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SHI systems in continuous finance reforms:

what can we learn from western Europe and CEE?

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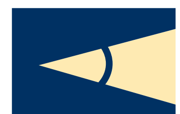


What makes a health system a SHI system?

Contribution collector

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

Third-party payer

= sickness funds

(bi)partite self-government

Limited government control

Population

Providers

Principal organisational forms of sickness funds

- One national monopoly fund:
  e.g. Estonia, Hungary, Poland
- Several regional monopoly funds: *e.g. Latvia, Romania; initially Estonia and Poland*
- Several non-choice funds organised on other principles (e.g. occupation):
  Austria, France, Luxembourg; Germany -1995
- Several funds in competition:
  Belgium, Germany, Netherlands, Switzerland;
  Czech Republic, Slovakia

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

Contracts

Limited government control

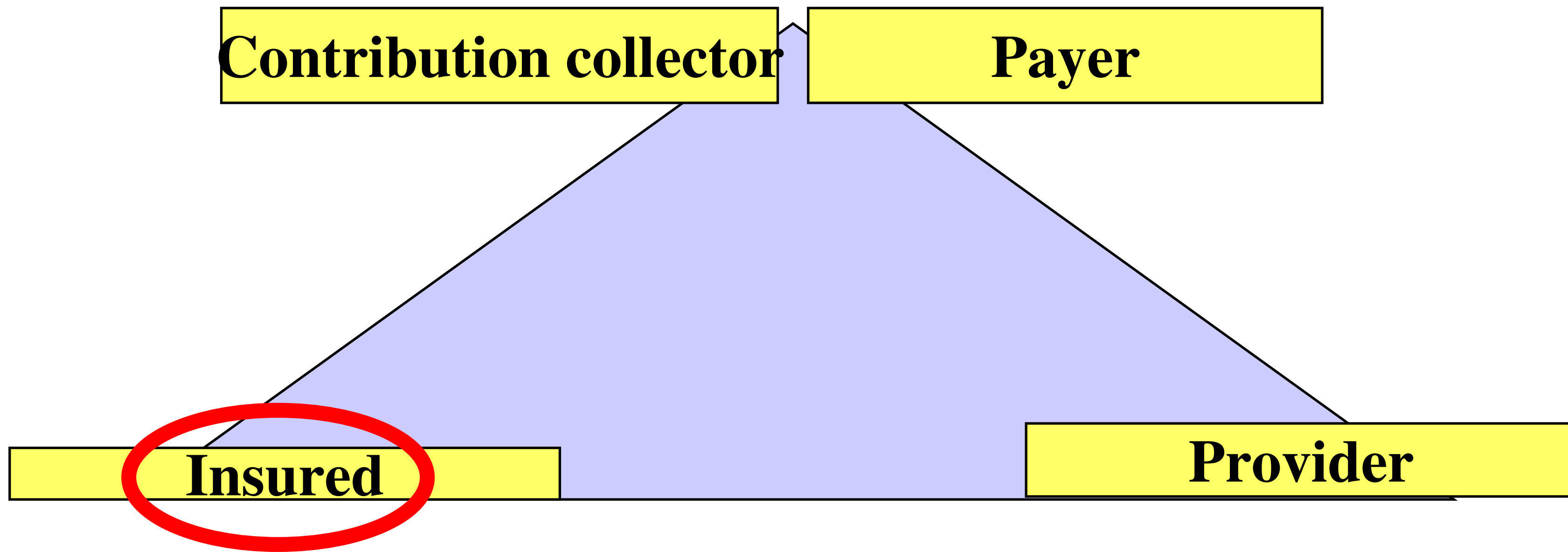
Free access

Population

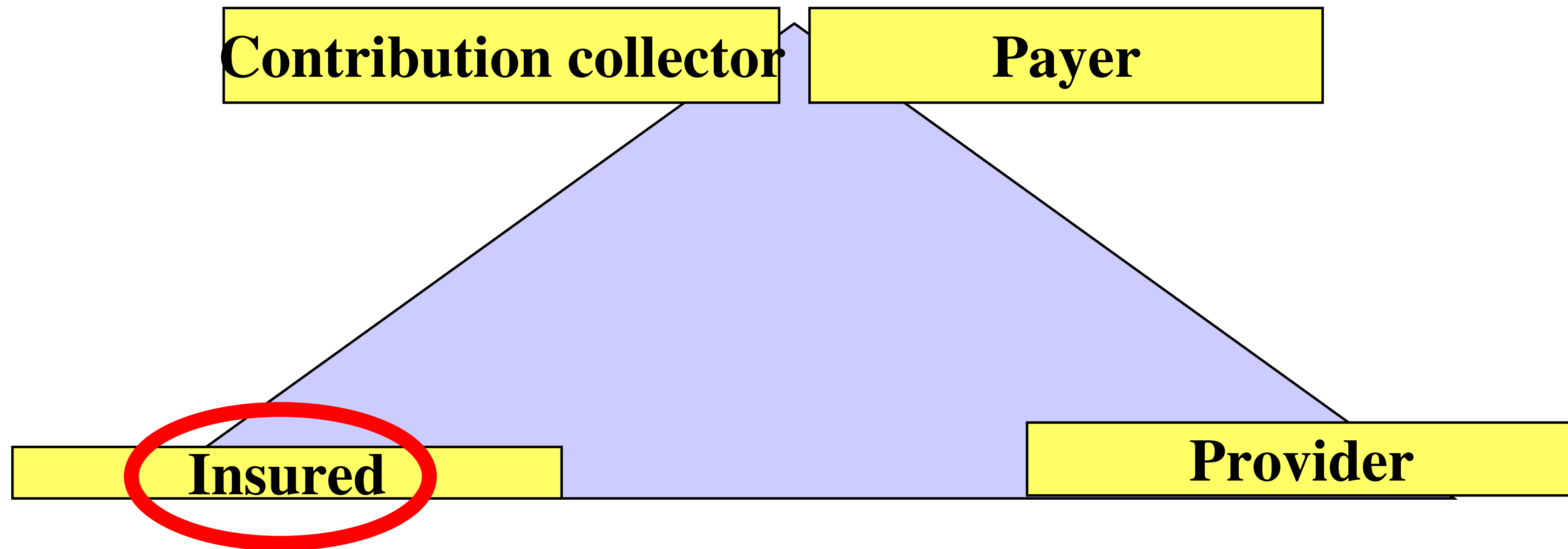
Mandatory insurance

Providers

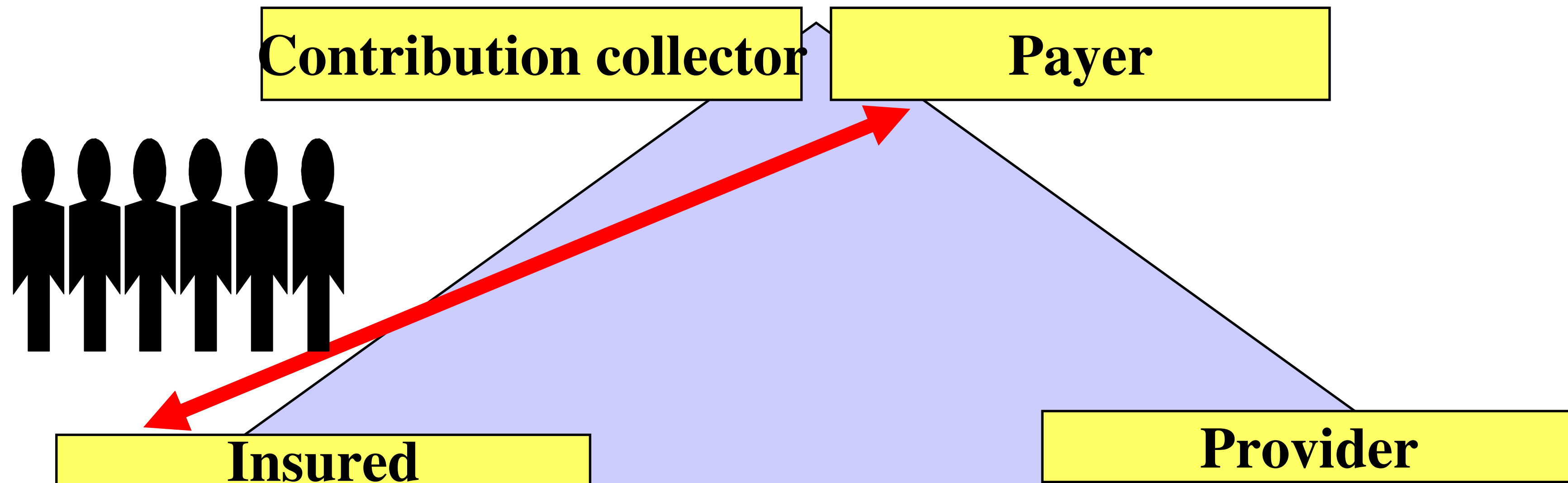
Public-private mix



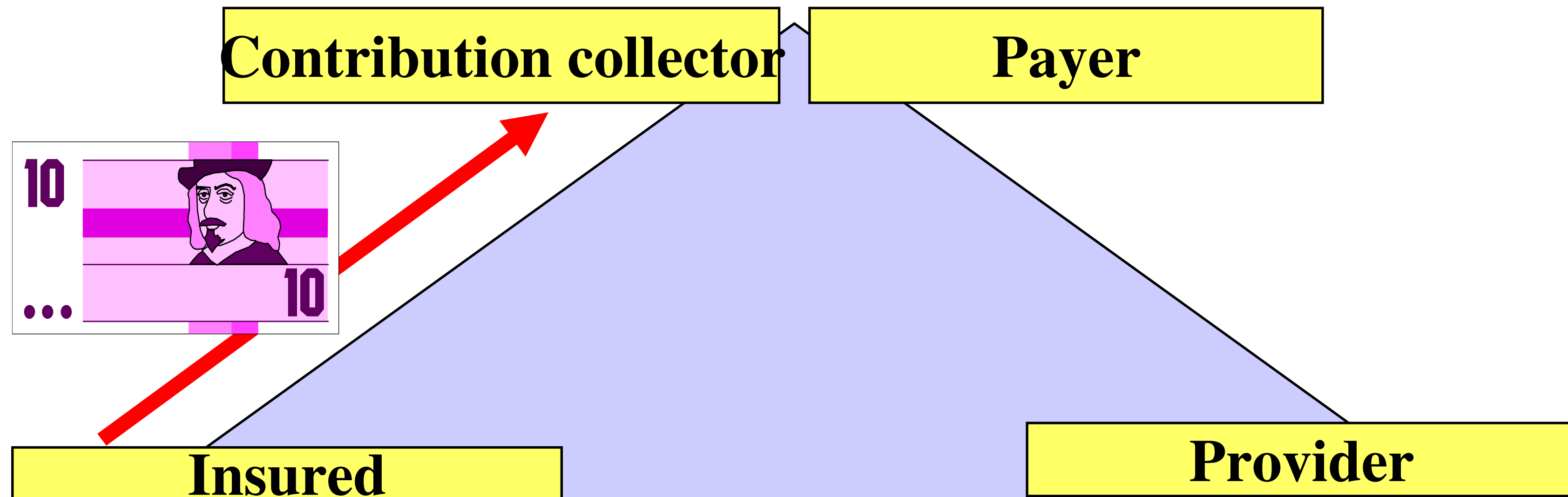
- SHI tradionally tied to employment
- later extended to defined other groups (dependents, pensioners, unemployed, students, self-employed etc.)
- no exclusion due to health status, but
- notion of “universal coverage“
  = very recent phenomenon



