Technische Universität Berlin

Künftige Anforderungen an Finanzierung und Vergütung im Gesundheitswesen

Verbreiterung der Finanzierungsbasis: Internationale Lösungsansätze

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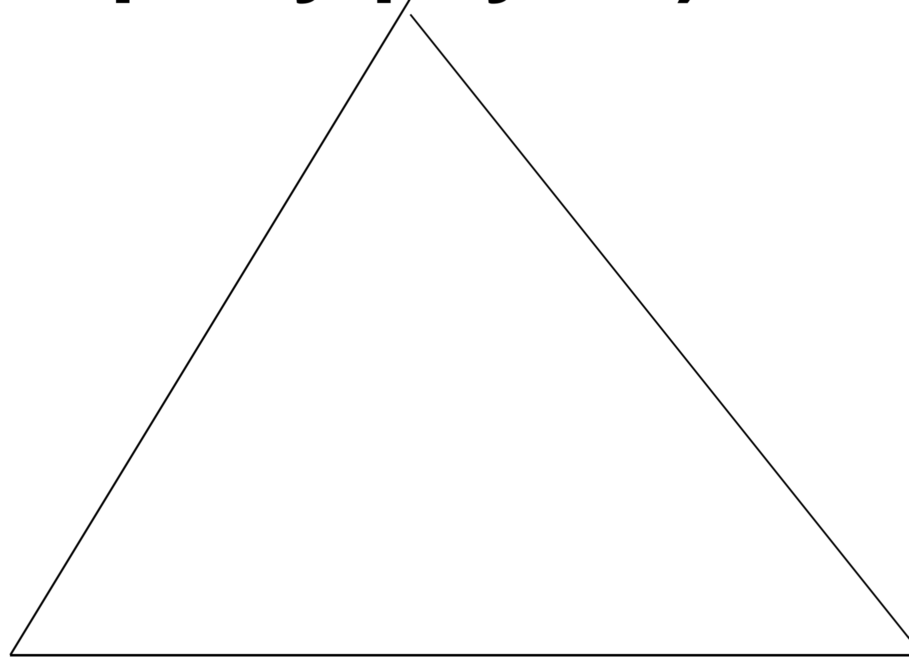
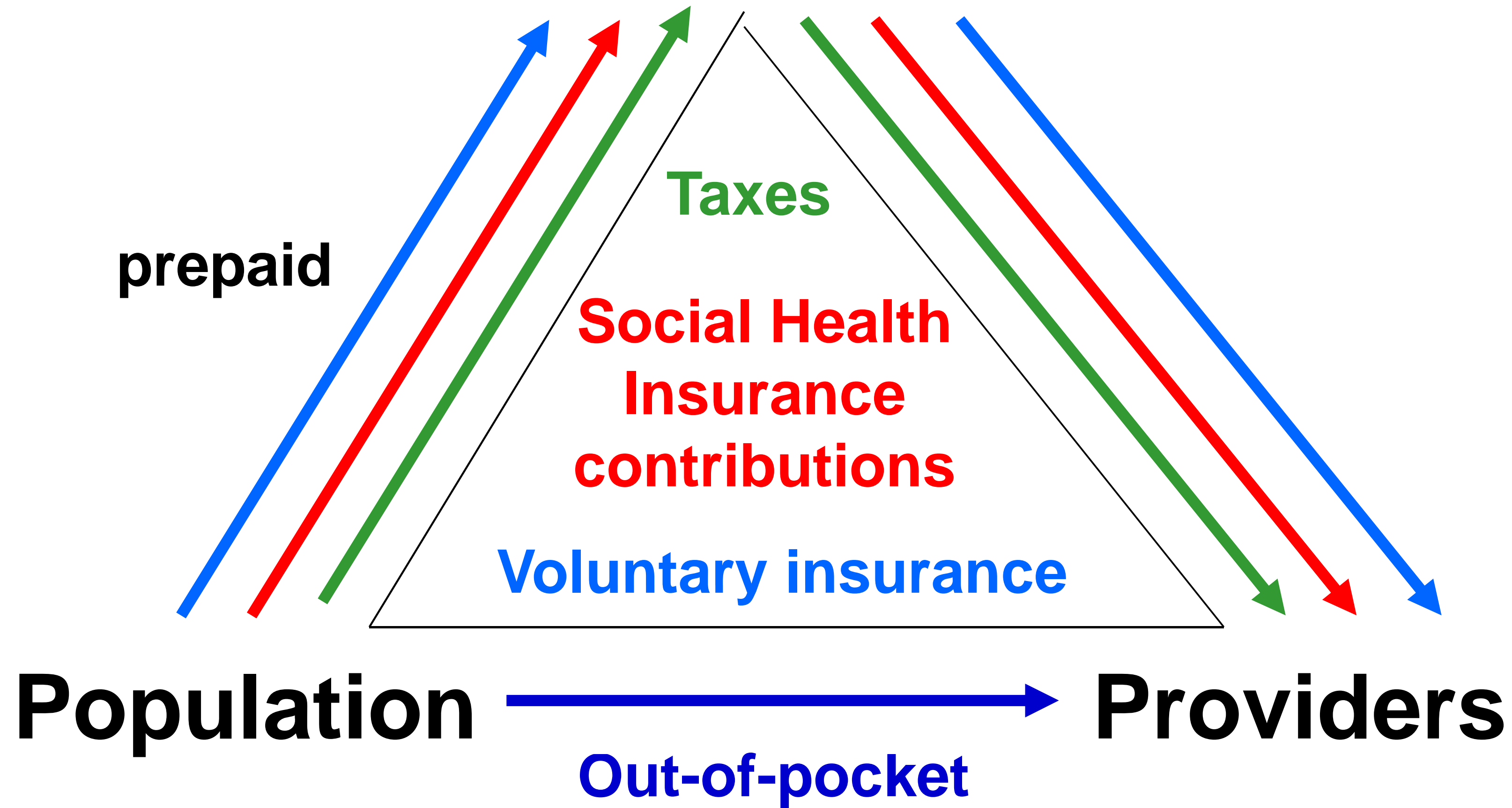
FG Management im Gesundheitswesen,
Technische Universität Berlin (WHO Collaborating Centre for Health Systems Research and Management) &
European Observatory on Health Systems and Policies

