Technische Universität Berlin

Experience of western European Social Health Insurance countries: reflections for Slovakia

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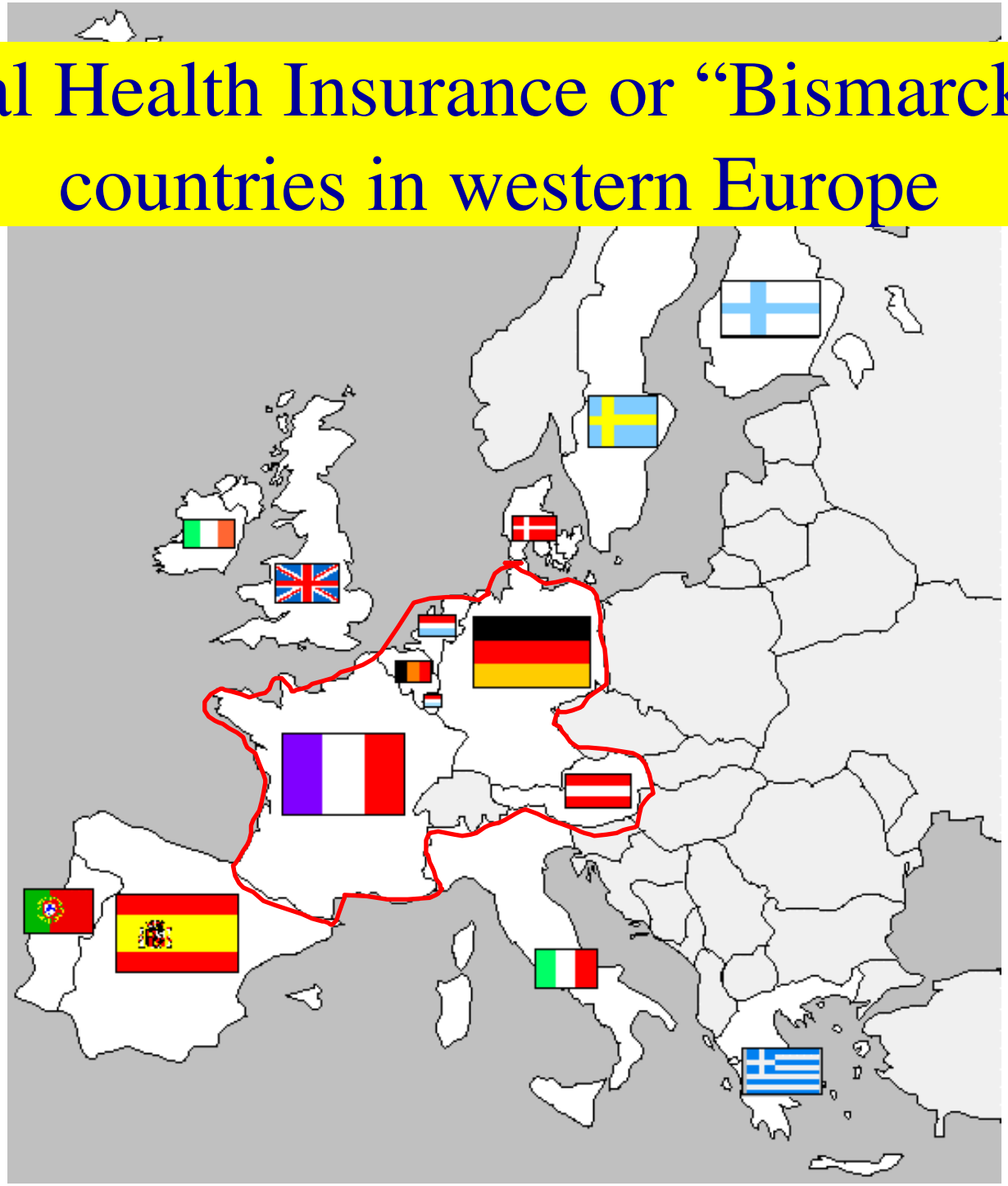
Social Health Insurance or “Bismarckian“ countries in western Europe