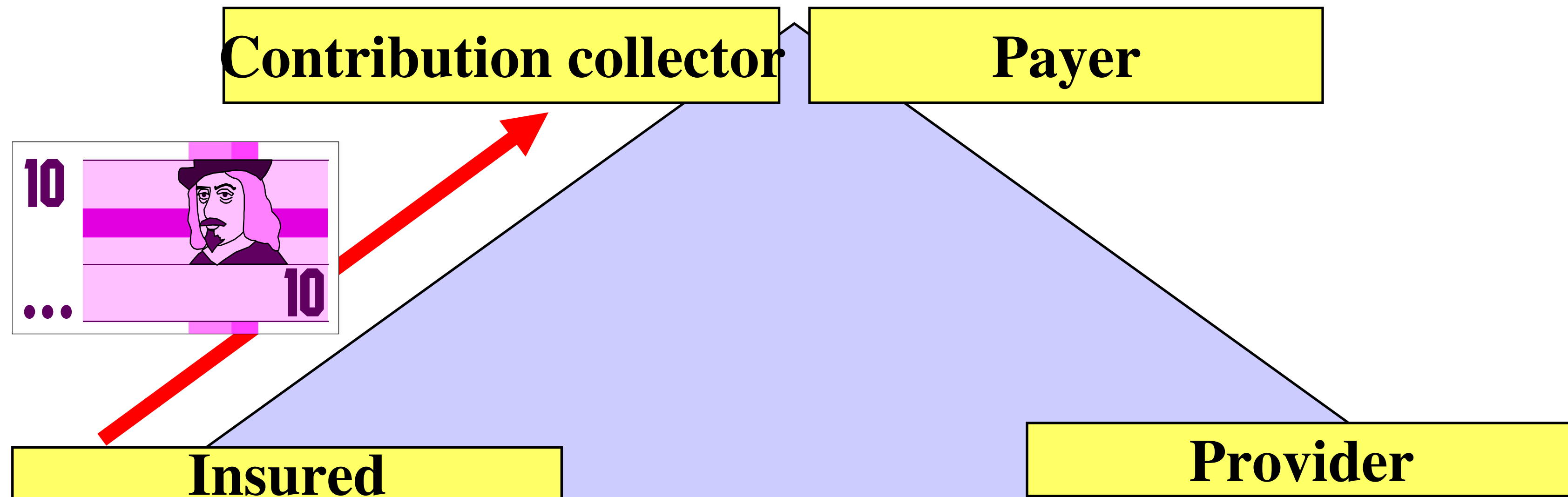
- 100% population coverage de facto in Austria and Luxembourg, legally in Belgium (since 1998), France (since 2000) and Switzerland (since 1996)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