European Observatory on Health Systems and Policies


Zahler ("Third-party payer")
Bevölkerung
Leistungs-erbringer

4 WESENTLICHE ARTEN VON FINANZIERUNG

Third-party Payer



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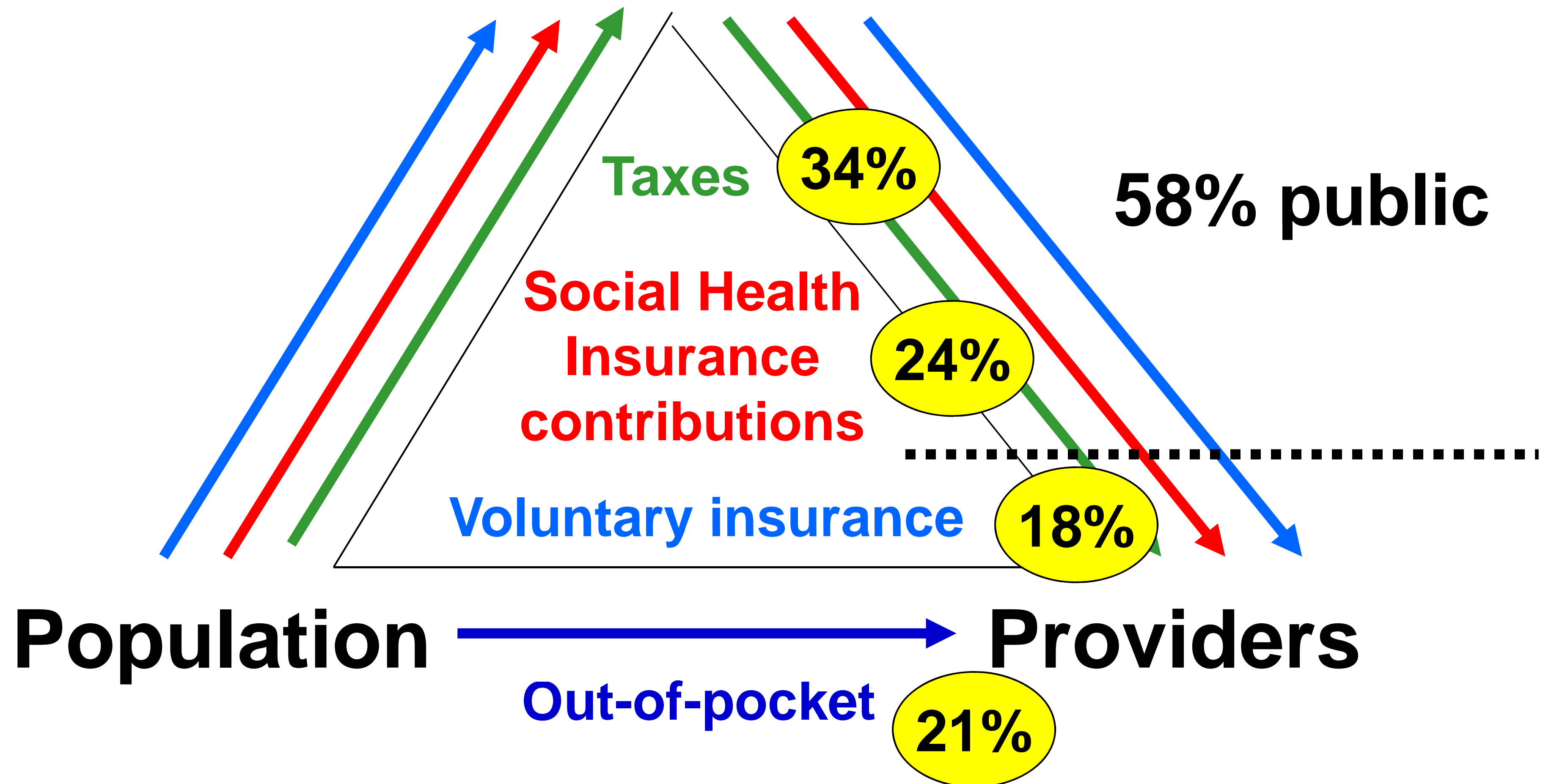
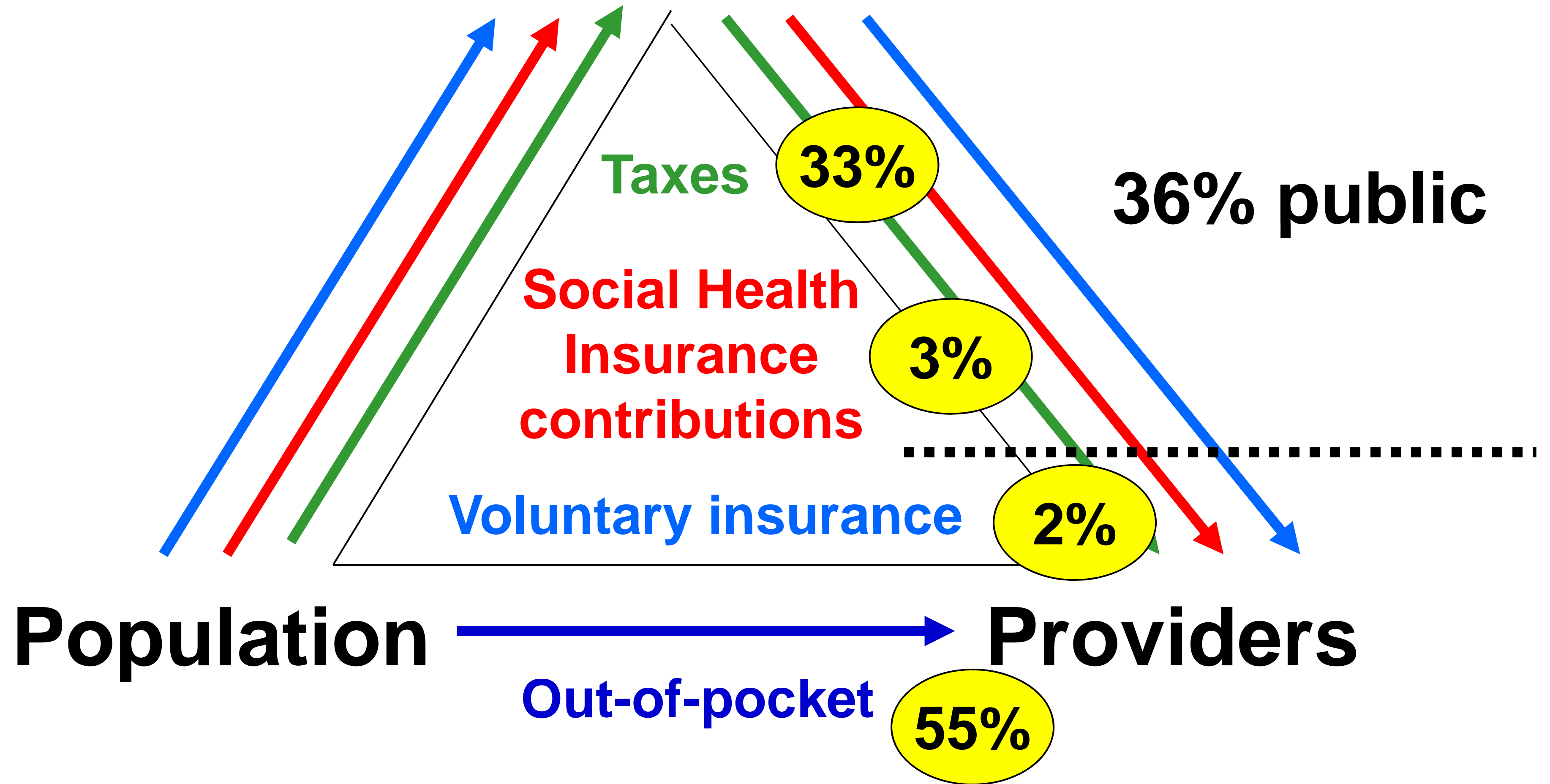
Third-party Payer