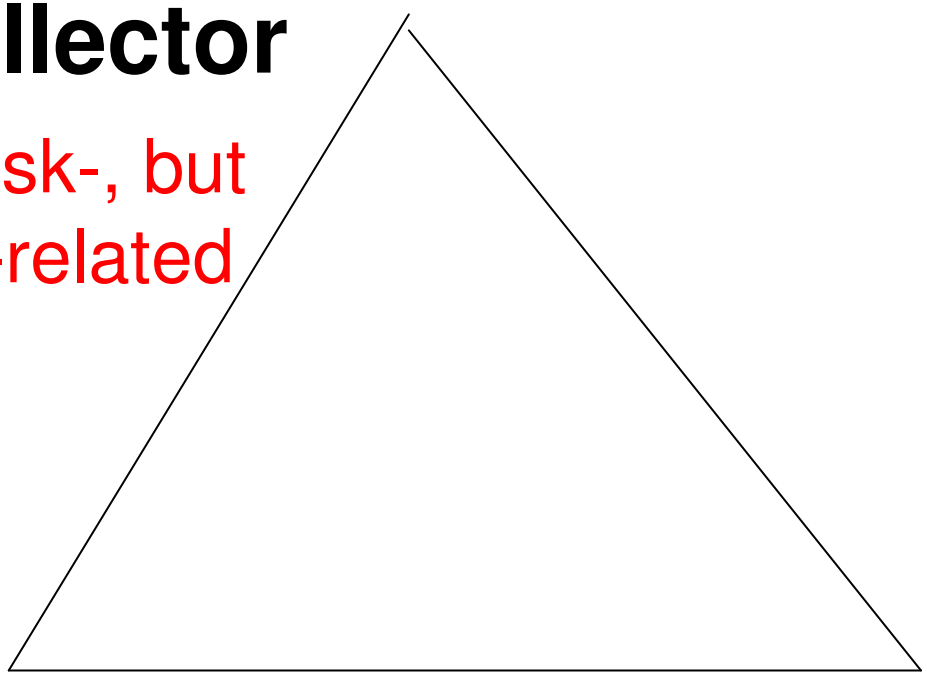


What makes a health system a SHI system?