- 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!*

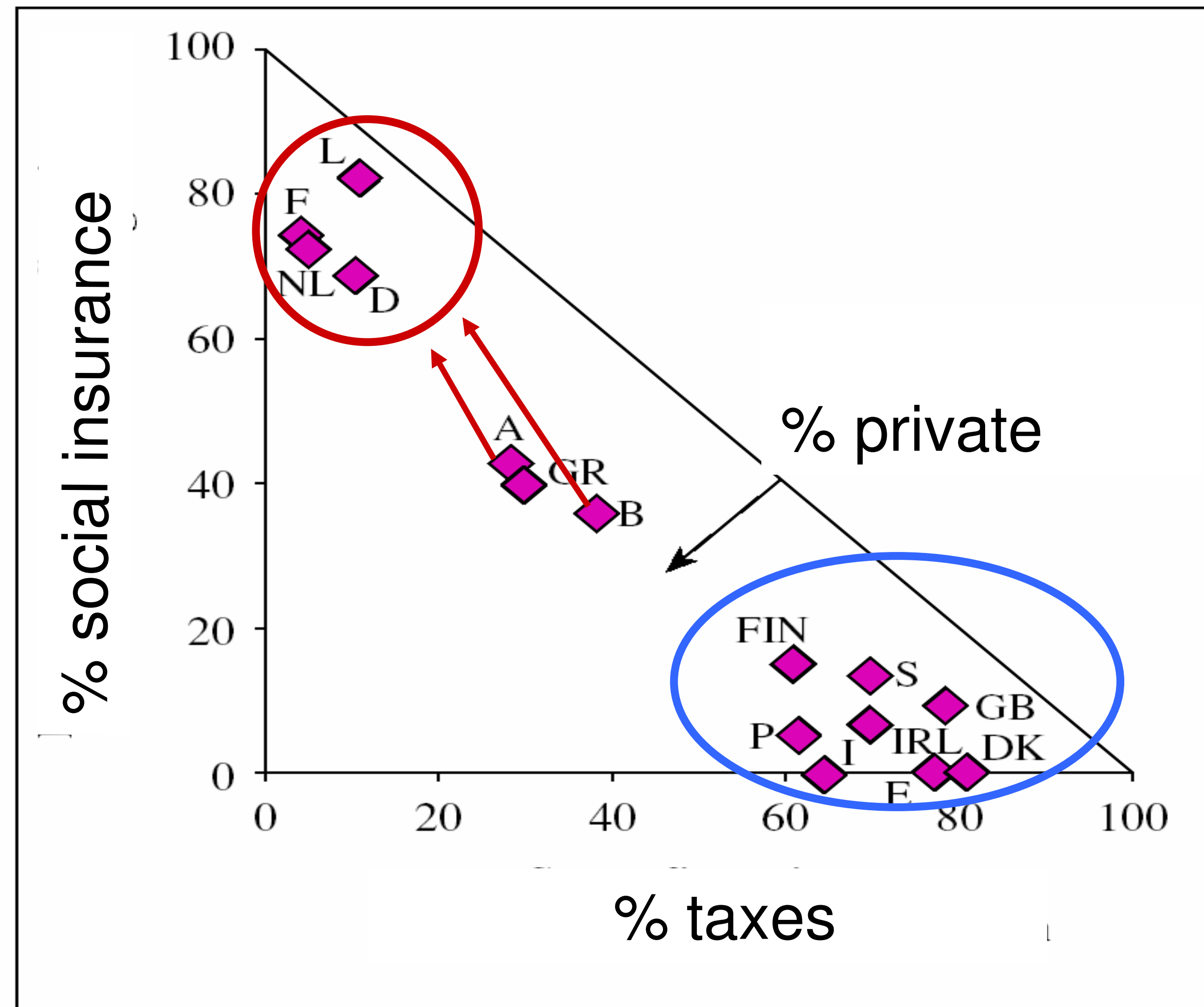


- Traditionally based on wages only (with an upper limit)
- Problem 1: increasing burden on labour costs as other income is rising faster
- Solution: broaden income base, e.g. by abolishing upper limit (Belgium, France)
- in France change from wage-based contribution of 8.9% to tax of 8.25% on all income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

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



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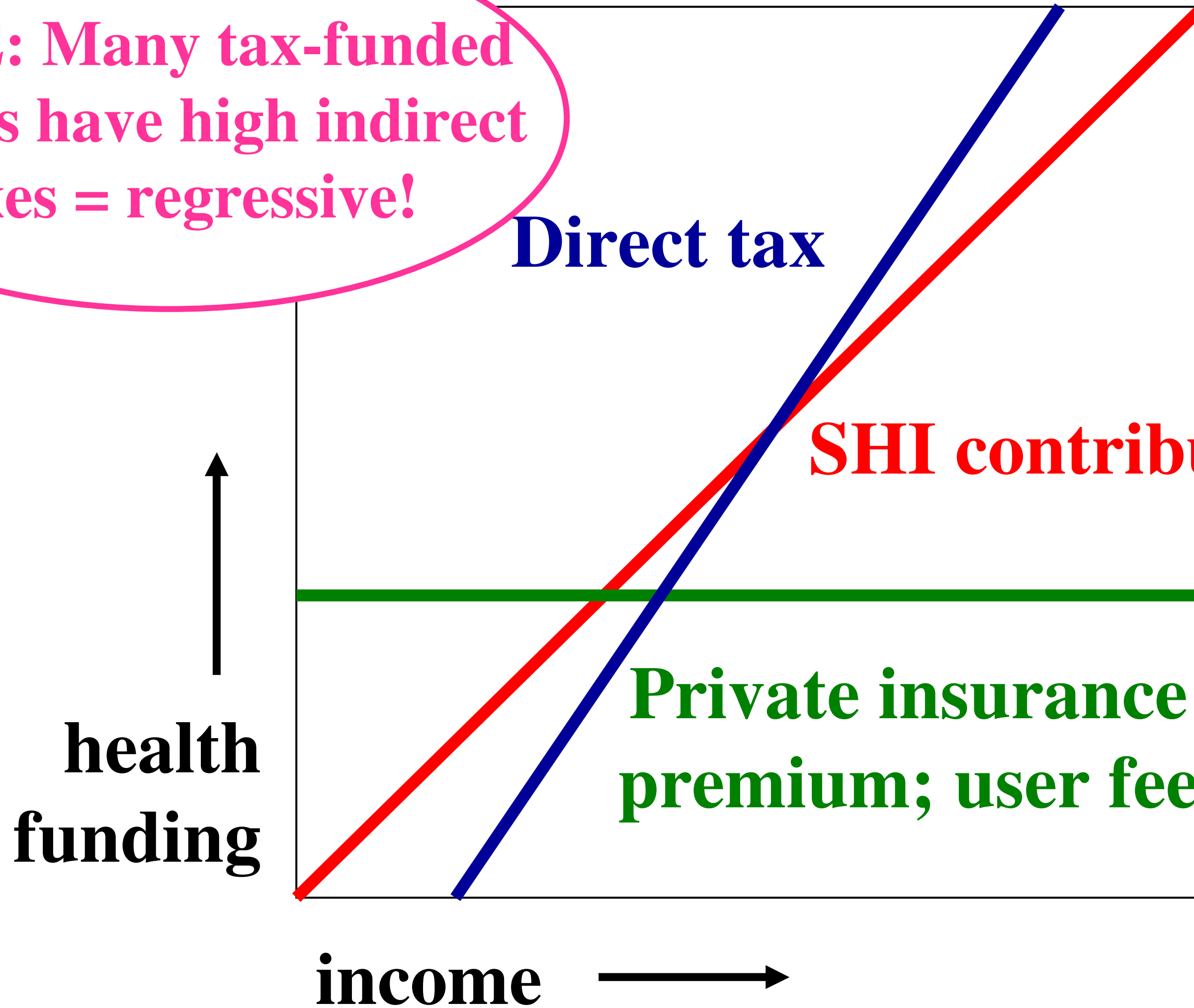

SHI systems have (CH) or will (NL) replace contributions by premiums = regressive!