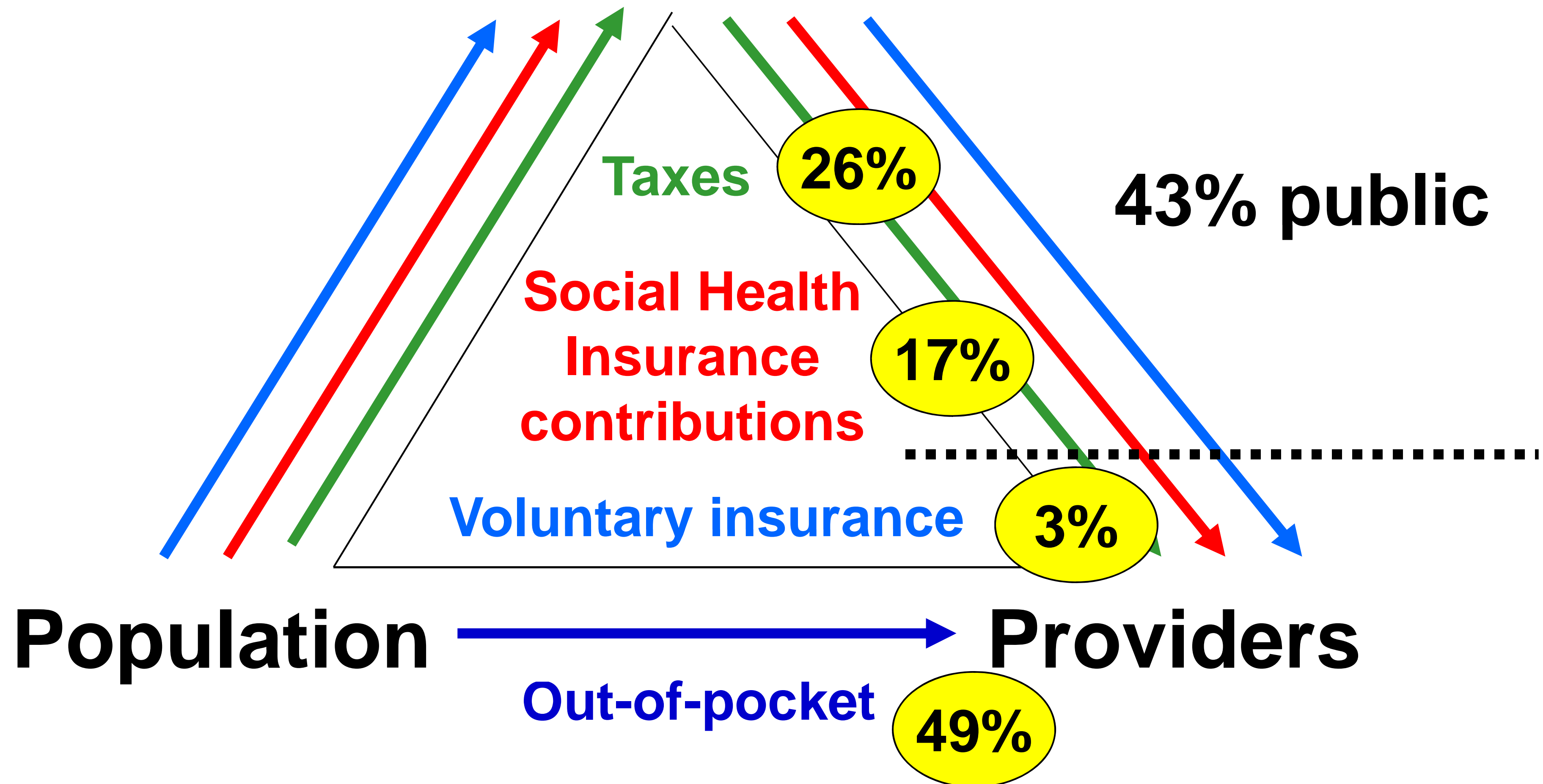


World-wide 2006 *(large US market!)*



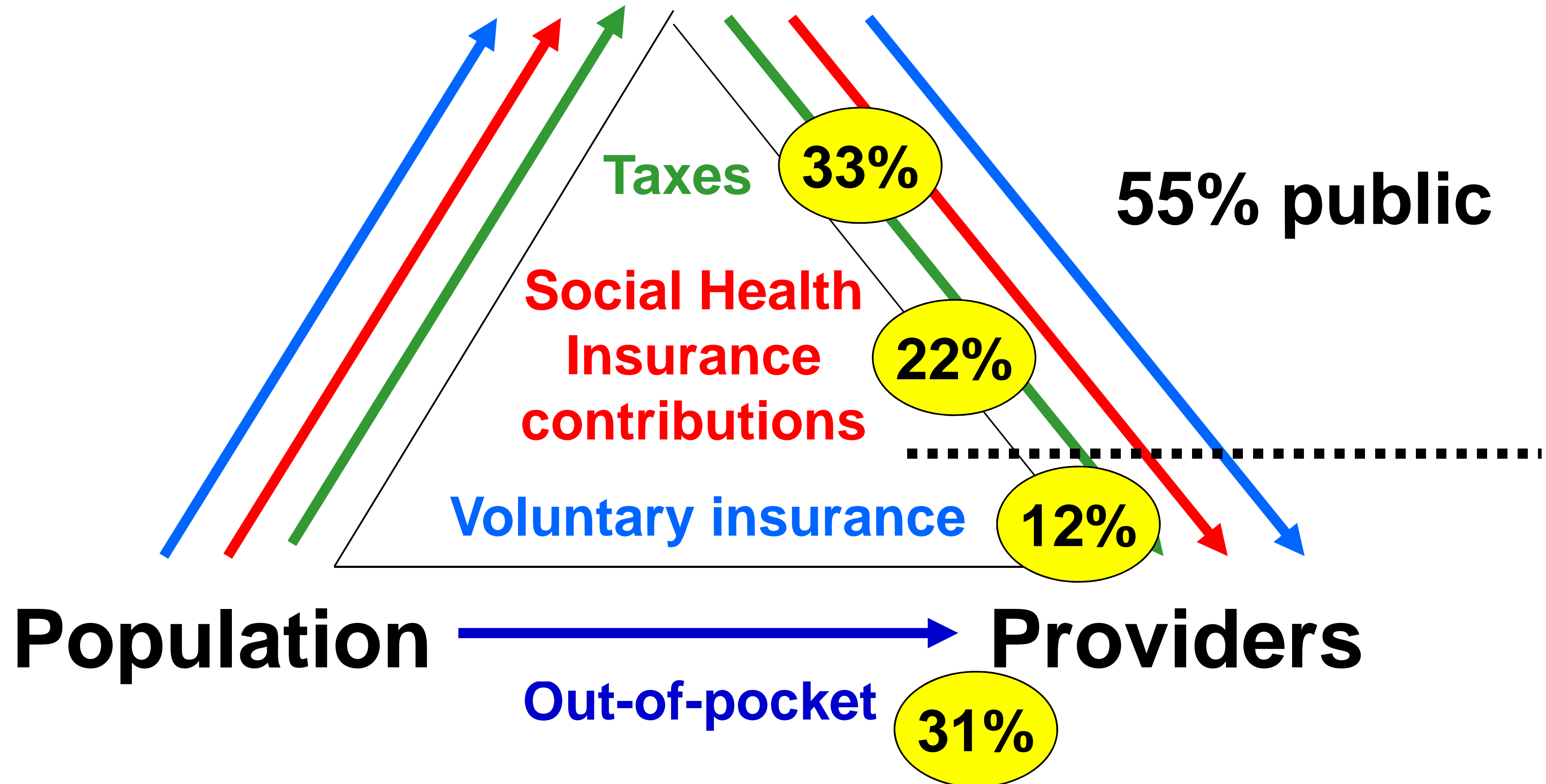
Low-income countries 2006

Third-party Payer

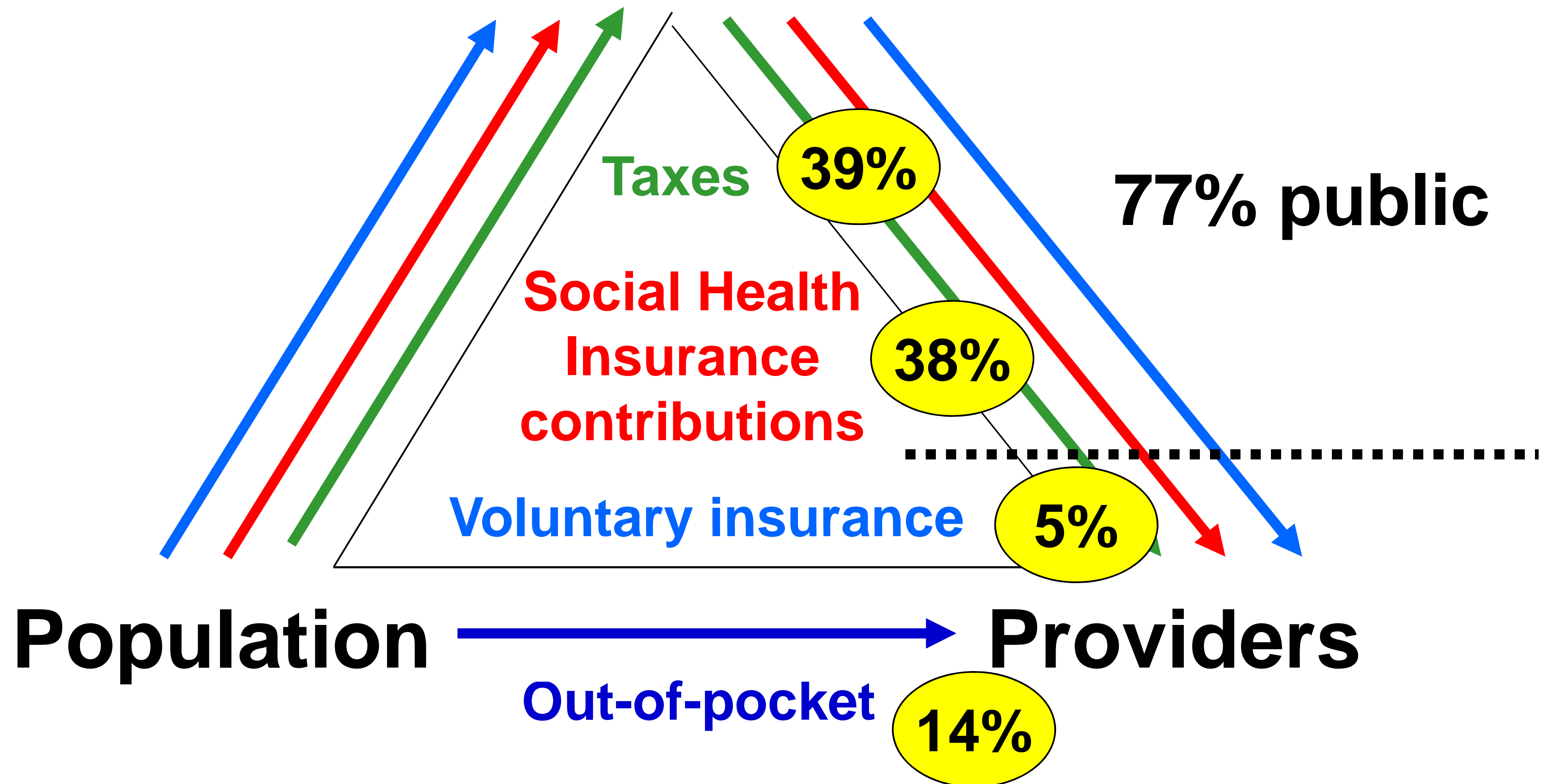


Lower middle income 2006

Third-party Payer