Contribution collector

Third-party payer

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

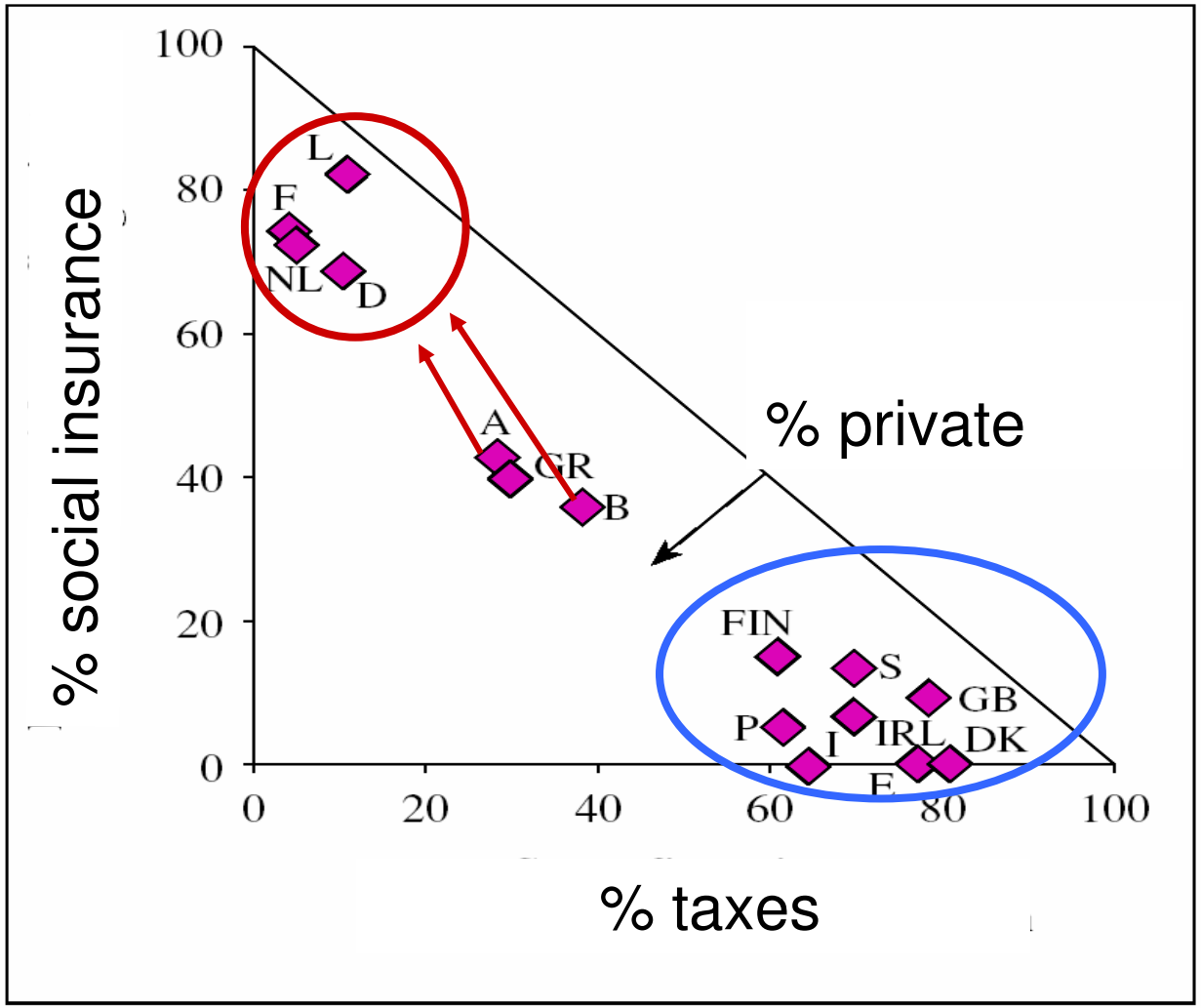


Population

Providers

European Observatory on Health Systems and Policies

Funding of health care in the old EU Member States: % contributed from three