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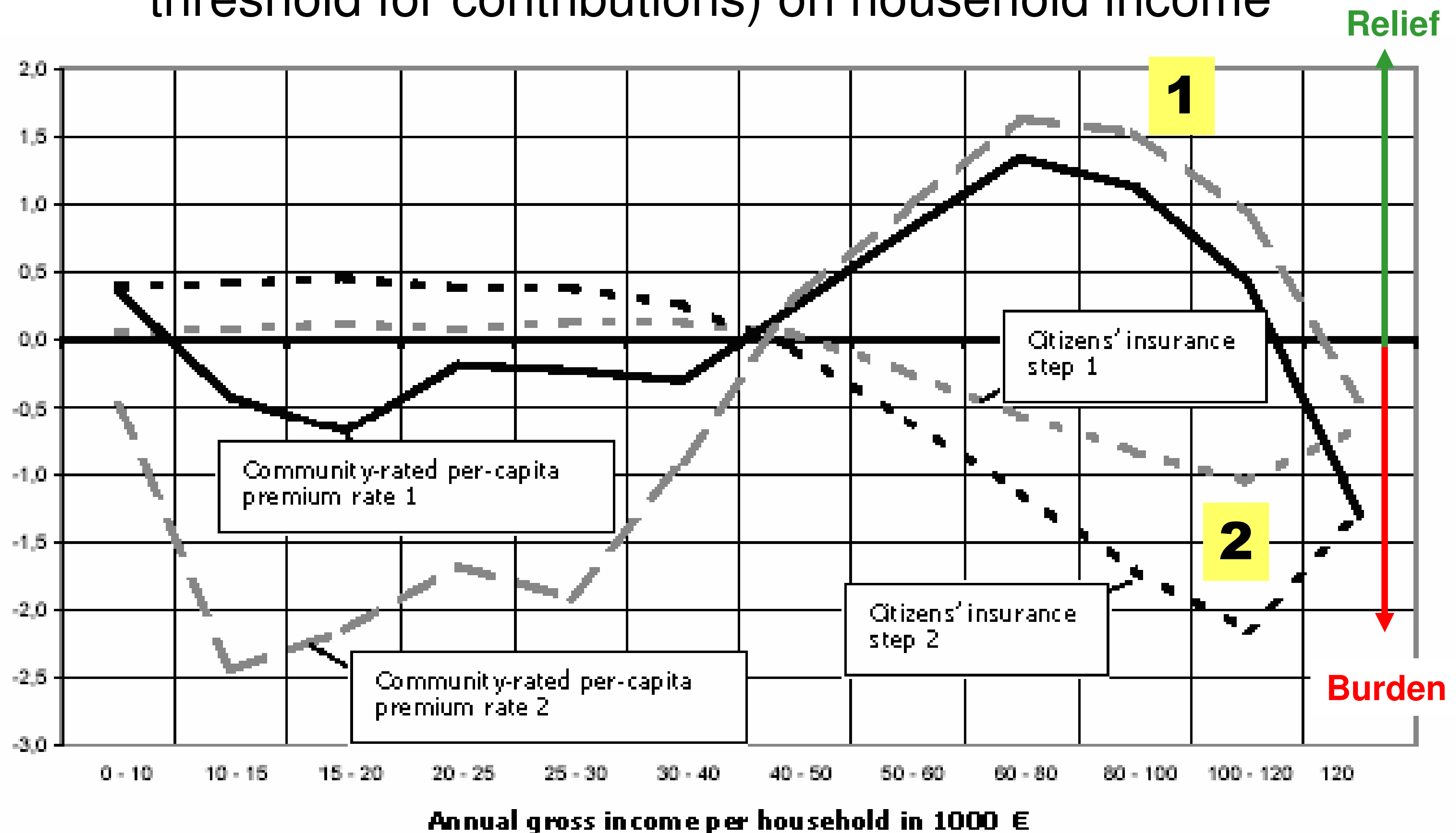
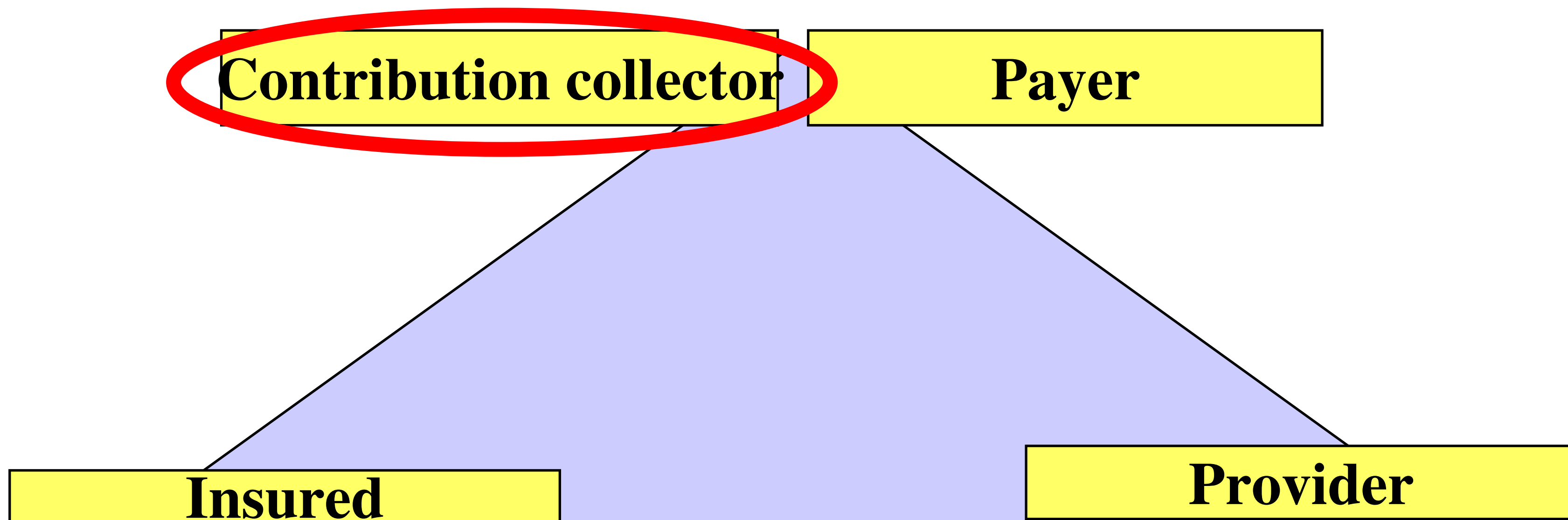
Financial effect of two reform options in Germany: 1. per-capita premium (with varying level of tax subsidies for low income) and 2. universal contributory insurance (with varying level of upper threshold for contributions) on household income

