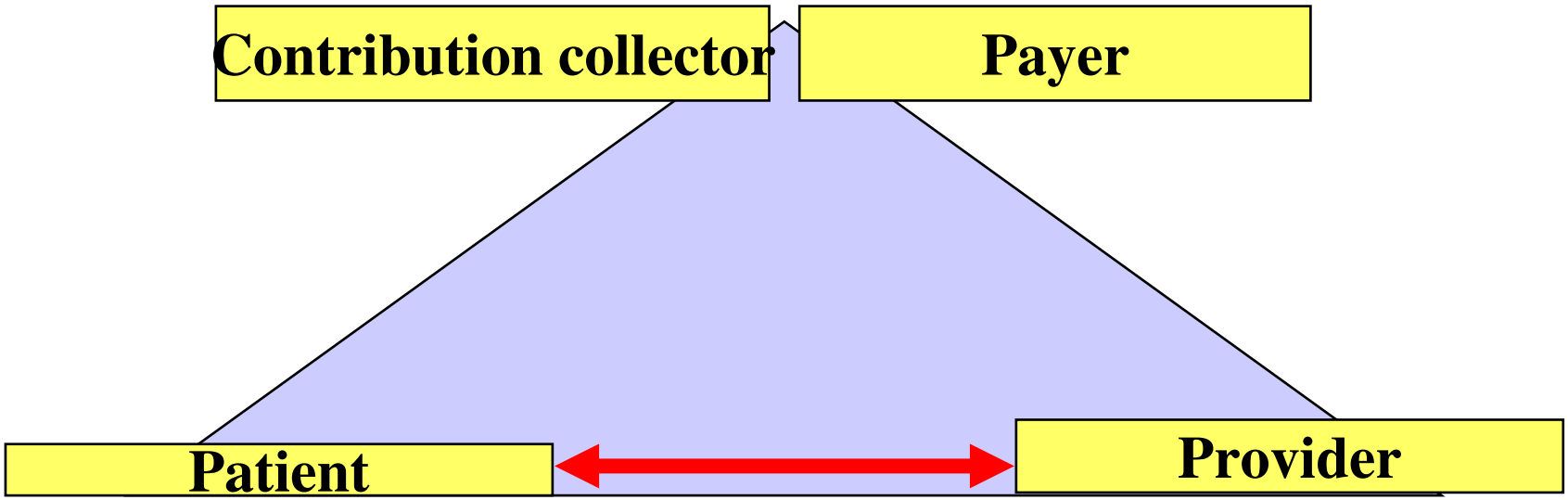
* typical bi-partite government



- allocation (Belgium, Netherlands) or re-allocation (Germany, Switzerland)
- area of allocation: nation vs. region (Switzerland), degree of retrospective compensation (not in Germany and Switzerland), differing factors in the formulas (e.g. region in NL), different types of expenditure included, use of high-risk pool

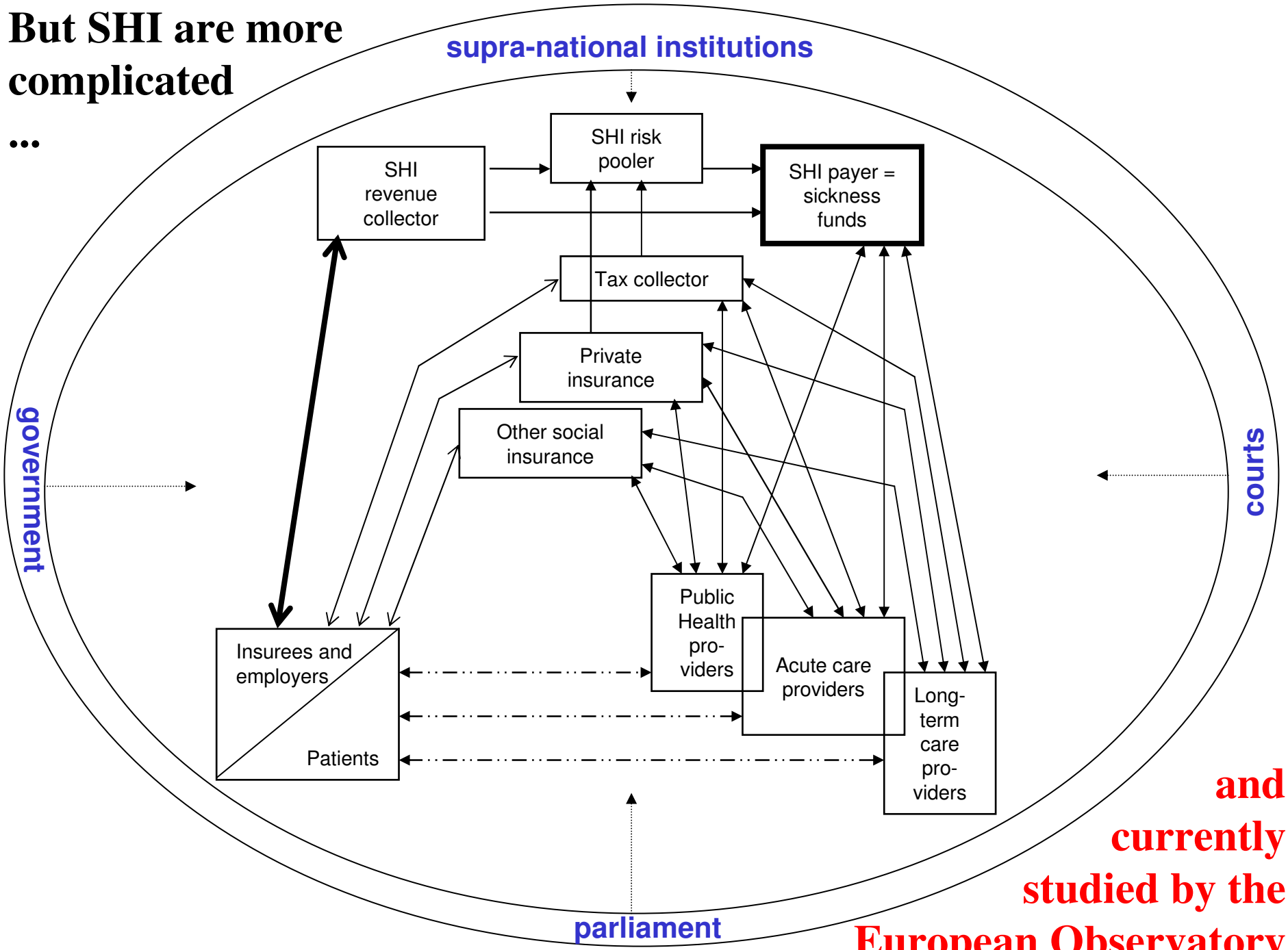


- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts will be illegal – but: funds hardly use selective contracts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



- Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular?
- 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

But SHI are more complicated ...