main sources – social insurance, taxes, and private



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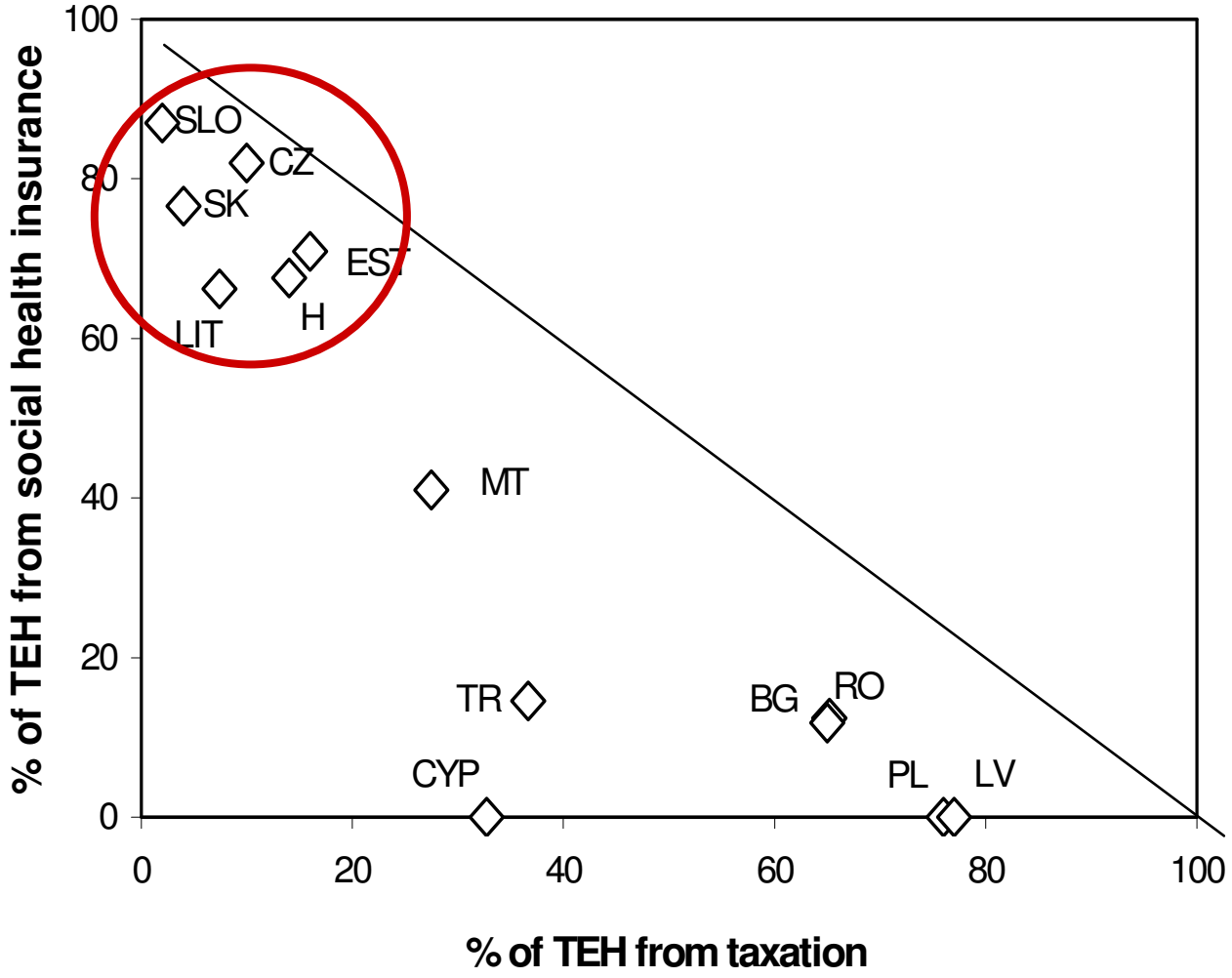
Funding of health care in the new EU Member States: % contributed from three main sources – social insurance, taxes, and private (in 2000)