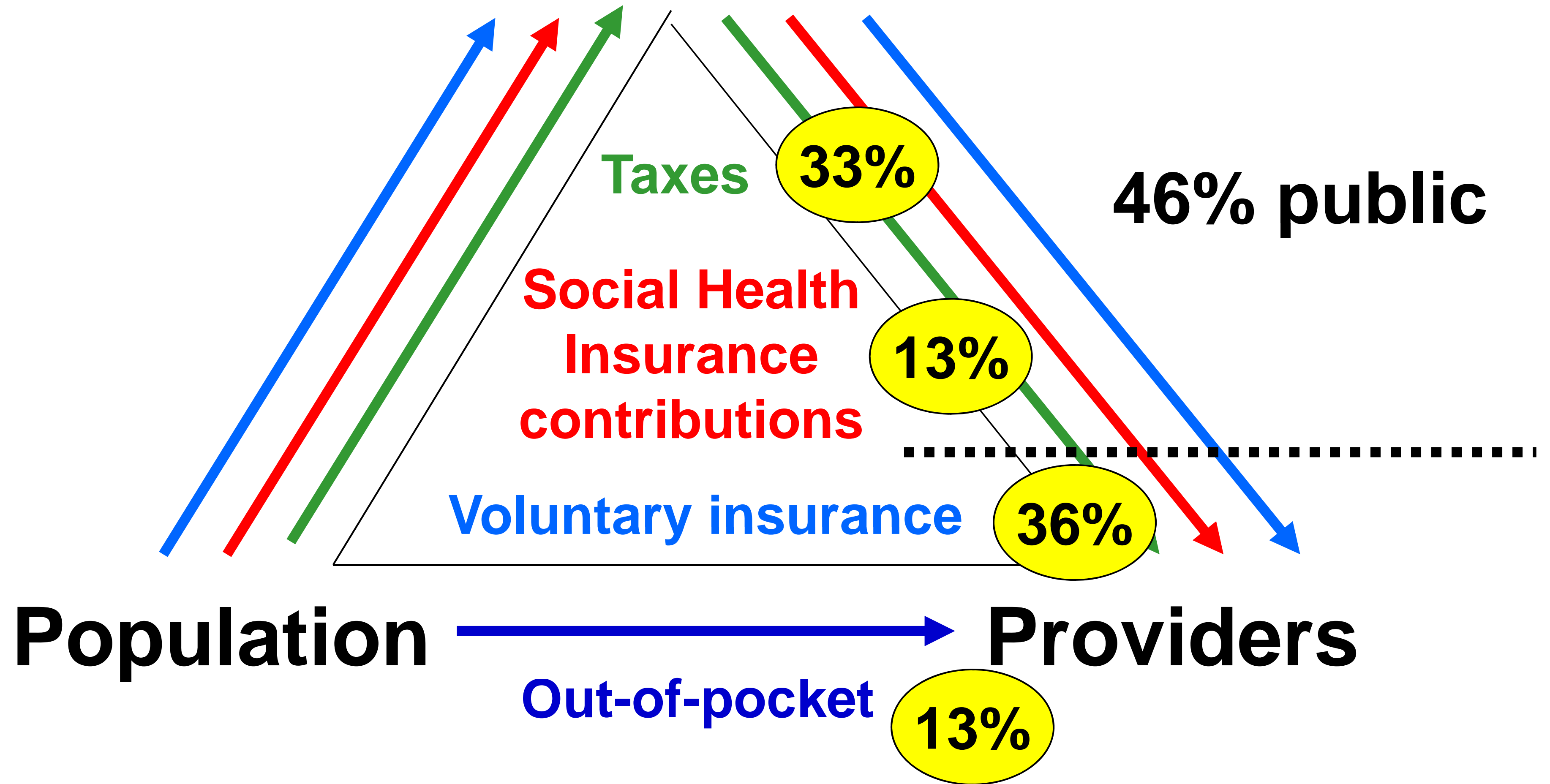


Upper middle income 2006



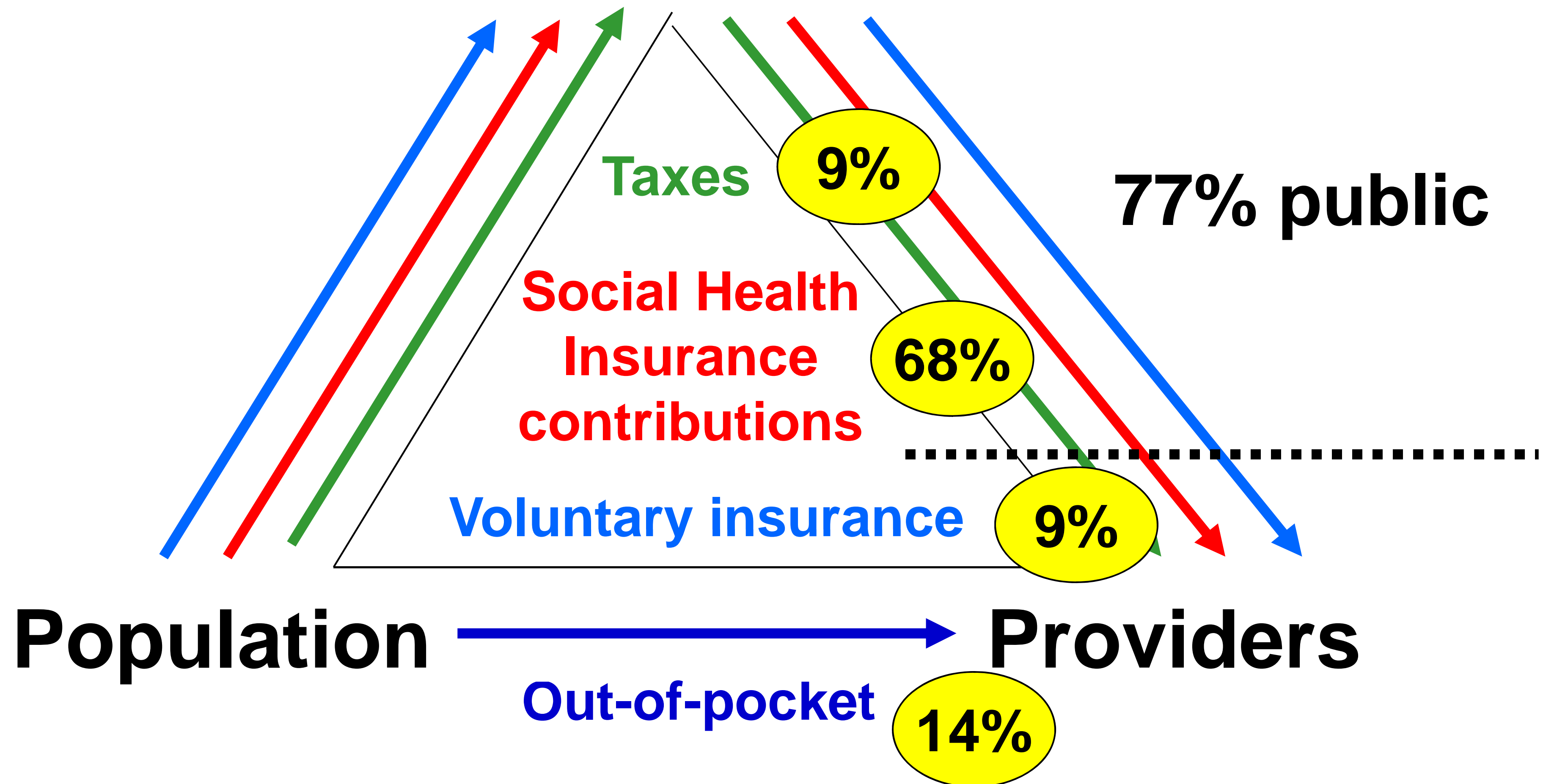
High income (excl. US) 2006

Third-party Payer



USA 2006

Third-party Payer



Germany 2006

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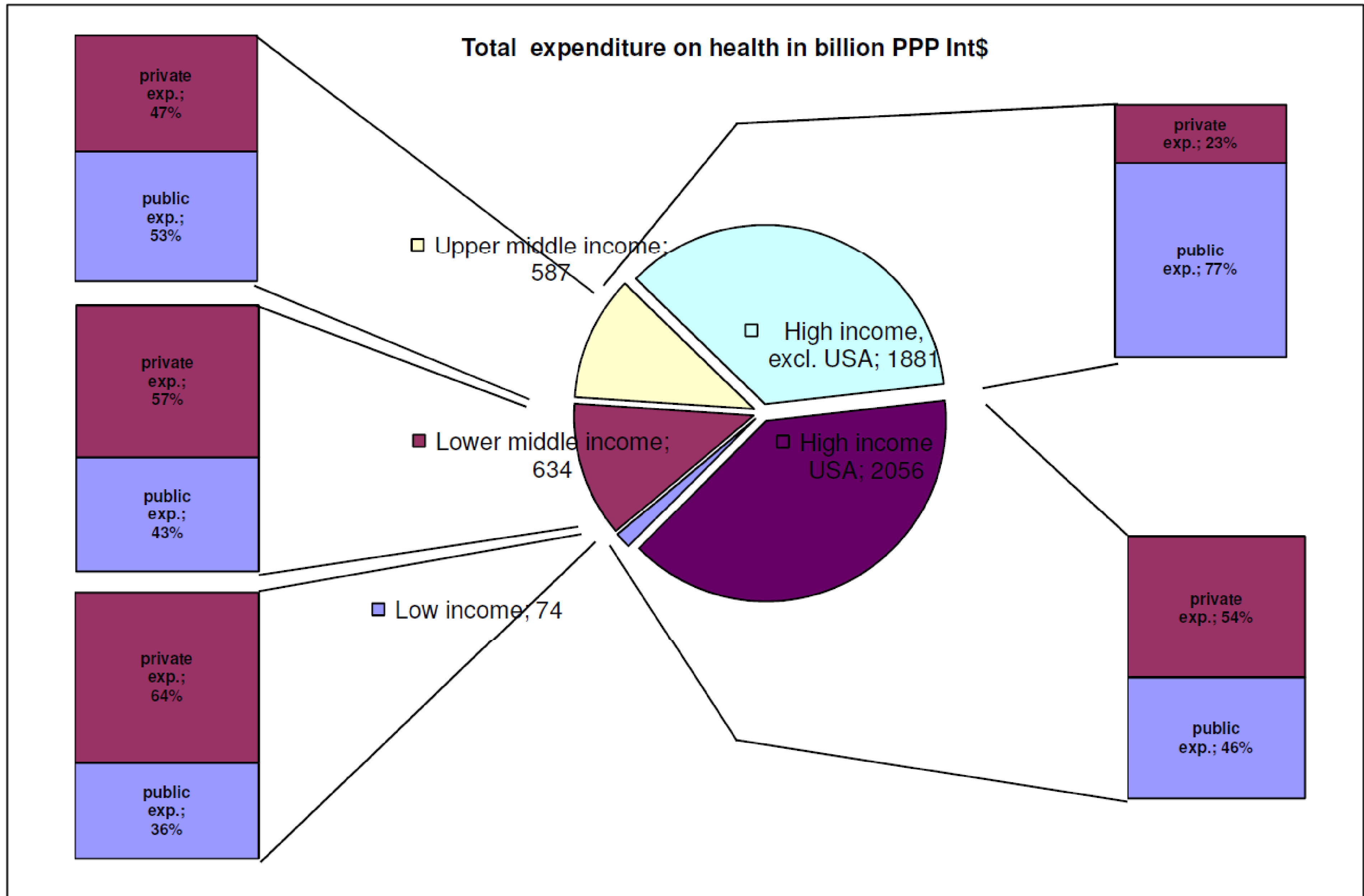
ÖFFENTLICHE VS. PRIVATE FINANZIERUNG



Je reicher das Land, desto mehr öffentliche Gesundheitsausgaben (Ausnahme: USA) …

… aber ist öffentlich auch „besser“ (fairer)?

Zumeist ja, aber es kommt auf die genaue Ausgestaltung an.