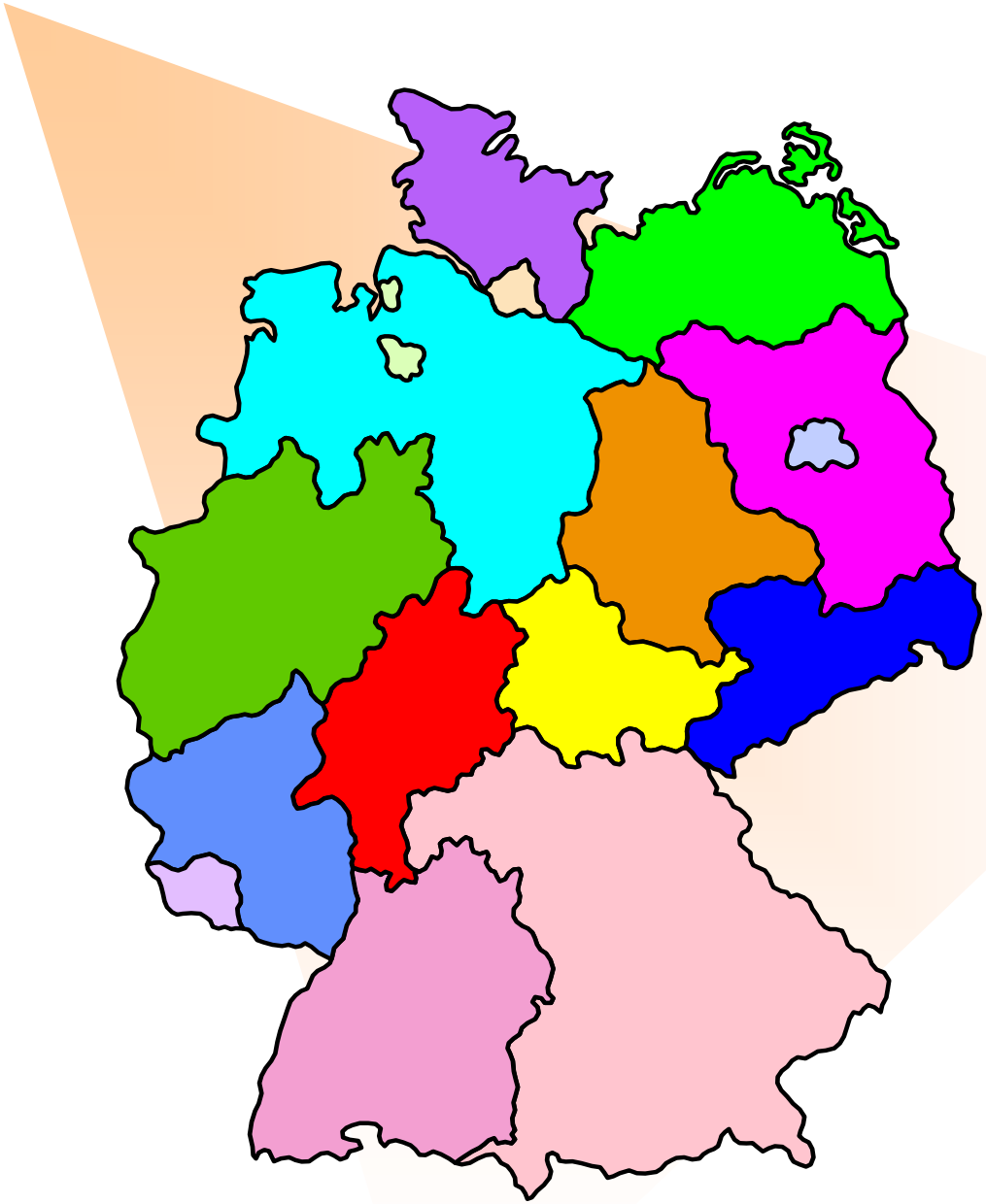


and currently studied by the European Observatory

Case study

Germany

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



Federalism,

German-style:

- Not devolved, but „bottom-up“
- Powers not explicitly given to the federal level remain with the „Länder“
- Länder have considerable power through Federal Council

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Germany: A note on terminology

We will speak mainly about
statutory (or social) health insurance [SHI],
even though it
covers "only" 89% of the population (75% mandatorily and 14% voluntarily) and
spends around 60% of all health care expenditure.

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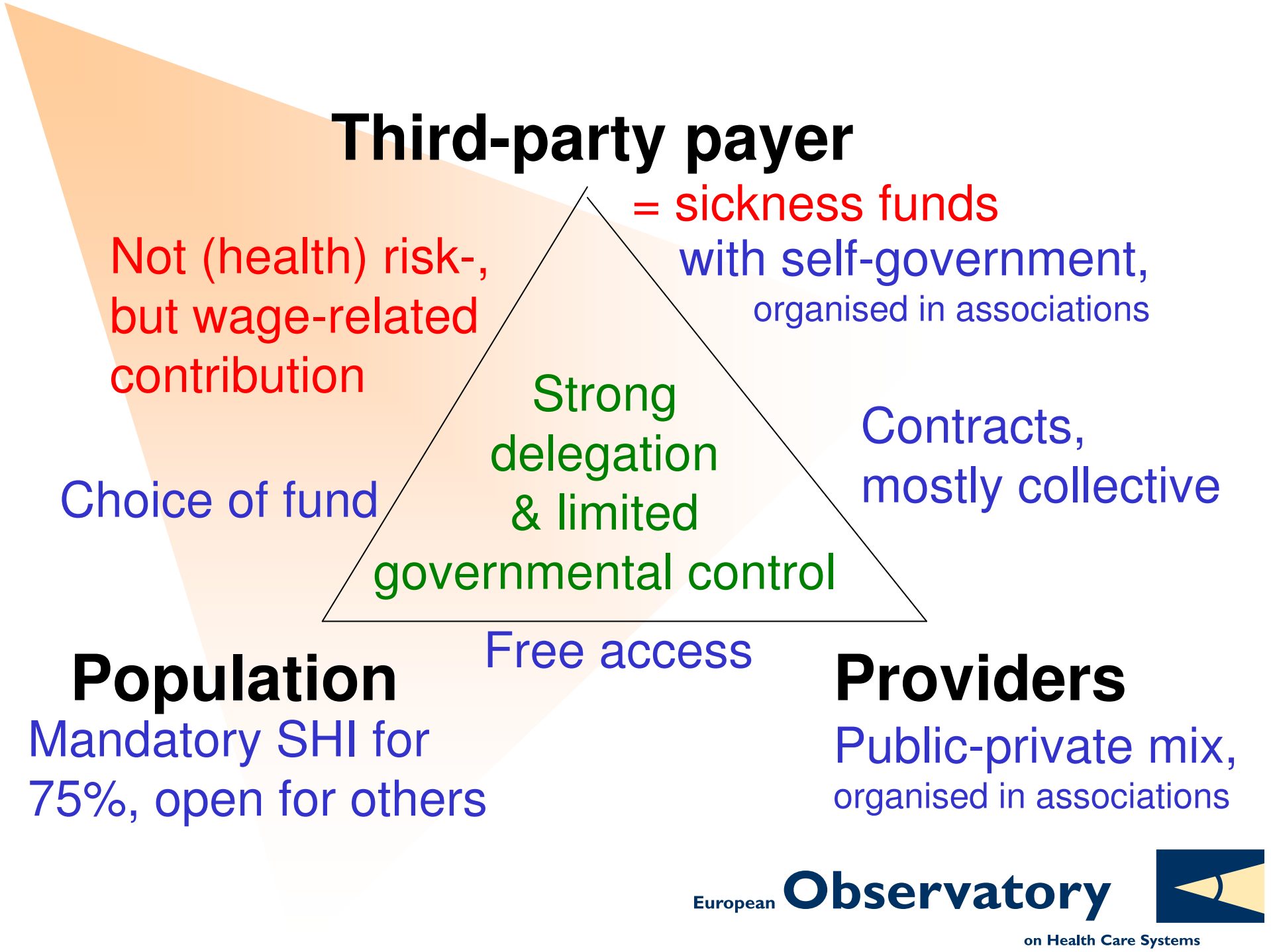