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	Distribution: fairness in financial contribution (1.00 = max.)	Threshold	
		% of households with catastrophic payments (total expenditure)	% of households with catastrophic pay-ments (out of pocket)
Slovakia	**0.941**	**0.00**	**0.00**
United Kingdom	**0.921**	0.33	0.04
Denmark	**0.920**	0.38	0.07
Sweden	0.920	0.39	0.18
Germany	0.913	0.54	**0.03**
Hungary	0.905	0.96	0.20
Czech Republic	0.904	**0.01**	0.00
Belgium	0.903	**0.23**	0.09
Finland	0.901	1.36	0.44
Spain	0.899	0.89	0.48
Slovenia	0.890	1.88	0.06
France	0.889	0.68	**0.01**
Lituania	0.875	1.68	1.34
Estonia	0.872	2.47	1.30
Greece	**0.858**	**3.29**	**2.17**
Portugal	**0.845**	**4.01**	**2.71**
Latvia	**0.828**	**4.05**	**2.75**

Data: Murray & Evans „Health Systems Performance Assessment: Debates, Methods and Empiricism“, WHO 2003: 525-6

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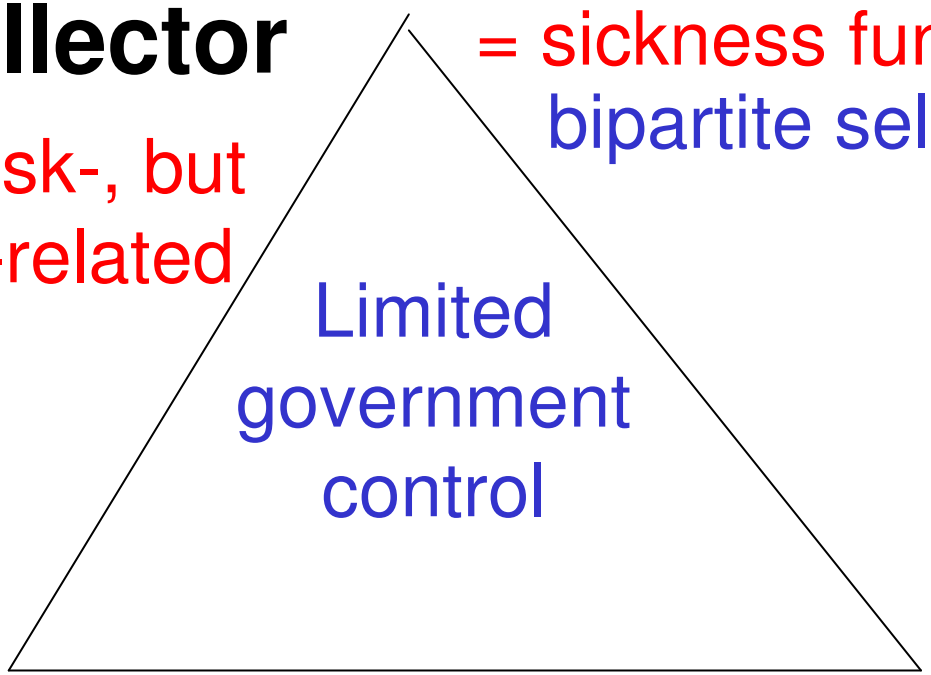
bipartite self-government