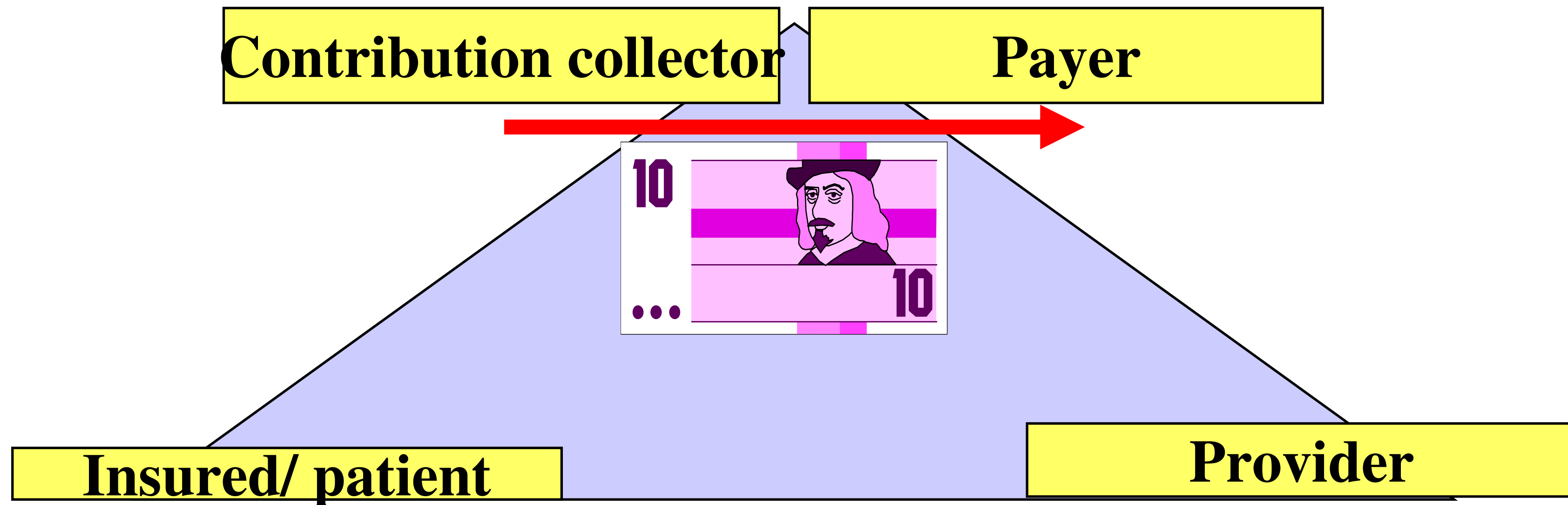


		Country	Distribution: fairness in financial contribution (1.00 = max.)	Threshold		
				% of households with catastrophic payments (total expenditure)	% of households with catastrophic pay-ments (out of pocket)	
	Slovakia	**0.941**	**0.00**	**0.00**	
	United Kingdom	**0.921**	0.33	0.04	
	Denmark	**0.920**	0.38	0.07	
	Sweden	0.920	0.39	0.18	
SHI	Germany	0.913	0.54	**0.03**	
	Hungary	0.905	0.96	0.20	
	Czech Republic	0.904	**0.01**	0.00	
SHI	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	
SHI	France	0.889	0.68	**0.01**	
→	Lituania	0.875	1.68	1.34	1999
	Switzerland	0.875	3.03	0.57	
→	Estonia	0.872	2.47	1.30	1995
	Greece	**0.858**	**3.29**	**2.17**	
	Portugal	**0.845**	**4.01**	**2.71**	
→	Latvia	**0.828**	**4.05**	**2.75**	1997/98

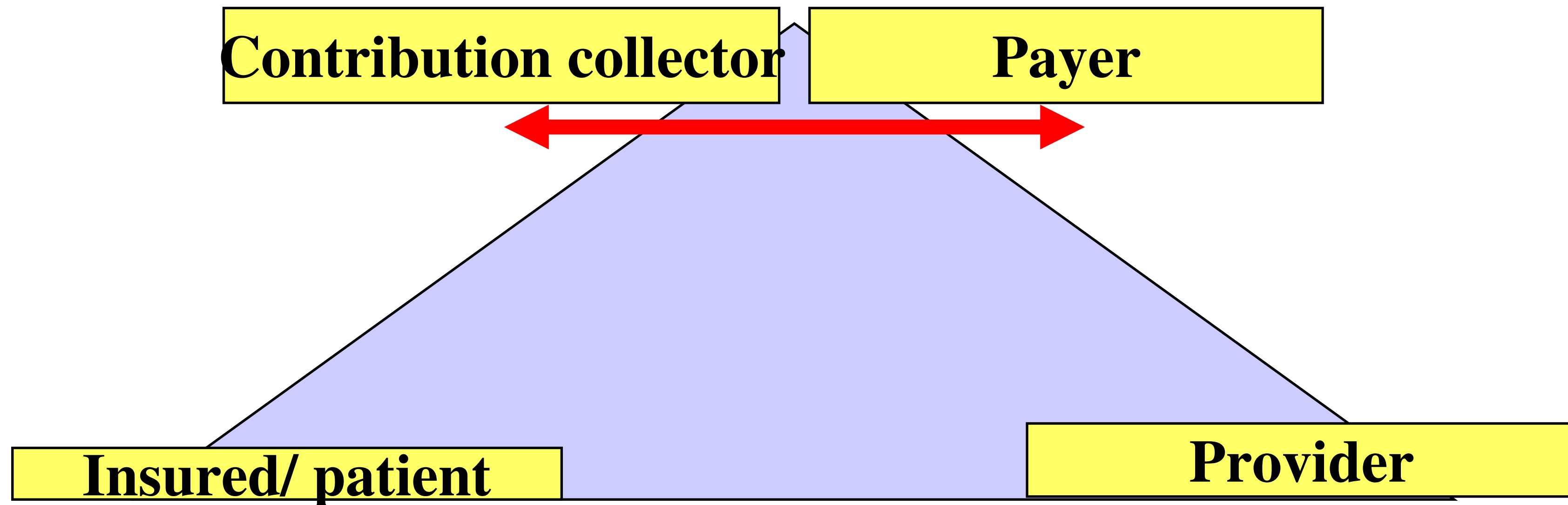
Data: Murray & Evans „Health Systems Performance Assessment: Debates, Methods and Empiricism“, WHO 2003: 525-6