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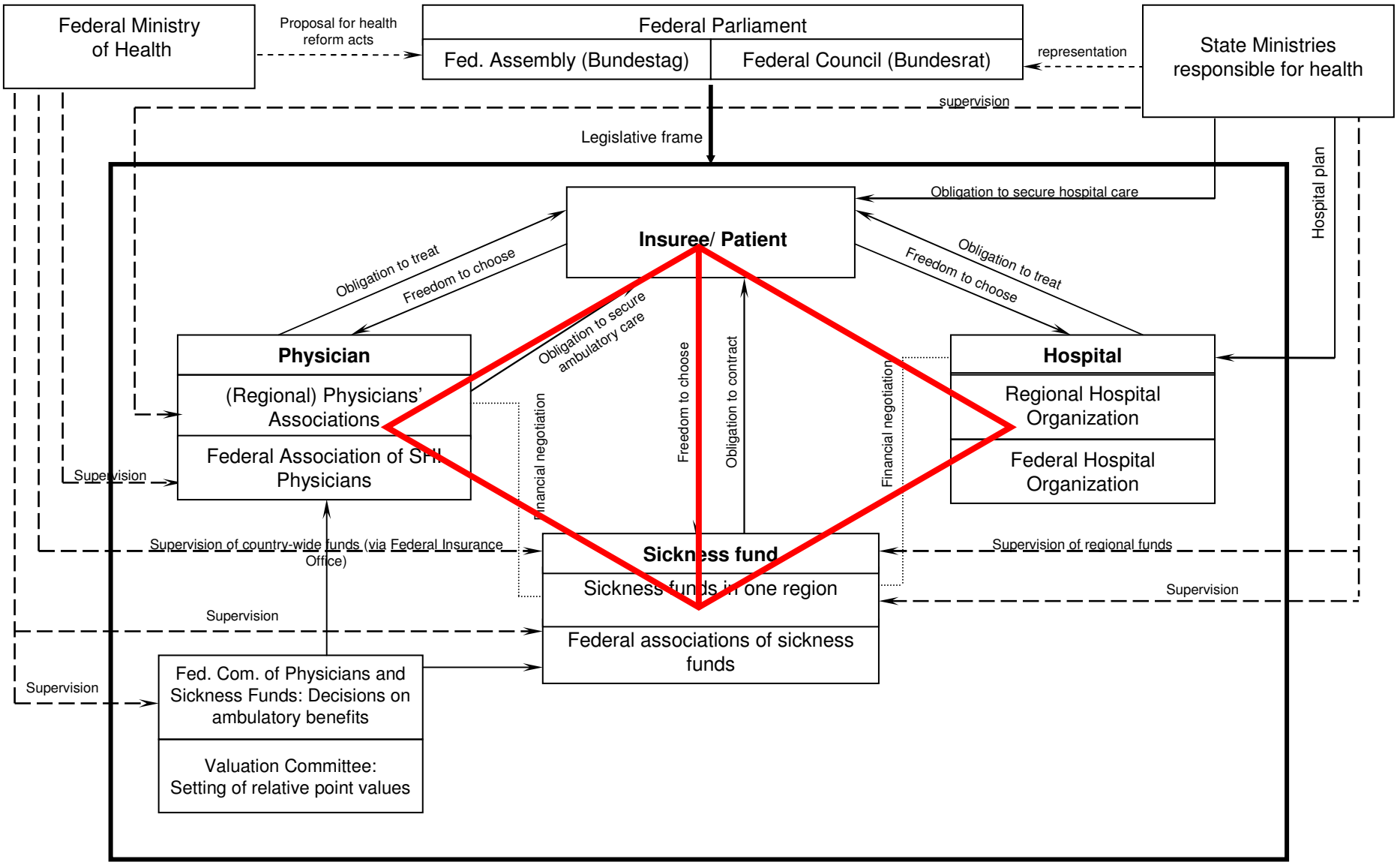
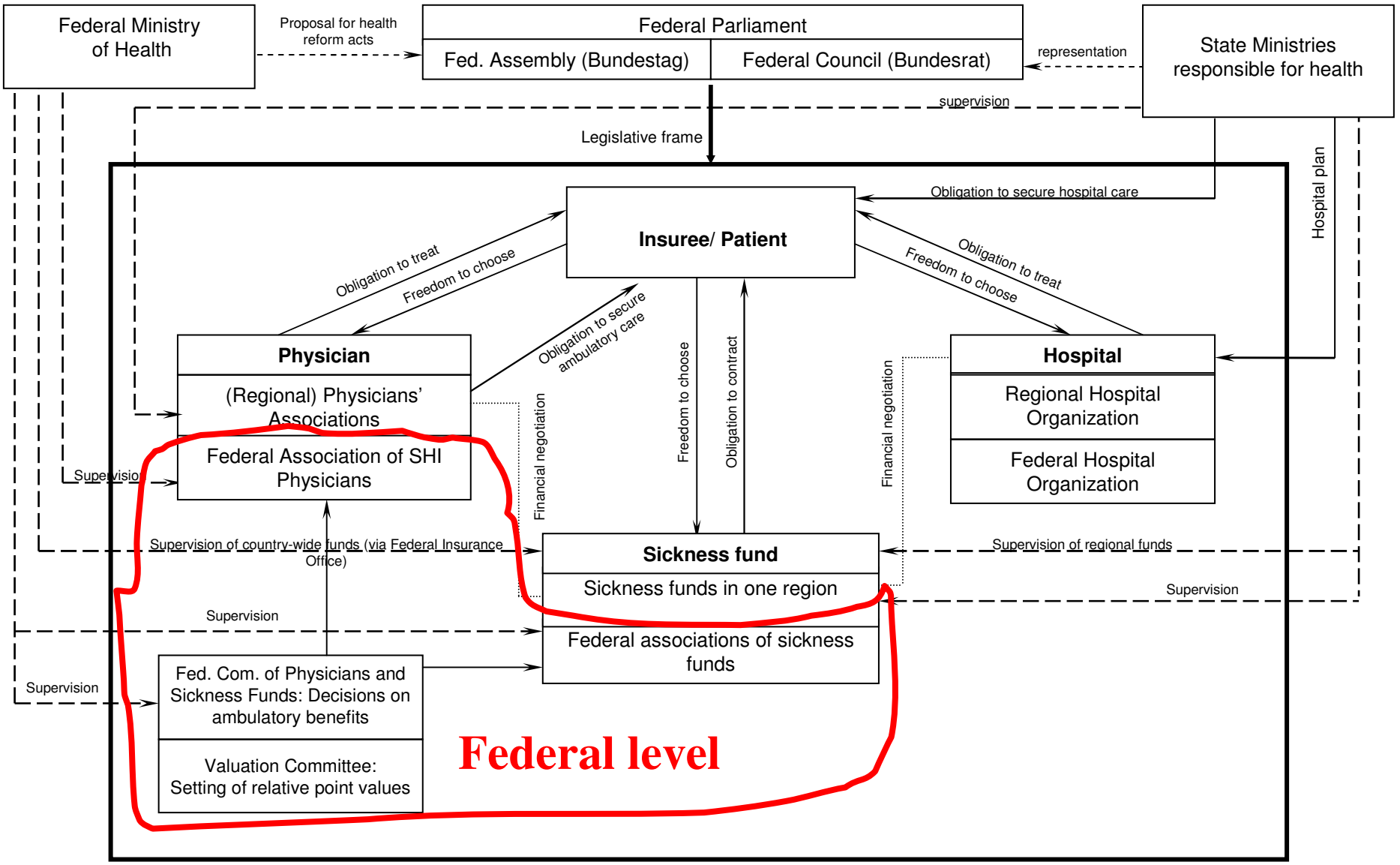


Statutory health insurance 1998



Statutory health insurance 1998

- An important aspect of self-regulation is termed "joint self-regulation" by (at least) two different actors. This type comes in two different forms: 1. Negotiations followed by contracts and 2. decisions by joint committees. While some delegated tasks always require decisions by joint committees (e.g. defining the benefits), others are only decided by joint com-mittees if no agreement can be found in open negotiations (e.g. on the budget for ambulatory care). In still others, a joint committee is the first level of appeal against decisions of another joint com-mittee (e.g. in the case of claims review).
- On the federal level, joint self-regulatory institutions in the German system include the Federal Committee of Physicians and Sickness Funds, the Federal Committee of Dentists and Sickness Funds, the Valuation Committee, the Extended Valuation Committee.

A substantial list of tasks is legally delegated to self-regulatory bodies:

- · defining the ambulatory benefits catalogue in detail;
- · defining rules for physicians' service delivery;
- · setting the relative weight for reimbursement to outpatient physicians;
- · determining the budget for ambulatory care and the spending cap for pharmaceuticals;
- · setting the rules for opening new physicians' practices ("needs-based planning") and deciding upon the actual opening of new practices;
- · defining the rules for and conducting the evaluation of appropriateness, quality and efficiency of the service delivery of physicians (utilisation review);
- · selecting appropriate groups of pharmaceuticals for reference price-setting and determining the actual reference prices;
- · defining the prescription chain for outpatient pharmaceuticals among sickness fund, physician, patient, and pharmacy;
- · defining benefits, prices and conditions for service delivery in the areas of medical devices, non-physicians services, nursing care at home, ambulance transportation, ambulatory rehabilitation.

Problem 1: sectorisation of health care delivery

- state-run public health service: decreasing as many activities (immunizations, screening ...) have moved to ambulatory sector
- office-based ambulatory care: powerful and still growing with full range of specialties
- hospitals concentrating on inpatient care (no regular out-patient departments)
- plus rehabilitation etc.

Why this separation?

different history, development and legislative framework:

- ambulatory care = “battle-field“ between physicians and sickness funds resulting in delivery monopoly for physicians´ associations but joint decision-making under federal law
- hospitals = originally not included in constitution, i.e. in responsibility of states, later transferred into joint federal-state responsibility

Differences in planning, regulation and financing

- Benefits: A = decided jointly by physicians and sickness funds, H = not explicit
- Capacity planning & accreditation: A = jointly by physicians and sickness funds, H = by states
- Reimbursement: A = according to uniform fee schedule but depending on overall utilization, H = mainly by per-diems, differing from hospital to hospital (DRGs from 2003); both under separate budgets

Problem 2: Rising expenditure and attempts to solve the problem

- Attempt 1: budgets and spending caps (1989-1996/7 and 1999ff)
- Attempt 2: regulated competition among sickness funds (1993ff)
- Attempt 3: higher co-payments, exclusion of benefits, “privatisation“ of patient-provider-relationship (1997/98; abolished; discussed again)
- Recently, attention is focussing at least as much on the income side.