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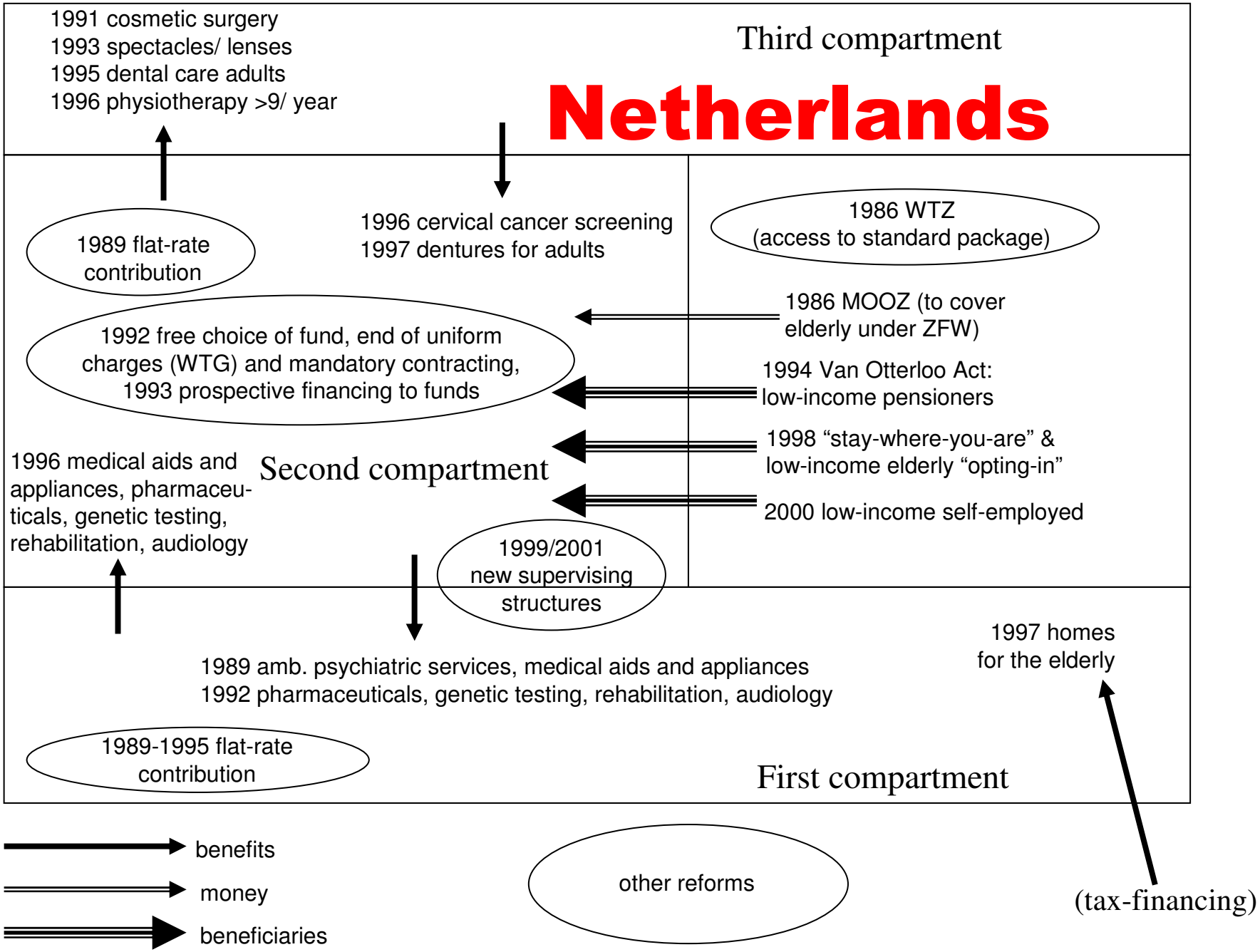
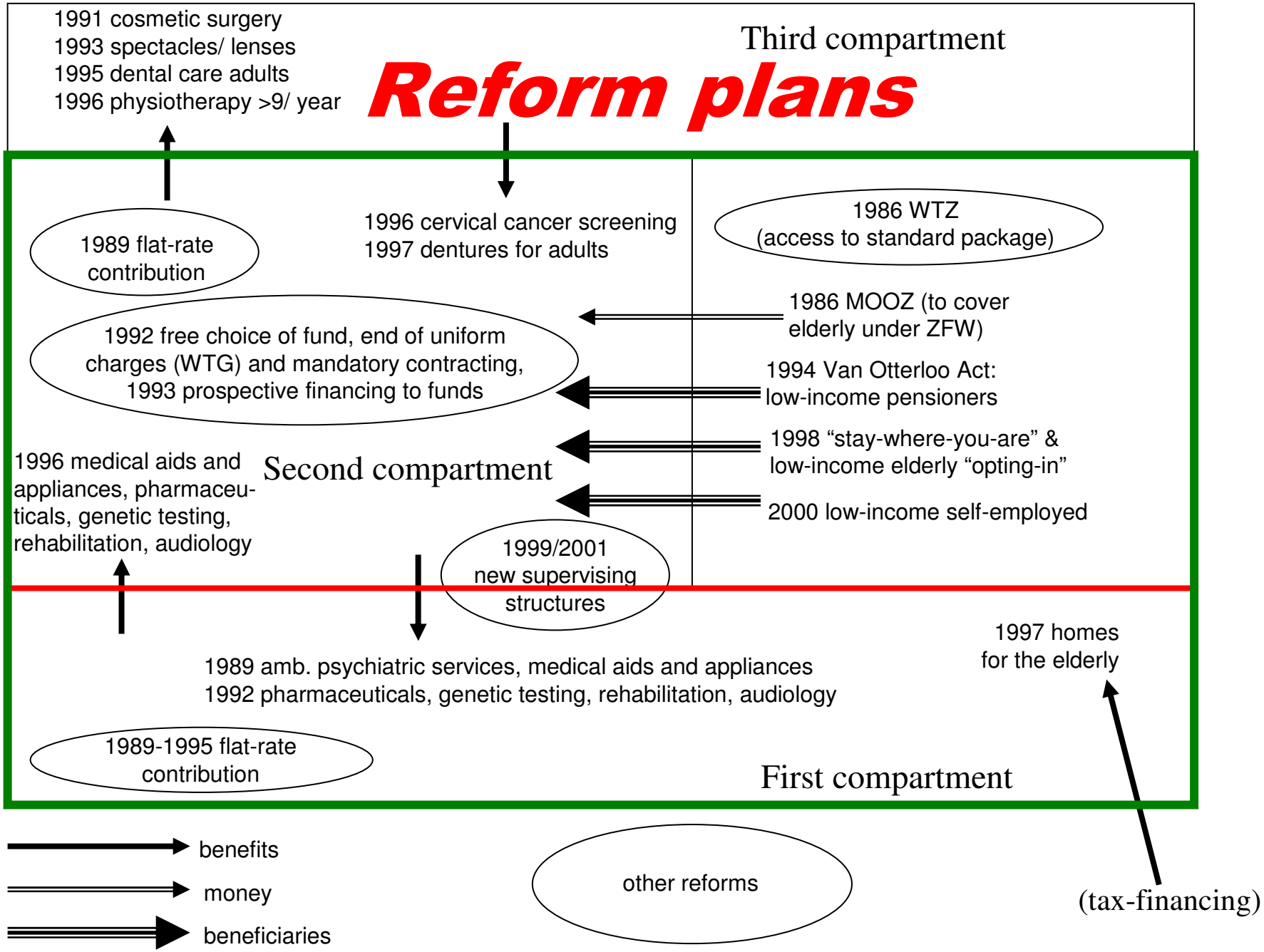
Principal organisational forms of sickness funds