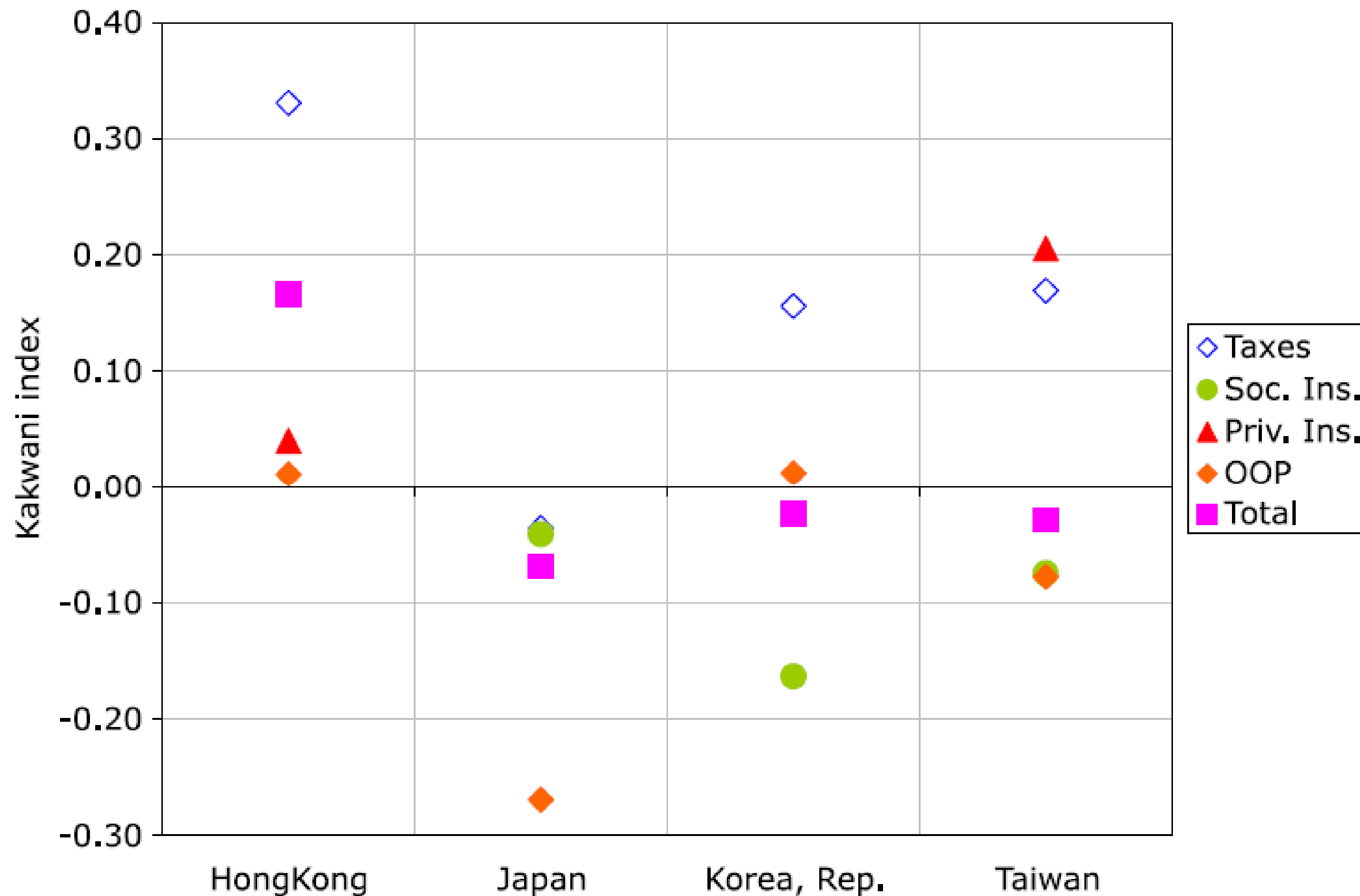
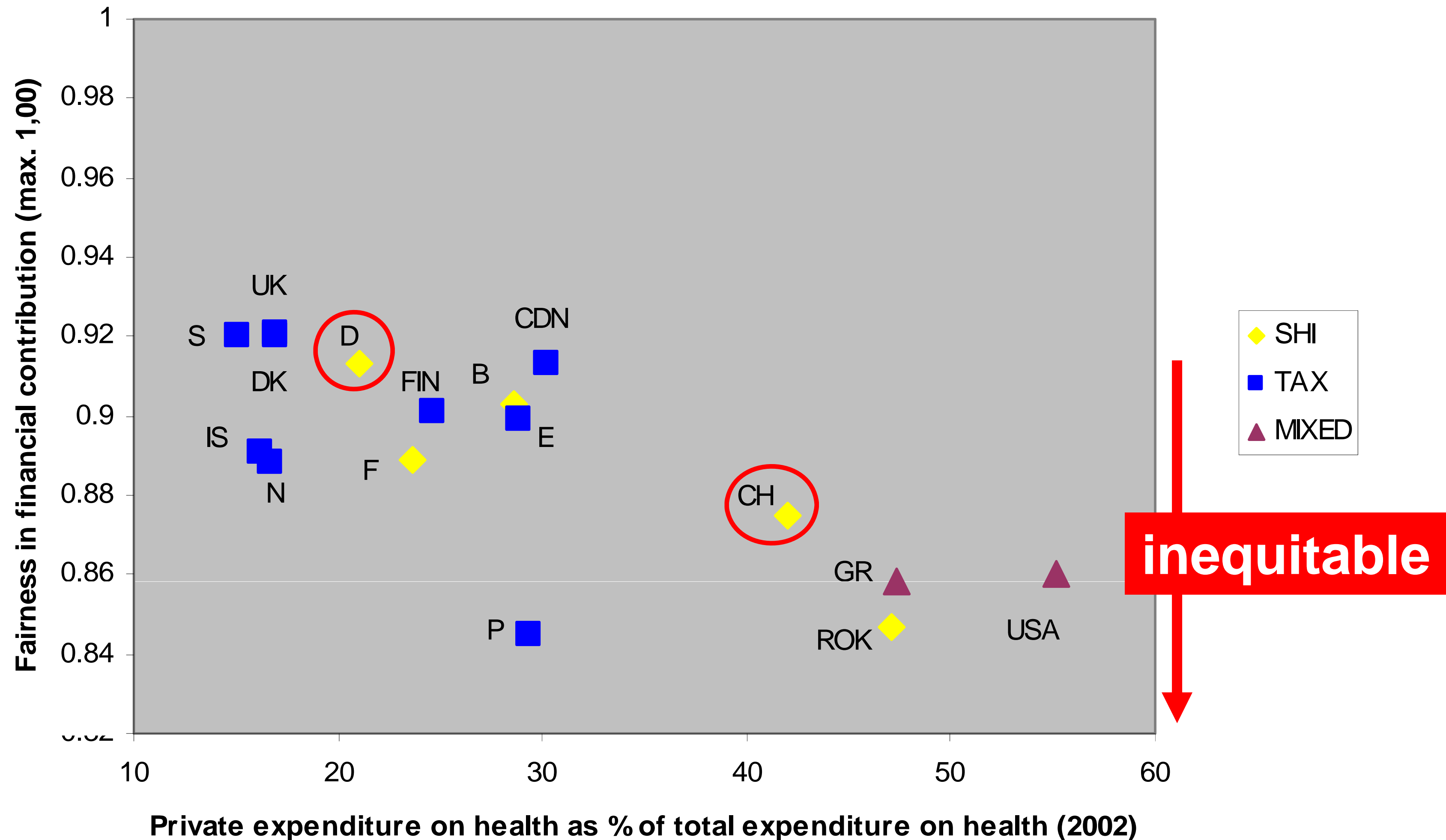
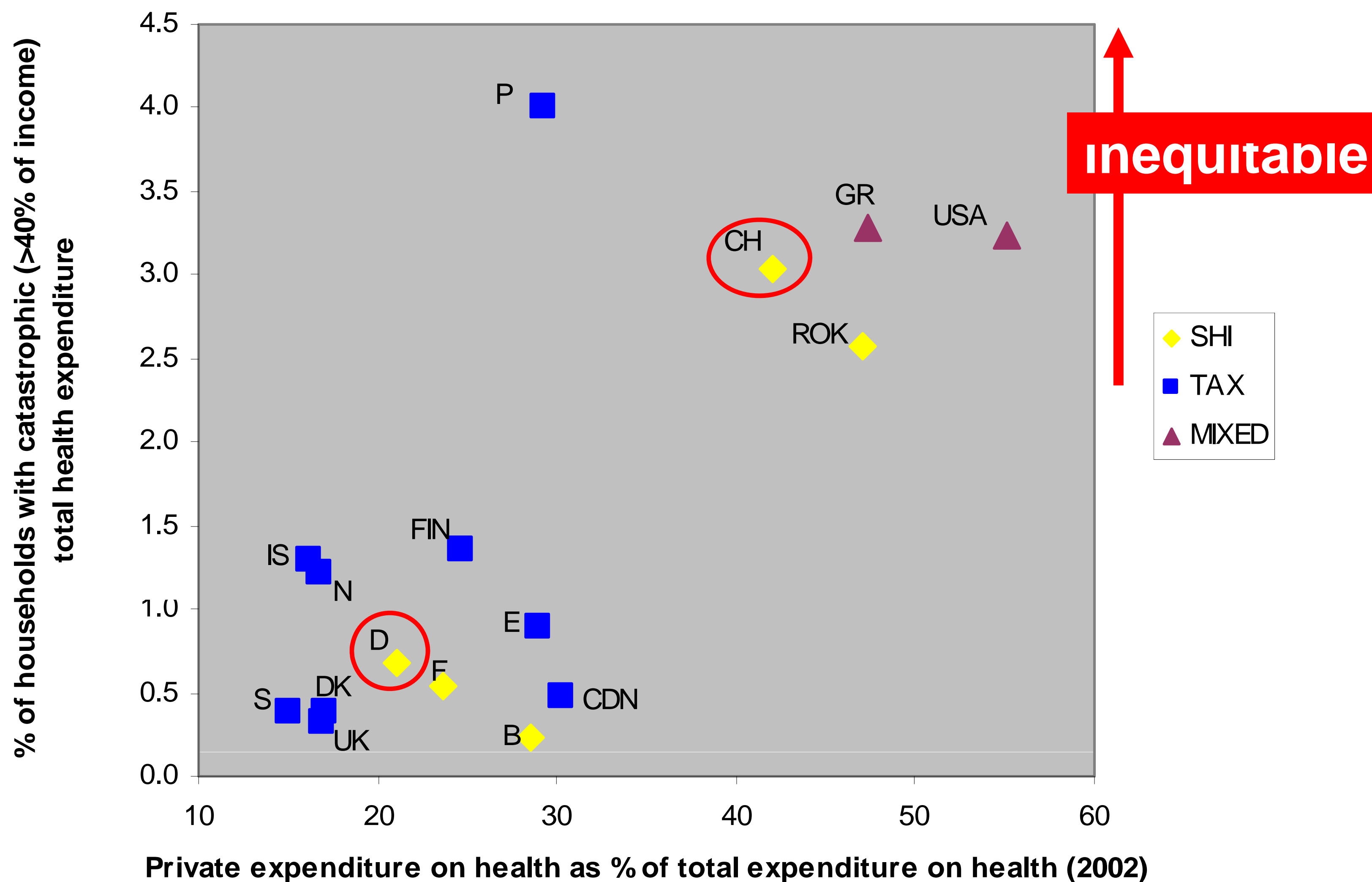