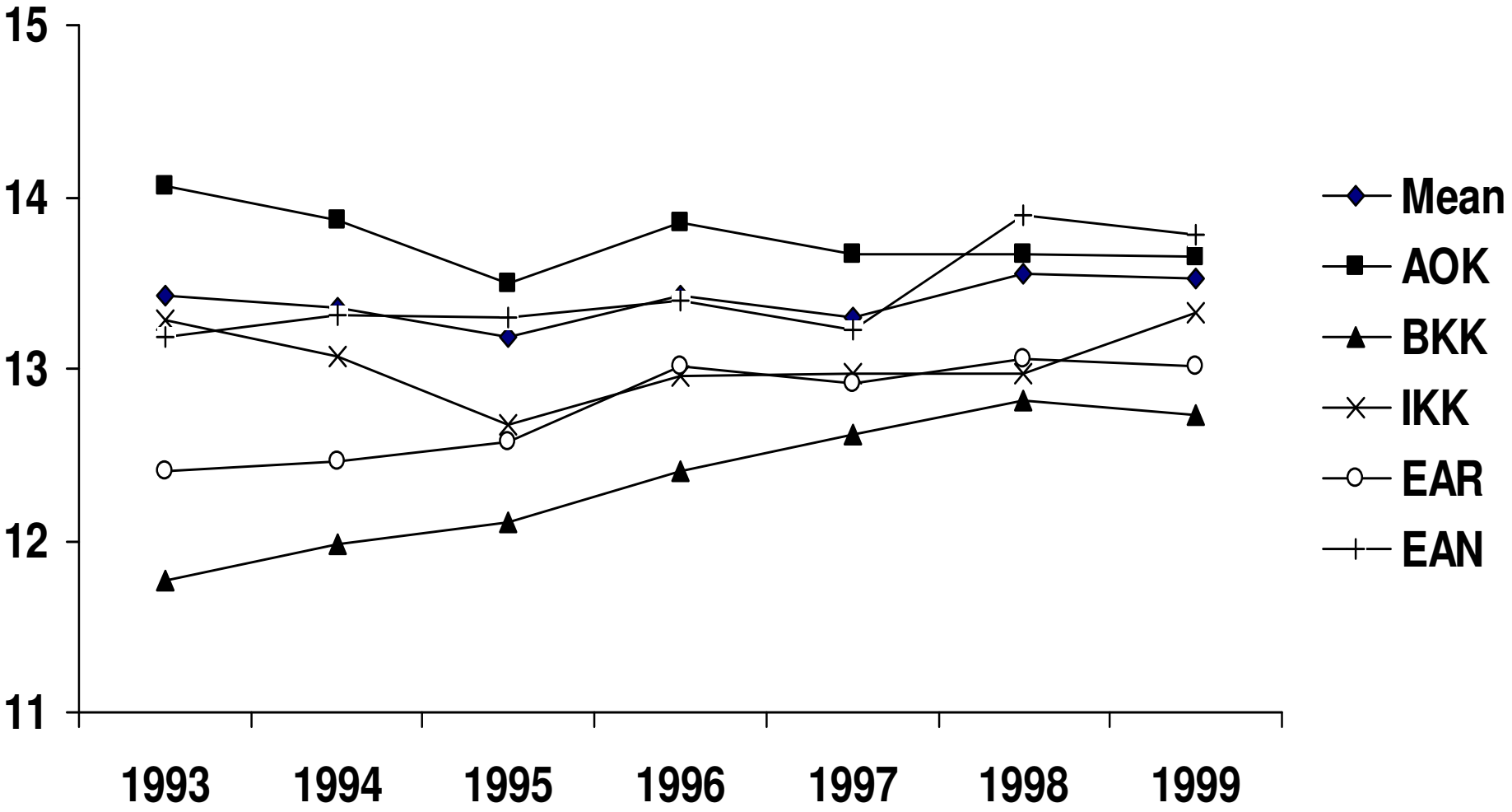
Budgets and spending caps since 1989

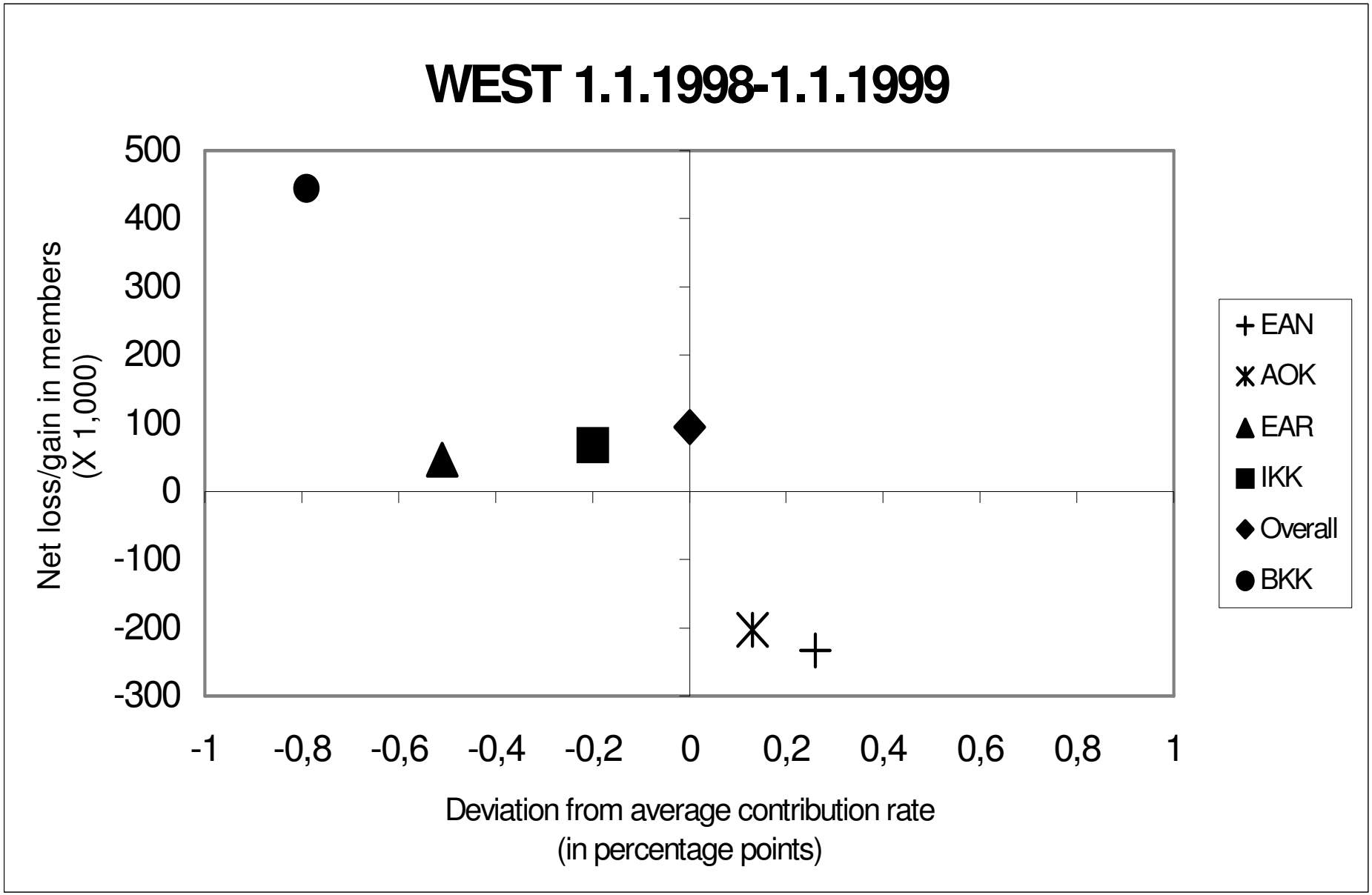
	Ambulatory care	Hospitals	Pharmaceuticals
1989 to 1992	negotiated regional fixed budgets	negotiated target budgets at hospital level	no budget or spending cap
1993	legally set regional fixed budgets	legally set fixed budgets at hospital level	legally set national spending cap
1994			negotiated regional spending caps
1995			
1996	negotiated regional fixed budgets		
1997		negotiated target budgets at hospital level	
1998	(target volumes for individual practice)		negotiated target volumes for individual practices
1999	**Failed attempt to introduce global budget**		legally set regional spending caps
2000	negotiated regional fixed budgets with legally set limit	negotiated target budgets at hospital level with legally set limit	negotiated regional spending caps
2001			negotiated target volumes for individual practices

Free choice among sickness funds but “risk structure compensation“

- 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 “standardised“ expenditure (by sex, age and incapacity to work) vary.

Development of contribution rates in the West (in %) before and after the introduction of the risk structure compensation in 1994/95





Gains/ losses in sickness fund membership

in the western part of Germany in relationship to contribution rate

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%

The dilemma of equality vs. competition

- **1989:** equalisation of benefits and health care provision between sickness funds
- **1994/95:** minimisation of contribution rate differences through ”risk compensation scheme”
- **1996:** free choice of sickness fund for (almost) everybody

> How to compete with (almost) identical benefit baskets, an (almost) identical system of health care provision and similar contribution rates?