- One national monopoly fund: e.g. Hungary
- Several regional monopoly funds: e.g. Romania (+ *de facto* Austria)
- Several monopoly funds organised on other principles (e.g. occupation): e.g. France, Luxembourg, Germany -96
- Several funds in competition: e.g. Belgium, Czech Rep., Germany (since 96), Netherlands, Slovakia, Switzerland
  - *Bi-partite: self-government is shared between employers and employees – government supervises (tri-partite = government participates directly)*

More than one fund raises many questions:

- Uniform benefit catalogue?
  For equity reasons – yes; but for competition?
- Uniform contribution rate (or per capita premium)?
  A, B, F, L = yes; CH, D = no, NL = mix
- If rate is uniform, should there be one collector?
  How should the money be allocated to funds?
  Which risk factors? What happens if that is not enough? Otherwise: re-allocation between funds needed (as in CH & D)!
- Is it worth it to have more than one fund???


1991 cosmetic surgery
1993 spectacles/ lenses
1995 dental care adults
1996 physiotherapy >9/ year
Third compartment
Netherlands
1989 flat-rate contribution
1996 cervical cancer screening
1997 dentures for adults
1986 WTZ (access to standard package)
1986 MOOZ (to cover elderly under ZFW)
1992 free choice of fund, end of uniform charges (WTG) and mandatory contracting, 1993 prospective financing to funds
1994 Van Otterloo Act: low-income pensioners
1998 "stay-where-you-are" & low-income elderly "opting-in"
2000 low-income self-employed
1996 medical aids and appliances, pharmaceuticals, genetic testing, rehabilitation, audiology
Second compartment
1999/2001 new supervising structures
1997 homes for the elderly
1989 amb. psychiatric services, medical aids and appliances
1992 pharmaceuticals, genetic testing, rehabilitation, audiology
1989-1995 flat-rate contribution
First compartment
benefits
money
beneficiaries
other reforms
(tax-financing)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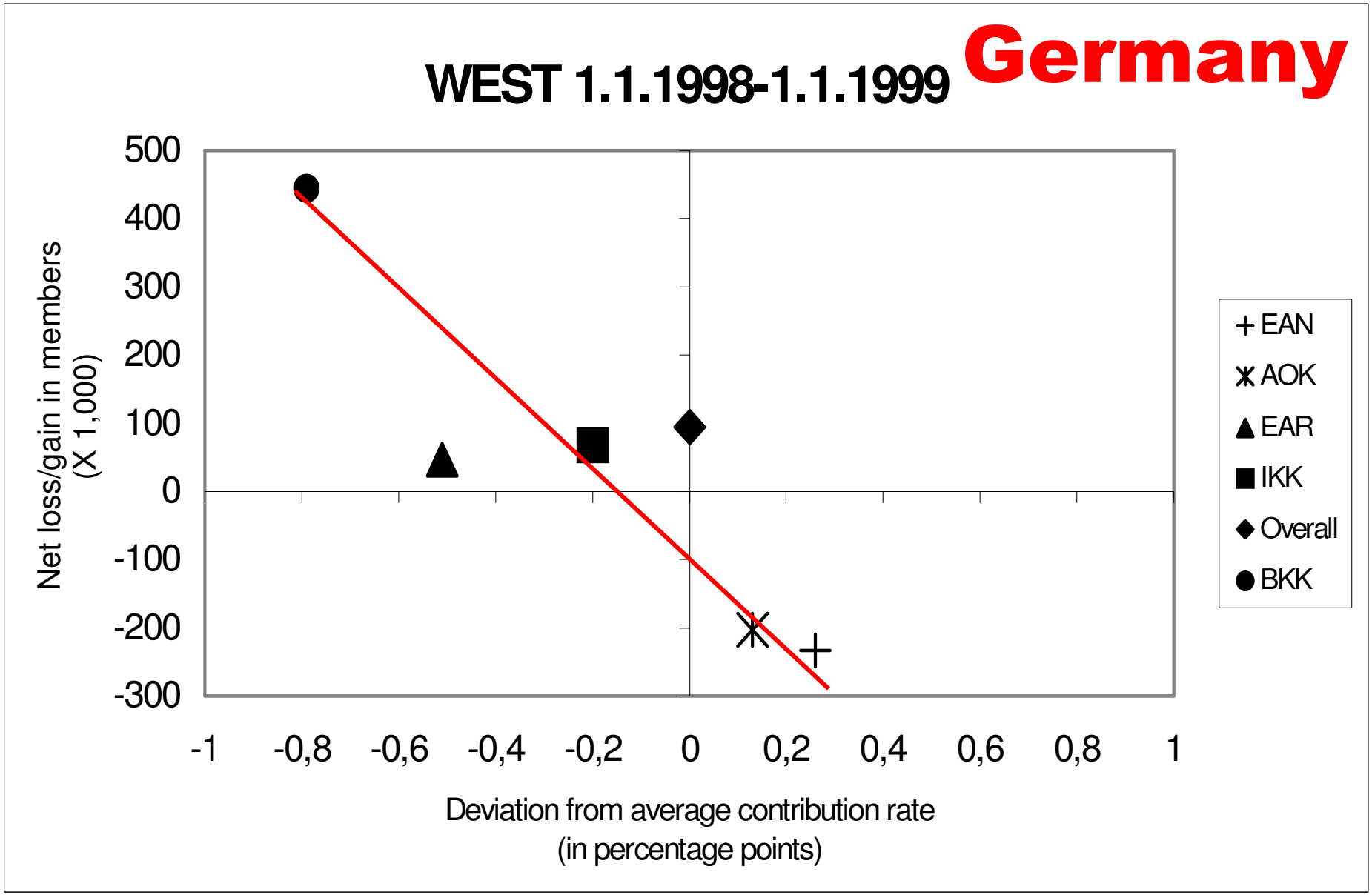

Gains/ losses in sickness fund membership

in the western part of Germany in relationship to contribution rate

Transferred money through "risk structure compensation"

	West			East			Germany		
	RSC* / expenditure** (billion Euro)		RSC as % of expenditure	RSC* / expenditure** (billion Euro)		RSC as % of expenditure	RSC* / expenditure** (billion Euro)		RSC as % of expenditure
1995	6.90/	97.29	7.1	2.36/	19.70	12.0	9.23/	116.99	7.9
1996	7.27/	100.41	7.2	2.51/	20.47	12.3	9.78/	120.88	8.1
1997	7.71/	98.23	7.8	2.63/	20.05	13.1	10.34/	118.29	8.7
1998	8.22/	99.74	8.2	2.80/	19.97	14.0	11.01/	119.71	9.2
1999	8.30/	102.68	8.1	3.29/	20.52	16.0	11.60/	123.21	9.4
2000	8.30/	105.05	7.9	3.73/	20.89	17.8	12.03/	125.94	9.6
2001	9.09/	108.89	8.3	4.43/	21.75	20.4	13.52/	130.63	10.3
2002	8.99/	111.79	8.0	4.53/	22.54	20.1	13.52/	134.33	10.1