Figure 5. Progressivity of health financing sources in Japan and the Asian Tigers. A positive value of Kakwani's (1977) index indicates a progressive payment structure, a zero value proportional payments, and a negative value a regressive structure. The data shown are from O'Donnell *et al*. (2005)

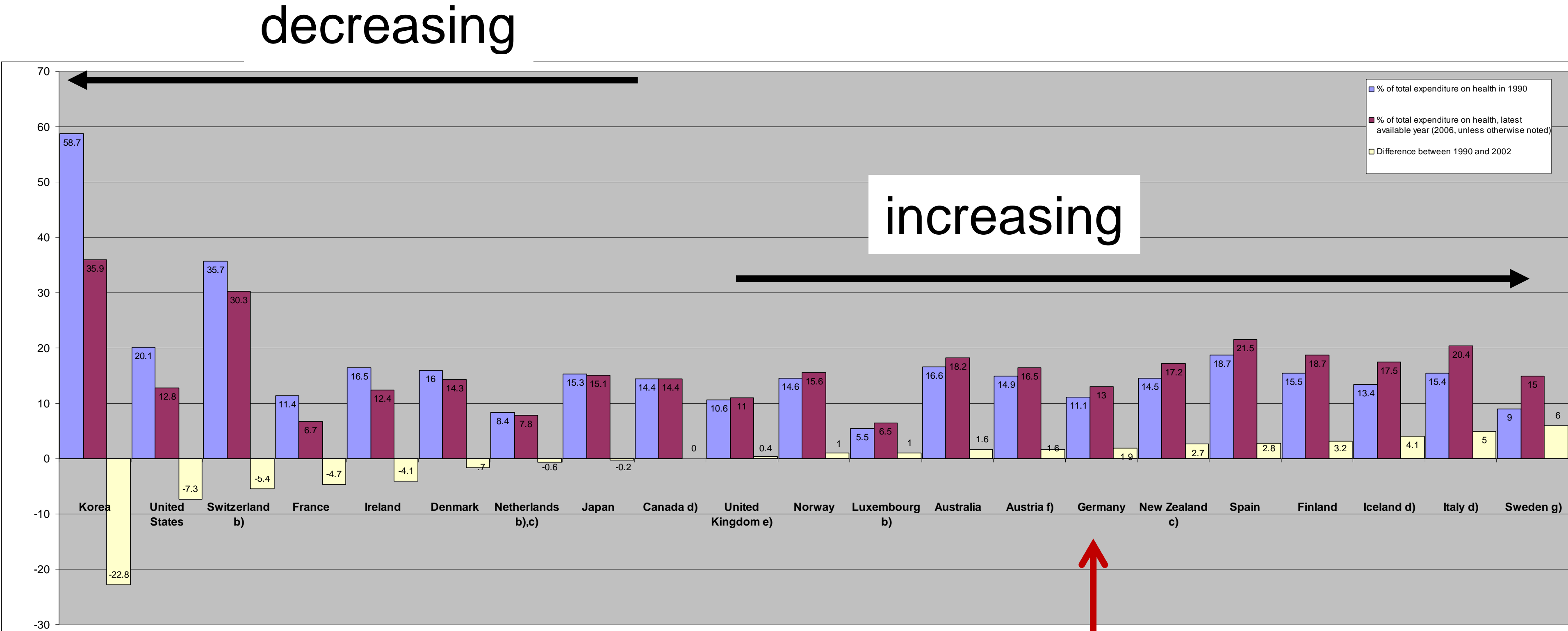
Correlation between private expenditure
(as % of total health care expenditure)
and the level of fairness in financing



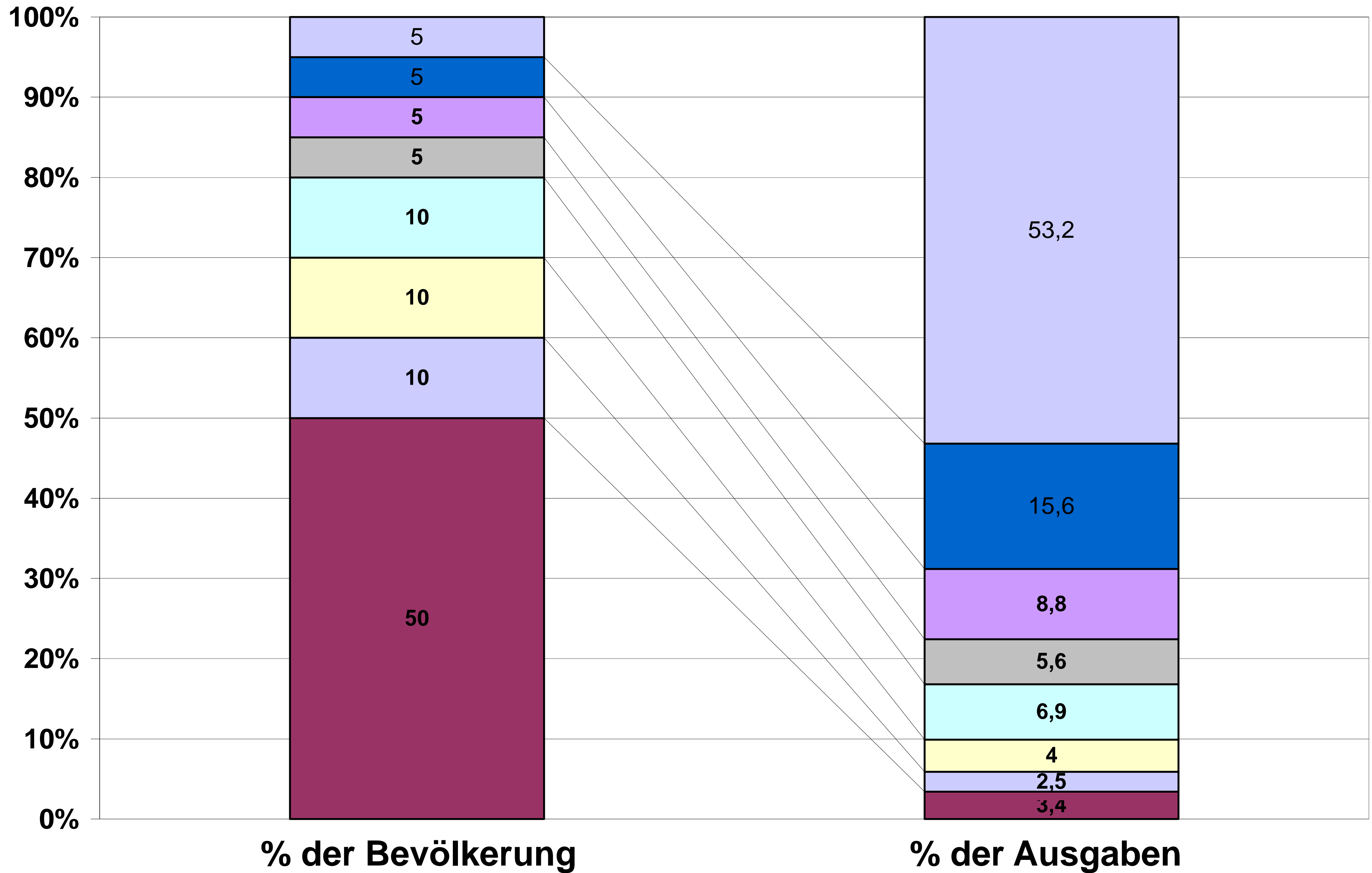
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure