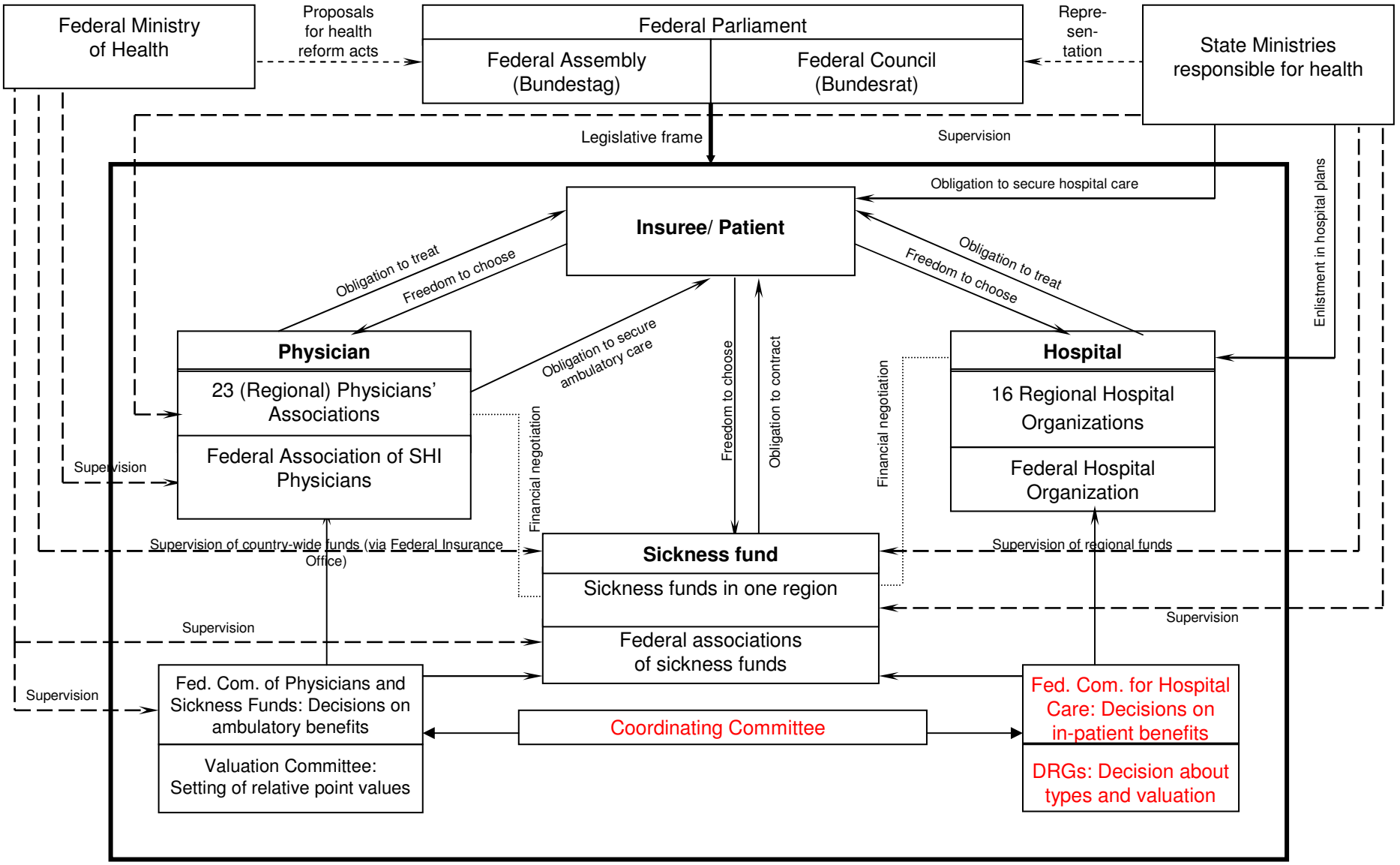
> Selective contracting!?

Problem 3: Quality and cost-effectiveness

- Benefit catalogue is generous and includes services of unproven effectiveness
  > Health Technology Assessment
- Financial incentives and insufficient knowledge lead to inapproriate services
  > guidelines & “disease management programmes“
- In international comparison, health care is expensive and only of average quality = low cost-effectiveness > more state intervention required?

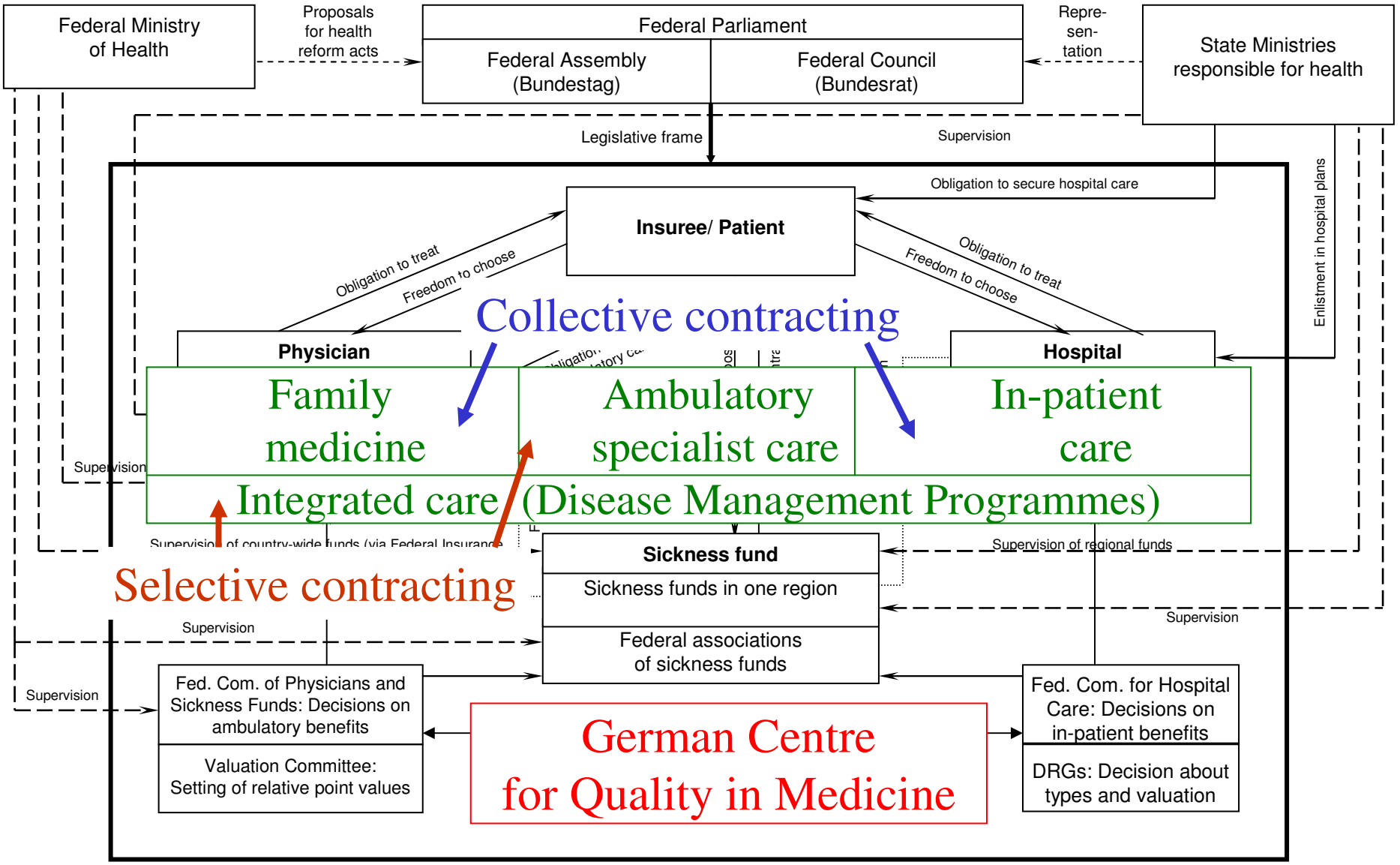
Reform Act of SHI 2000

- change to a uniform, DRG-based reimbursement system for hospitals from 2003/04 - thereby also making the benefits catalogue explicit
- introduction of a coordinating committee, e.g. to pass guidelines for care across sectors
- GP role strenghtened: budget separated from specialists and option for gatekeeping
- possibility for sickness funds to contract with trans-sectoral groups of providers which receive their own budget



Statutory health insurance 2000

• Act to Newly Regulate Choice of Sickness Fund • Act to Introduce the Residency Principle for Physicians' and Dentists' Reimbursement • Act to Reform the SHI Risk Adjustment Mechanism • Act to Adjust Reference Price-Setting Regulations • Pharmaceutical Spending Cap Lifting Act	2001 **Health care Reform a la Ulla Schmidt**
• Act to Limit SHI Pharmaceutical Spending • Act to Introduce a Case Fees-System in Hospitals	2002