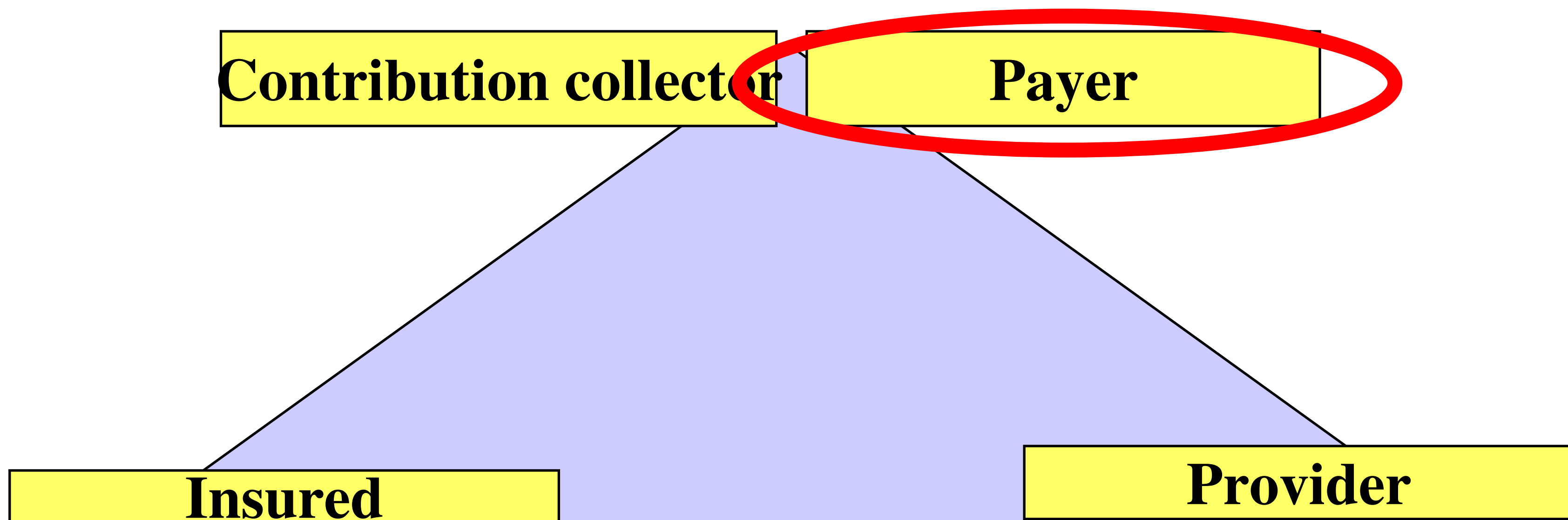
- Governmental agencies (Belgium, France, Netherlands)
- Union of sickness funds (Luxembourg)
- Individual sickness funds (Austria, Germany, Switzerland)



- 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



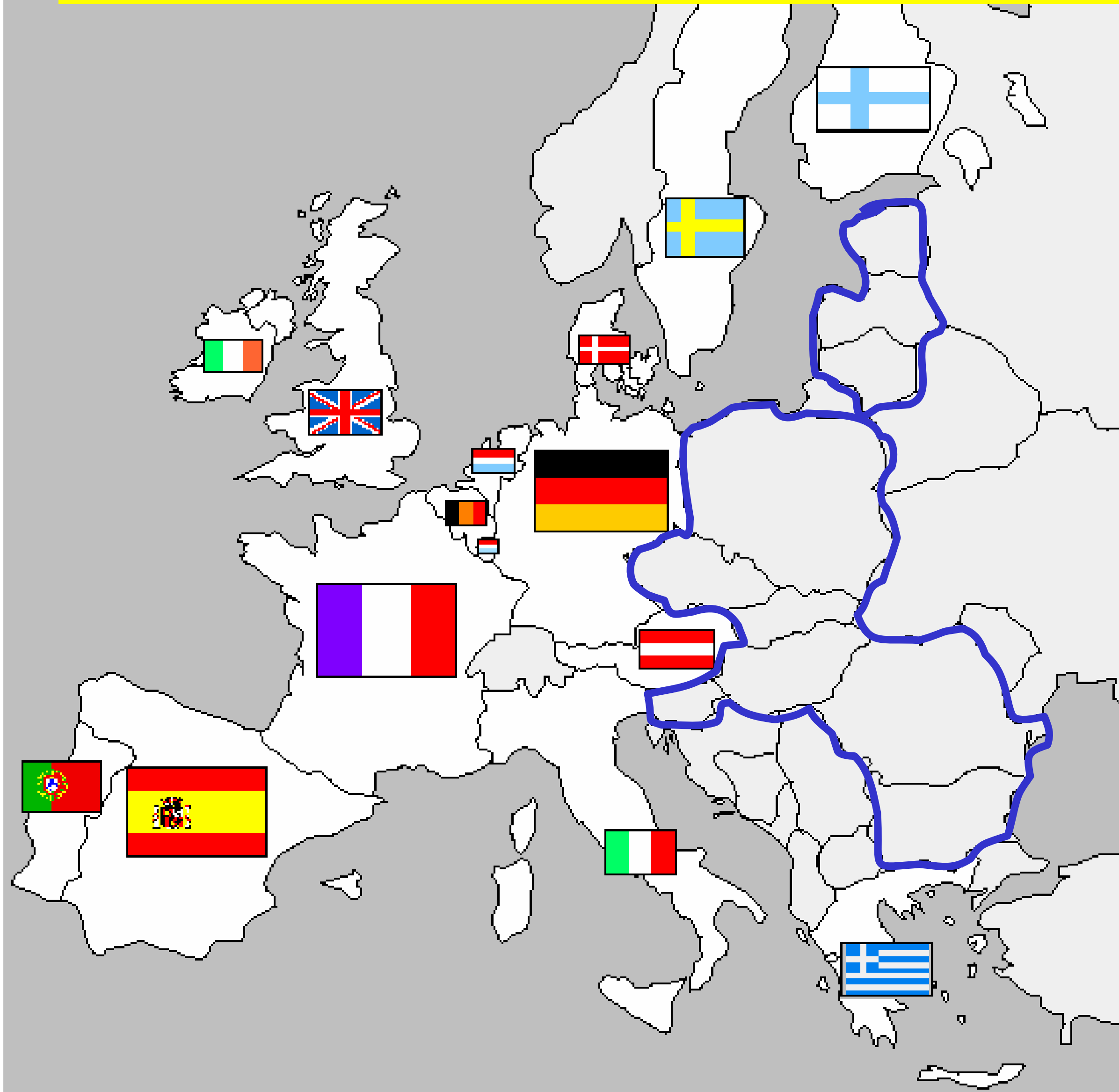
- Main problem with all risk adjustment formulae: included factors explain only a small part of variation as (costly) morbidity is not captured, *i.e. sickness funds with a high share of chronically ill are disadvantaged!*
- Most innovative approach: to tie risk adjustment to inscription into disease management programmes *– but high administrative hurdles!*



