

# Competition and regulation in a statutory health insurance system

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What makes a health system a SHI system?

**Contribution collector**

**Third-party payer**

= sickness funds

(bi)partite self-government

Not (health) risk-, but usually wage-related contribution - *separate from taxes*

Health expenditure visible; population willing to pay more

Sole raison d'être: to ensure health care as efficient (cost per quality) and responsive as possible

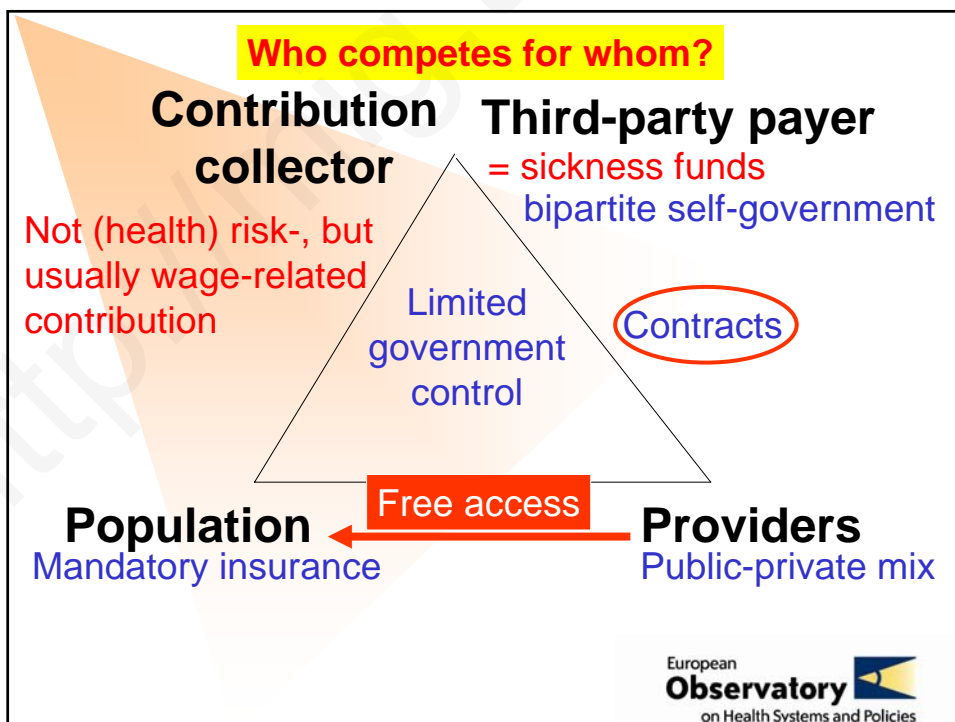
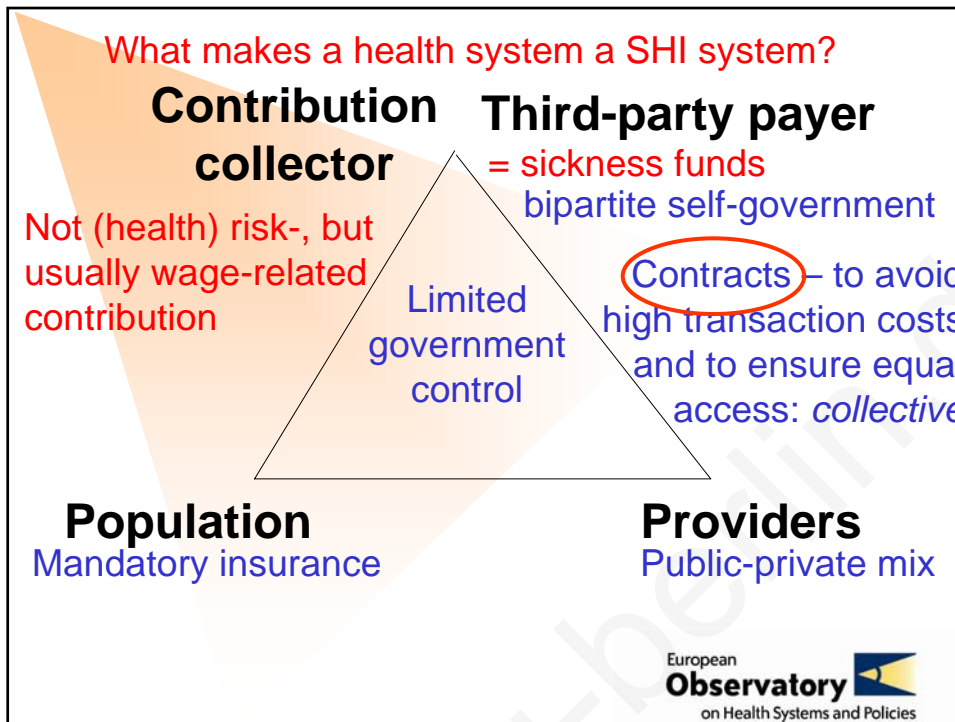
**Population**  
Mandatory insurance