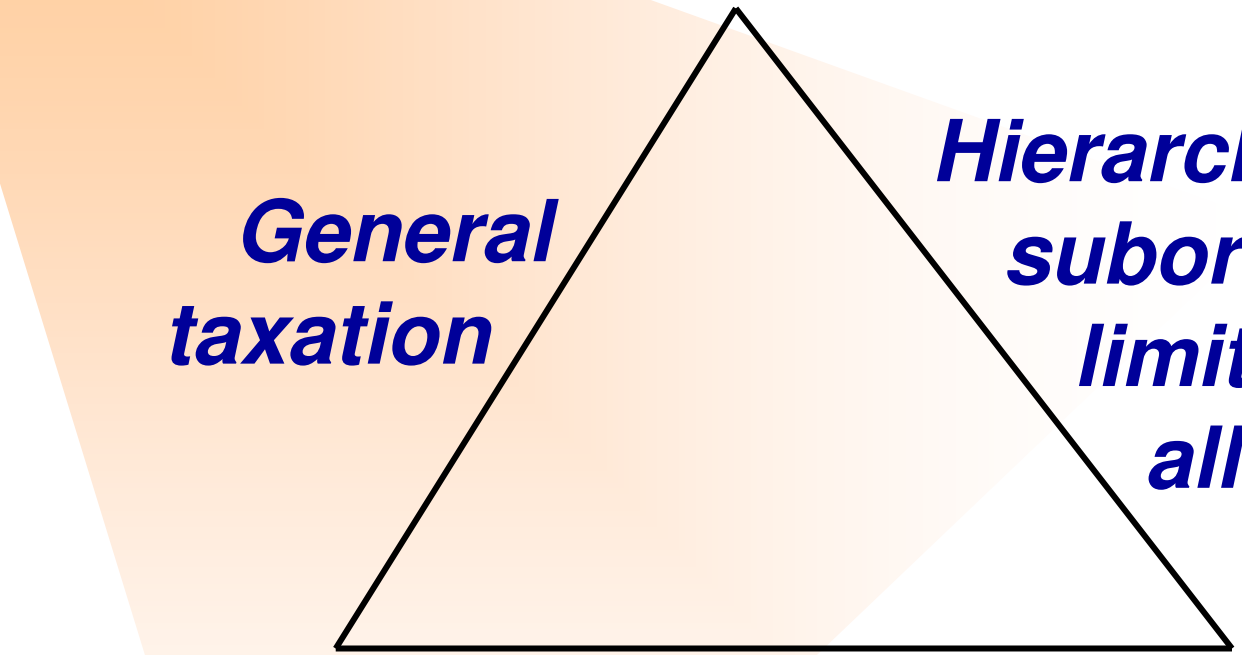


Proposed Health Care System "Modernisation" Act 2003

Central and eastern Europe

Bulgaria
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia

The health care systems in 1990



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Reform strategies in the 1990s

- Dezentralization and privatization
- More money for health care,
  especially through introducing health insurance
- Planned reduction of capacities

No country has successfully tackled all three!

- Often overlooked: population health

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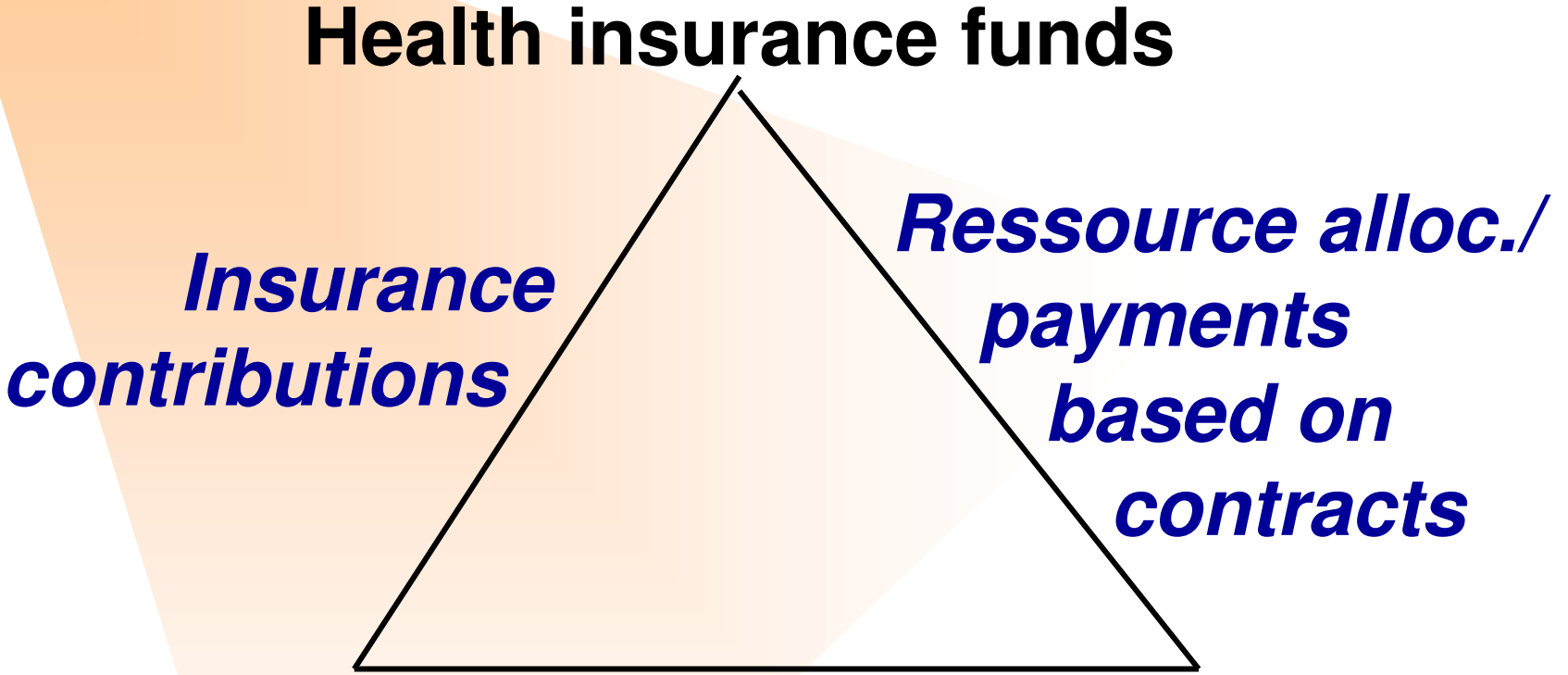
Dezentralization and privatization

- devolution to - newly created - regional levels (which often became responsible for hospitals)
- delegation to physician chambers, health insurance funds etc.
- privatization especially of ambulatory physicians, dentists and pharmacies
    - Problem: physicians were quite powerful in several countries, pushing for privatization, forgetting public health

From Semashko to Bismarck

- "Early wave" 1991/93: Czech Republic, Estonia, Hungary, Slovakia, Slovenia *("Back to Europe - back to Bismarck")*
- "Late wave" 1998/99: Bulgaria, Lithuania, Poland, Romania
- not yet (funds are still tax-funded): Latvia

The health care systems in 2000



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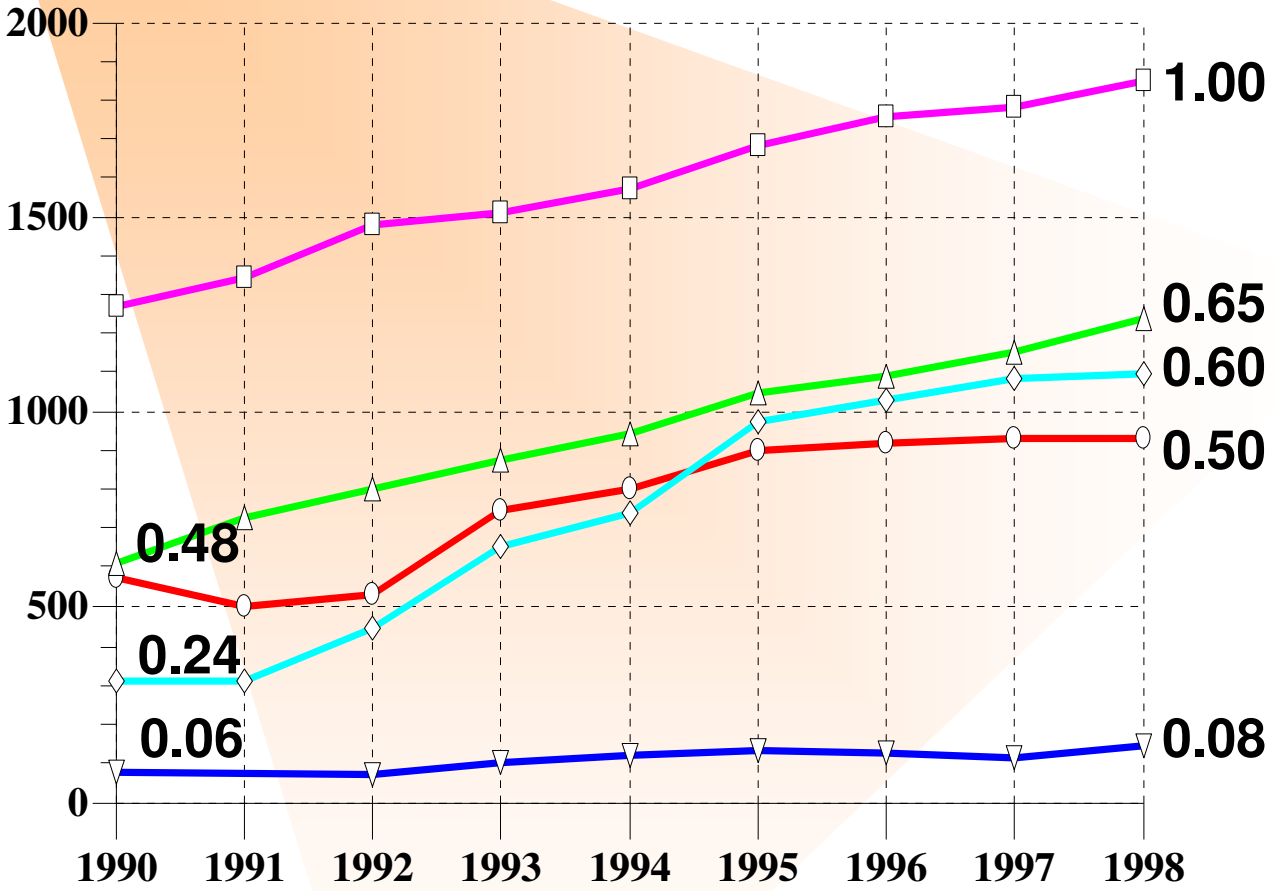
Health insurance variation