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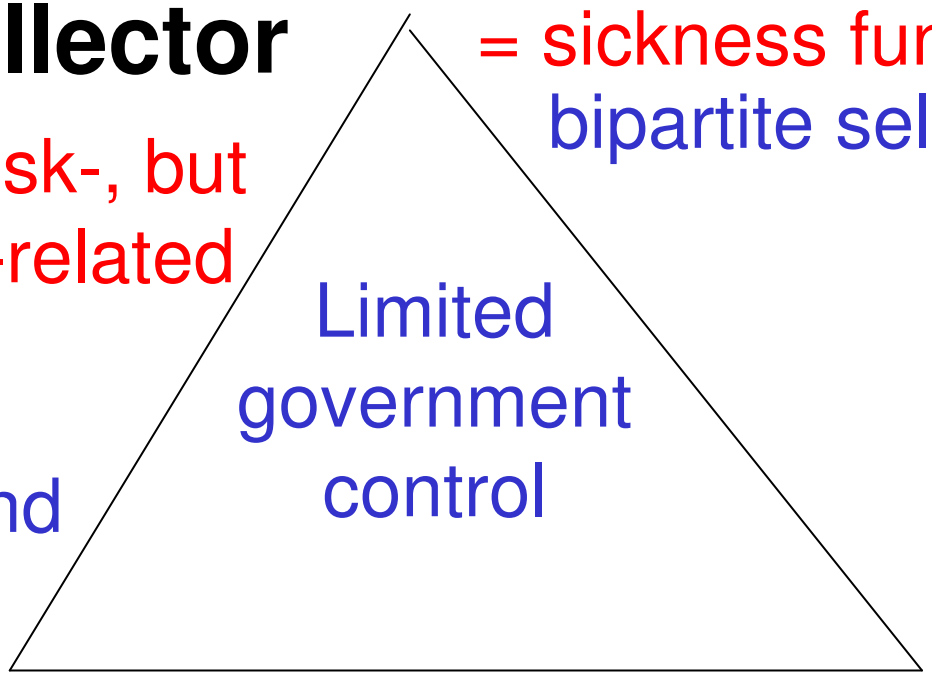

Population

Mandatory insurance

Providers

Public-private mix

In Germany discussed in 2003 – 120 years after SHI introduction!

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Public-private ownership of acute care hospital beds in SHI 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%	

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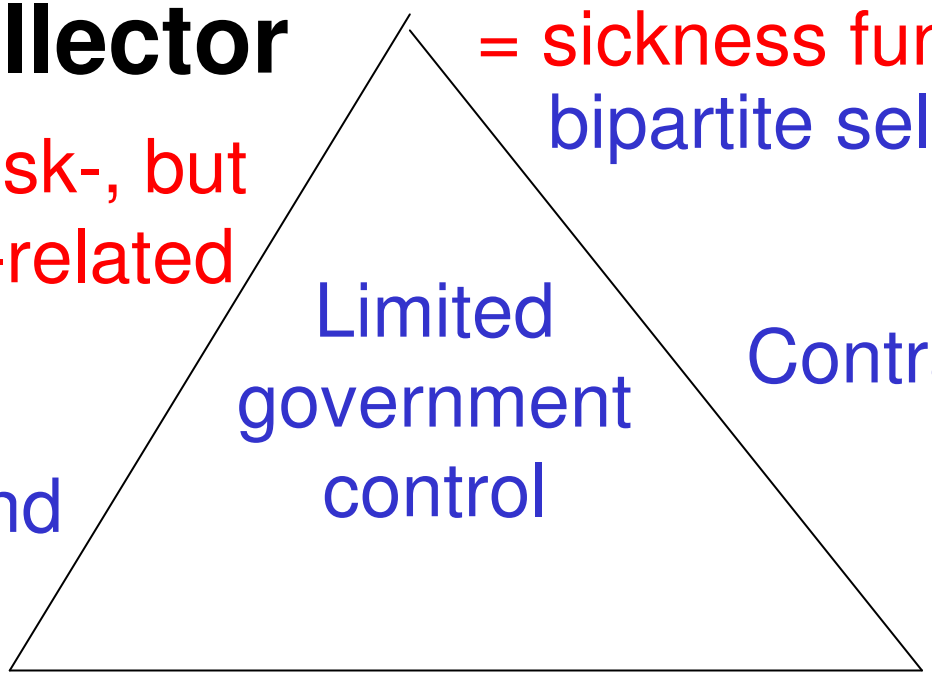

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Limited government control

Contracts

Choice of fund

Free access

Population

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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)

What does this all mean?

- Social health insurance systems with more than sickness fund are close to the actors but complicated to steer and manage!
- We do not have convincing data that it‘s really worth it in terms of improved health outcomes – especially for the chronically ill who need coordinated/ integrated care (disease management programmes) more than competition!

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