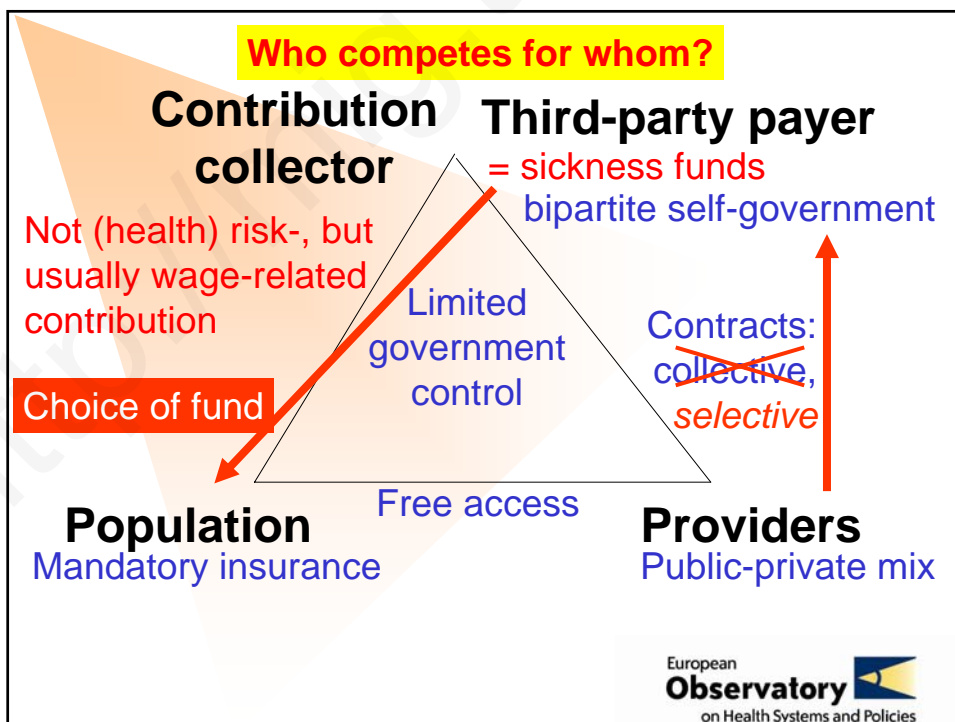
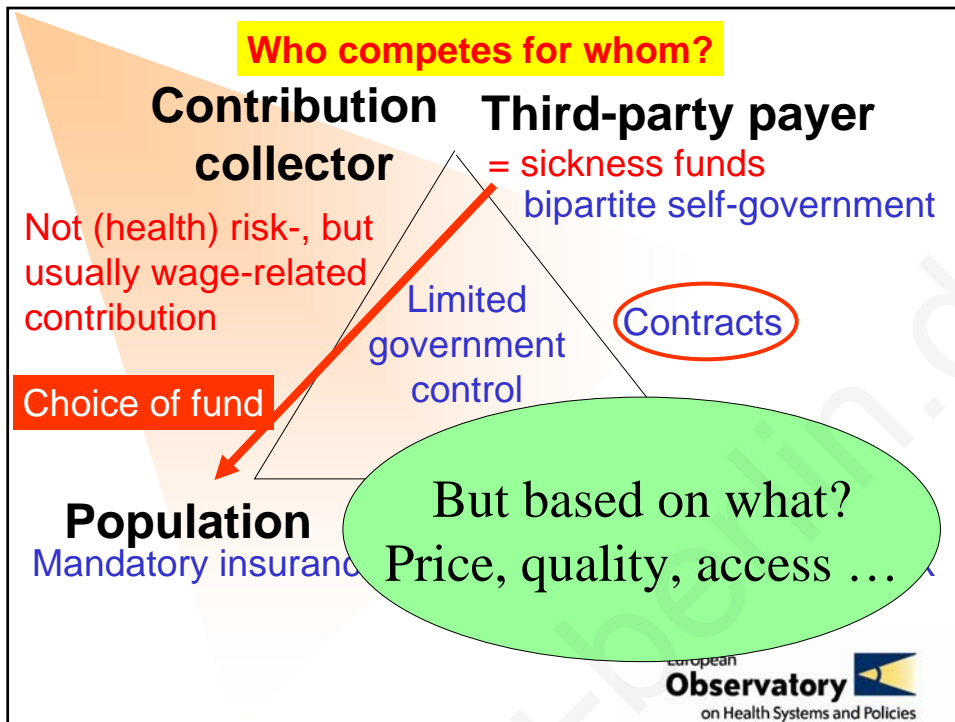
**Providers**