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

Central and eastern Europe



Bulgaria
Czech Republic
Estonia
Hungary
Latvia
Lithuania
Poland
Romania
Slovakia
Slovenia

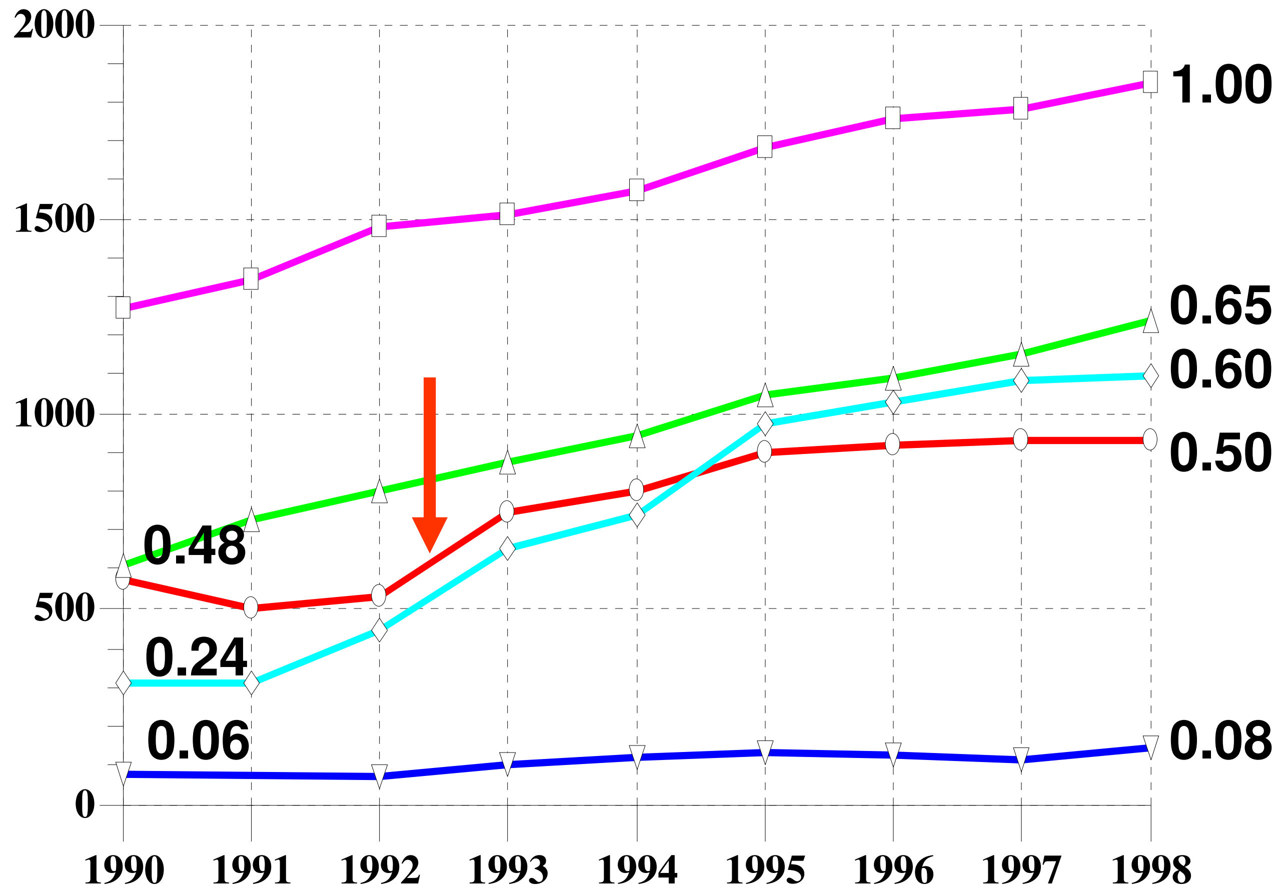
From Semashko to Bismarck

- "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

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)

992701 Total health expenditure in PPP$ per capita



Czech Republic
Slovenia
Portugal
EU average
Romania

Successes

Introduction of insurance system and of funds was generally smooth

and expenditure did go up!

… 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

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Presentation, articles etc. are available at:

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