- Organization of funds (single, regional monopolies, competing)
- Governance: no board (Hungary), boards with limited to substantial powers
- Contributions: collection (state vs. funds), coverage of non-wage earners (free, reduced contribution, by state)



Successes

Introduction of insurance system and of funds was generally smooth

and expenditure did go up!

Czech Republic
Slovenia
Portugal
EU average
Romania

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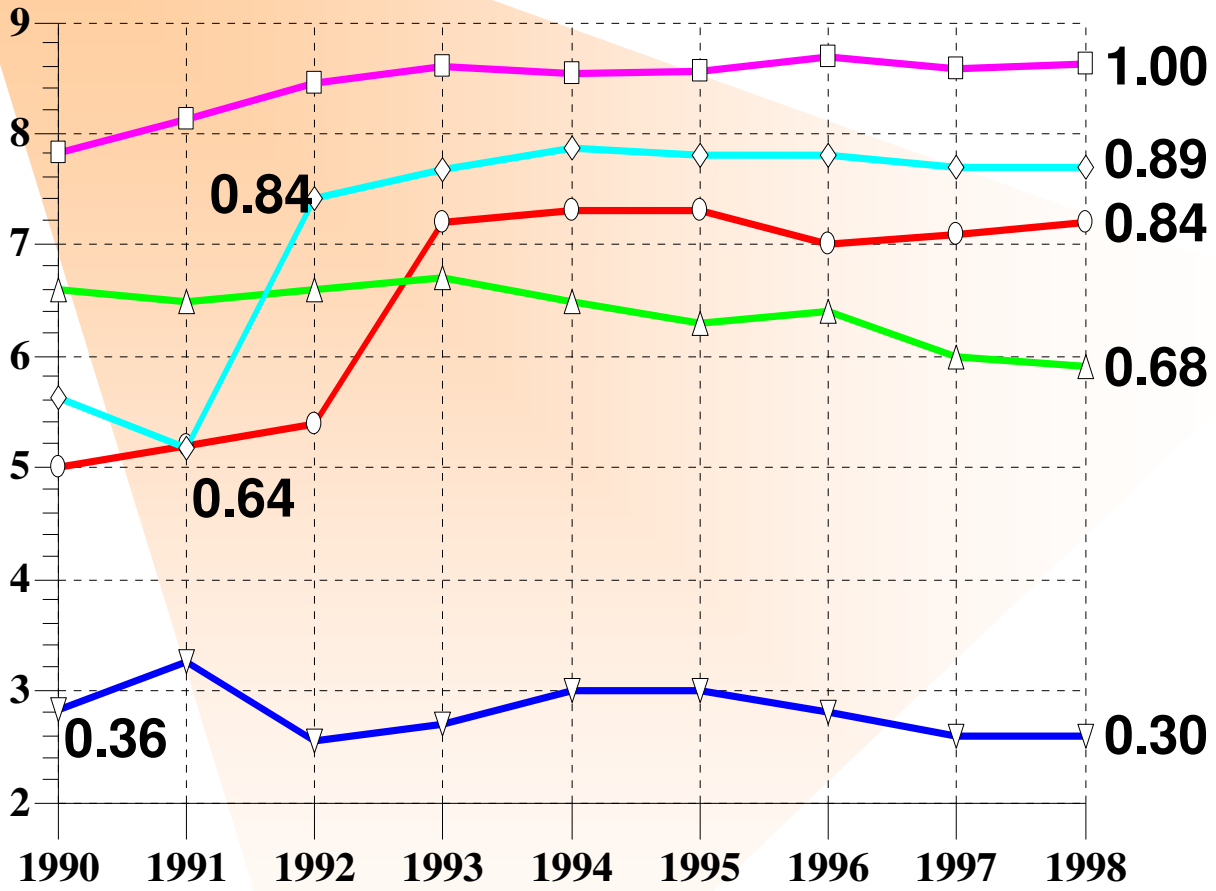
340102 Total health expenditure as % of GDP



Czech Republic
Slovenia
Luxembourg
EU average
Romania

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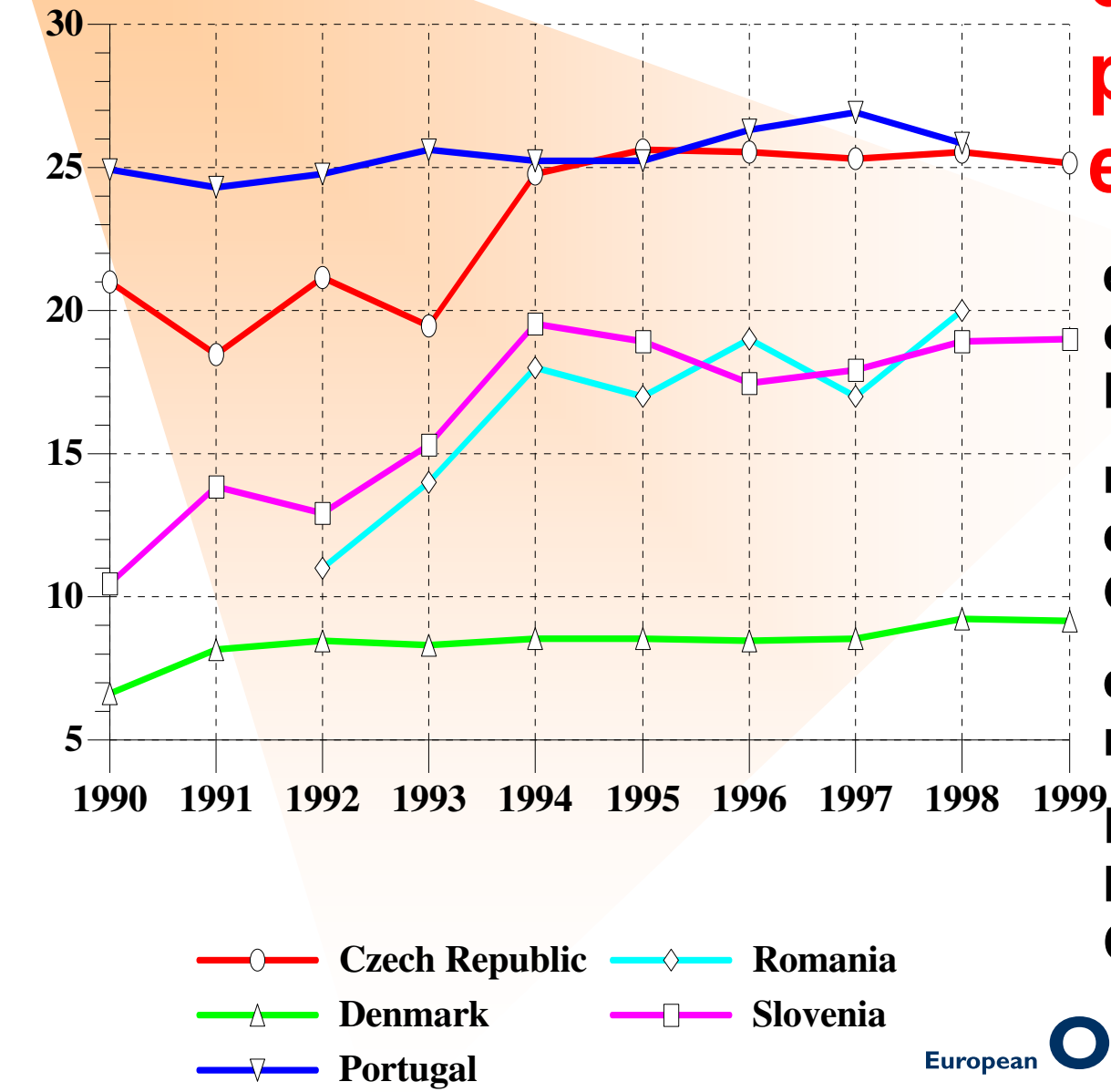
… and problems