**Ability to pay**

**Solidarity**

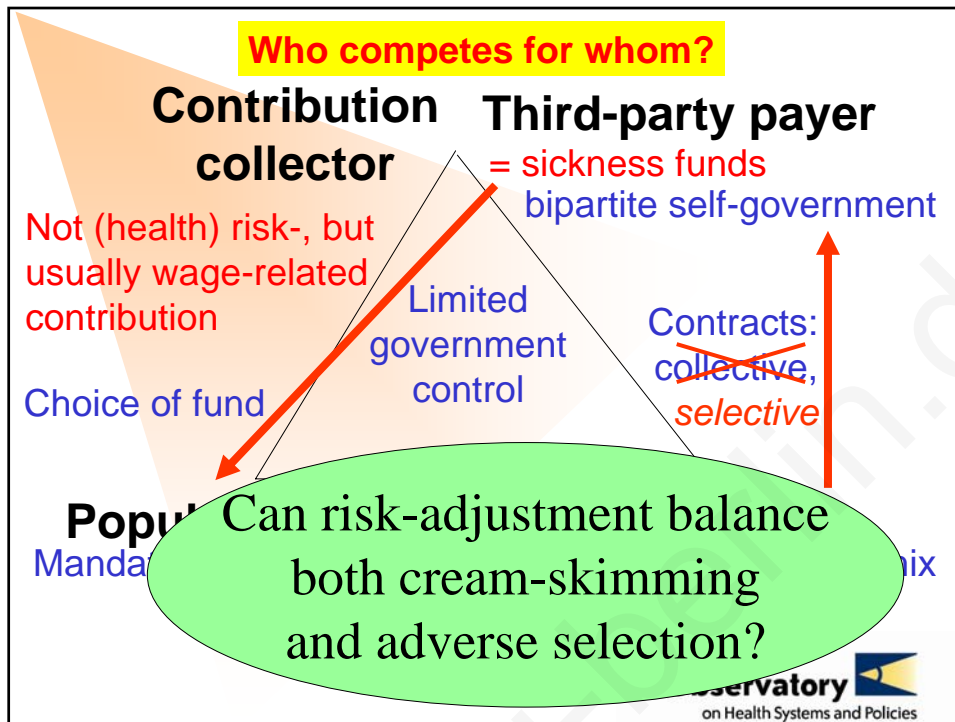
**Need**





1. Does it work, i.e. does selective contracting/ application of Managed Care instruments produce better outcomes and/or lower costs?
2. For which persons/ indications does it work? For the 75-80% chronically healthy? For the 5% really ill? For the 15-20% chronically ill?

1. -
2. -
3. Does it have adverse effects on somebody else's access?
4. Is it financially successful because of cream-skimming?
5. Is it quality-wise so successful that it leads to adverse selection?



1. Assuming it works – i.e. there are more benefits than harm, and assuming risk-adjustment can get us over the negative aspects –, who should benefit?
  2. Is it worth it? Do we need less competition (unite sickness funds)? More self-responsibility?
- European  
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