- funding expectations partly not met due to evasion of employers and self-employed as well as government
- (re-)allocation of funds still insufficient
- competition among funds in CZ and SK - in conjunction with loose regulations - led to bankruptcies and deficits

An often quoted problem: pharmaceutical expenditure



expenditure is high - and often rising - but not higher than in Portugal

main problem: many drugs are imported and OECD-priced

delisting & co-payments not without dangers

EUROASPIRE: good hypertension control in Czech Rep. & Hungary

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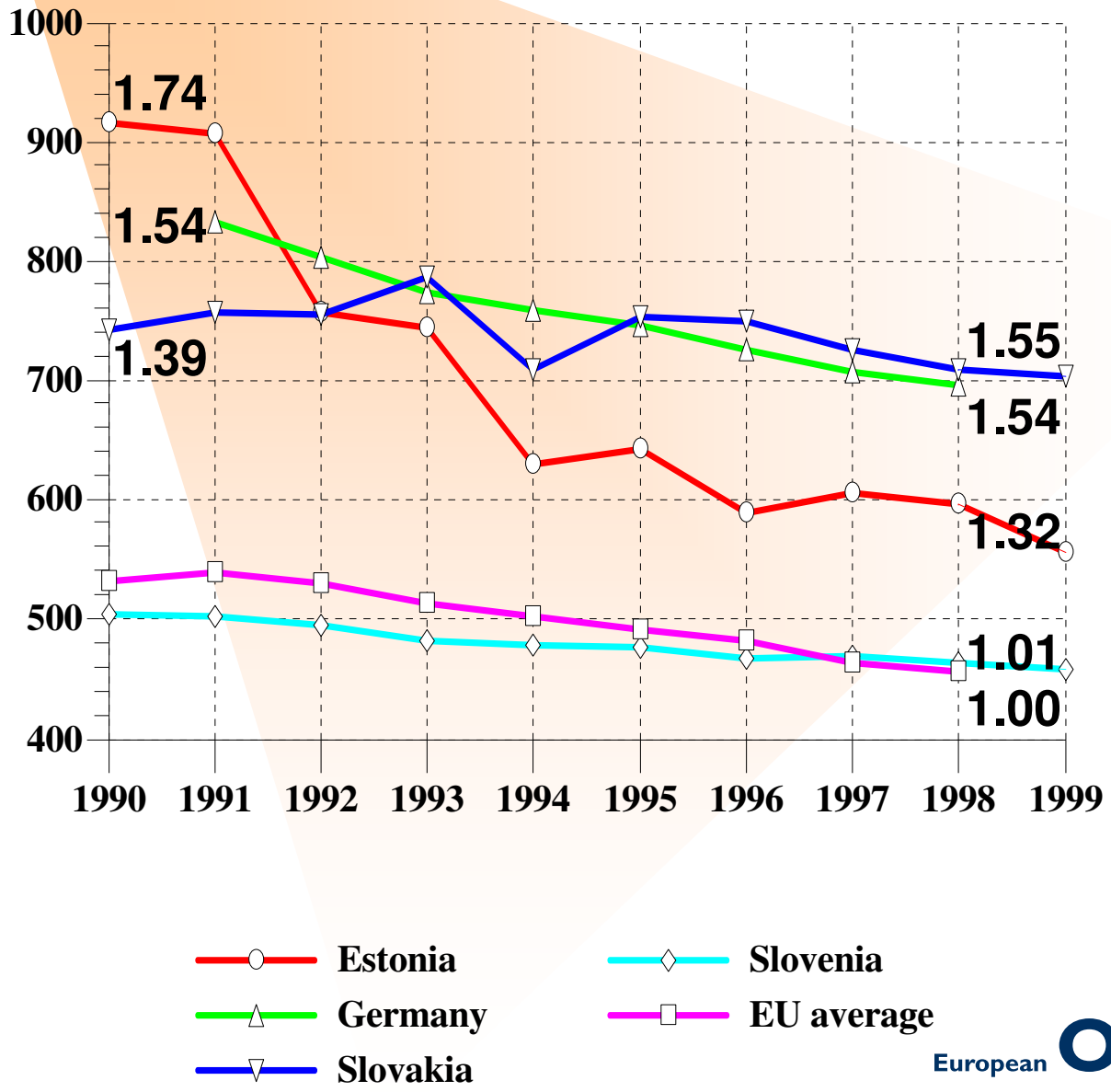
Hospital capacity reductions



early capacity reduction only in Estonia and Romania (1992/93)

in Czech Republic only in mid-90s after belief in markets had failed

no substantial reduction in Poland and Slovenia

as well as Slovakia (with German level capacities)

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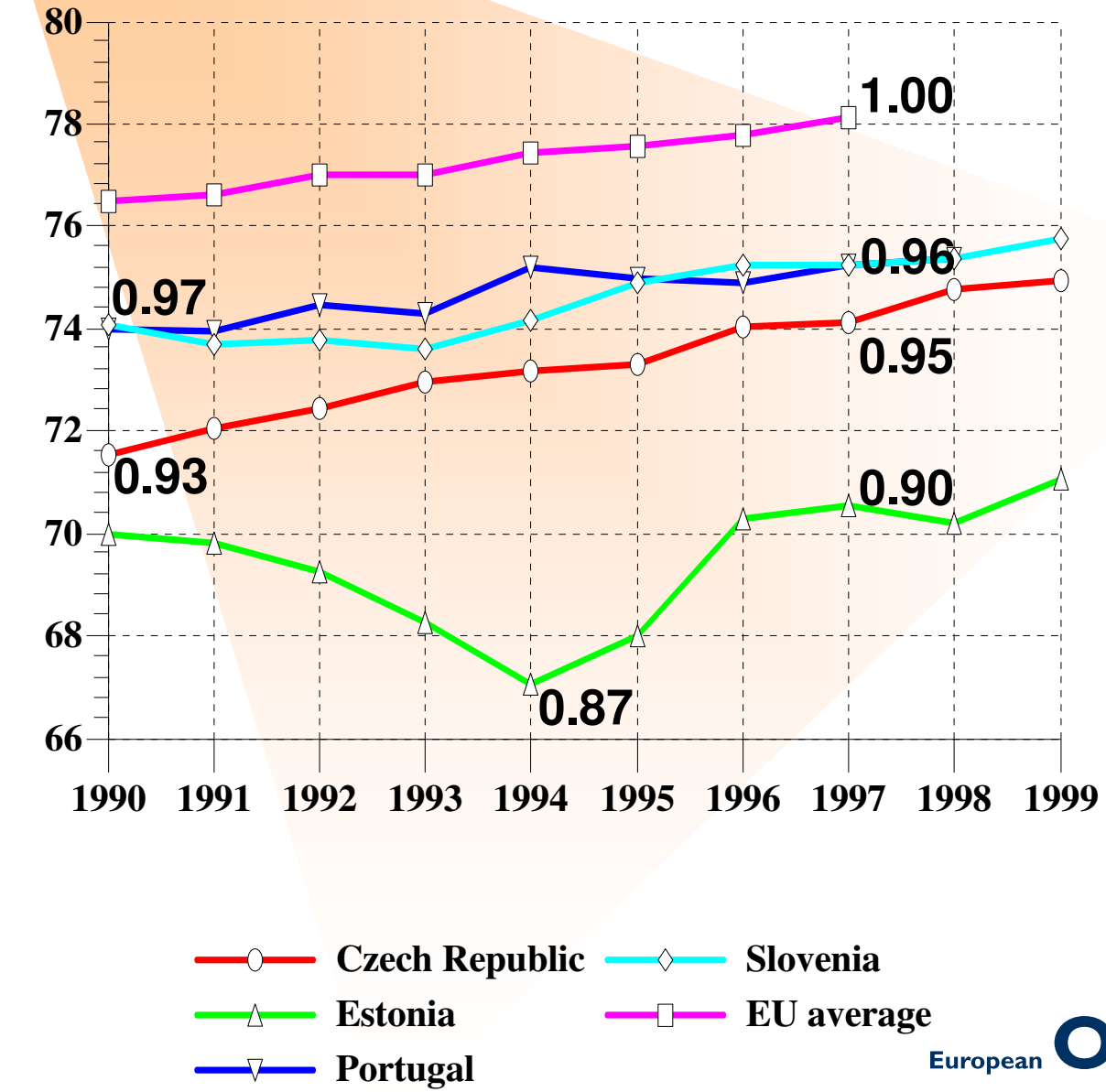
Usually overlooked: population health



1990: gap to EU
2.4 to 6.9 years

drop in Baltics by up to 4 years until 1994,

by ca. 1 year in Romania and Bulgaria in 1996/97

1997: gap up to 8.9 years

only CZ improved vs. EU

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