Out-of-pocket 1990-2006: a mixed picture



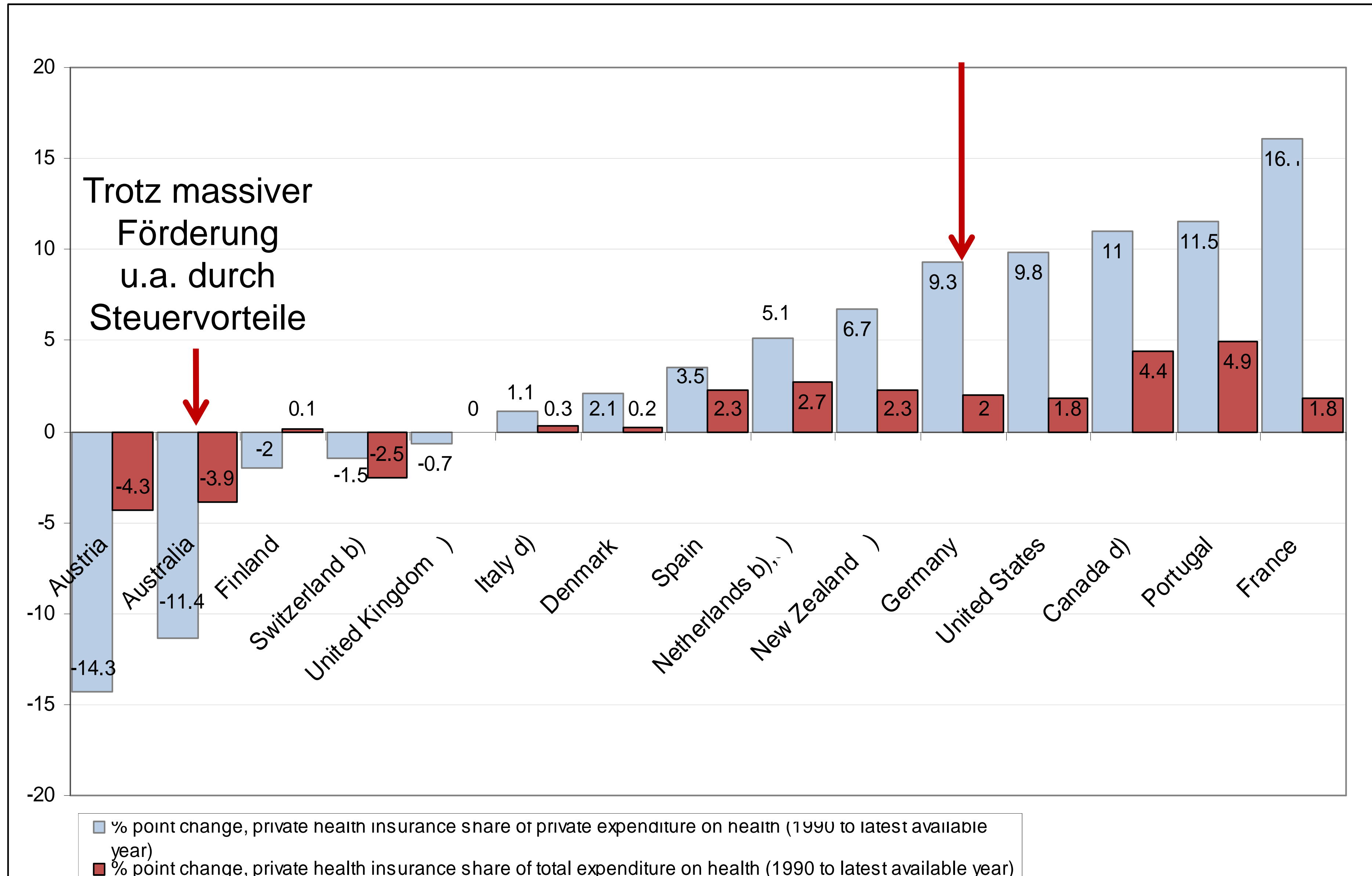
European Observatory on Health Systems and Policies


Die Verteilung von Leistungsausgaben auf Versicherte ist extrem konzentriert ….
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
5
5
5
5
10
10
10
50
53,2
15,6
8,8
5,6
6,9
4
2,5
3,4
% der Bevölkerung
% der Ausgaben

Reduced rates or exemptions commonly relate to one or more of the following:

- **clinical condition** – diabetics in Sweden, pregnant women in the UK and people with specified chronic illnesses in Ireland, Finland, Spain and the UK
- **level of income** – all those with low incomes in Austria, Belgium, Germany, Ireland and the UK and older people with low income in Greece
- **age** – older people in Belgium, Ireland, Korea, Japan, Spain and the UK and children and adolescents in many countries, e.g. in Germany, Japan and the UK
- **type of drug** – drugs for chronic illnesses in Portugal, drugs for life-threatening illnesses in Belgium, both types of drug in Greece and effective drugs in France

Private health insurance 1990-2006: a mixed picture



DEN FINANZIERUNGSMIX FINDEN UND ÄNDERN

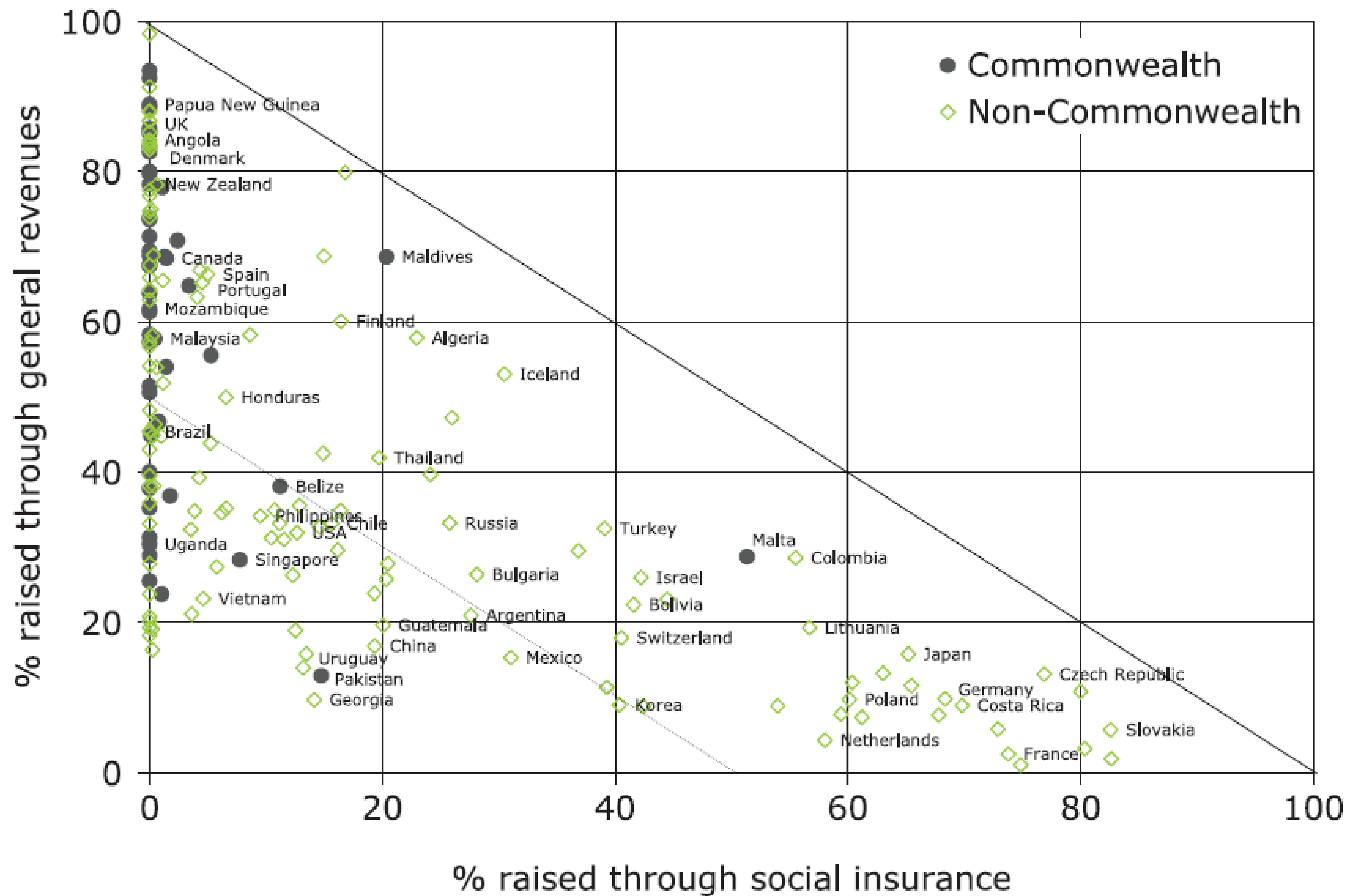


Figure 1. SHI vs taxes in health financing, 2003. *Source*: WHO World Health Report 2007

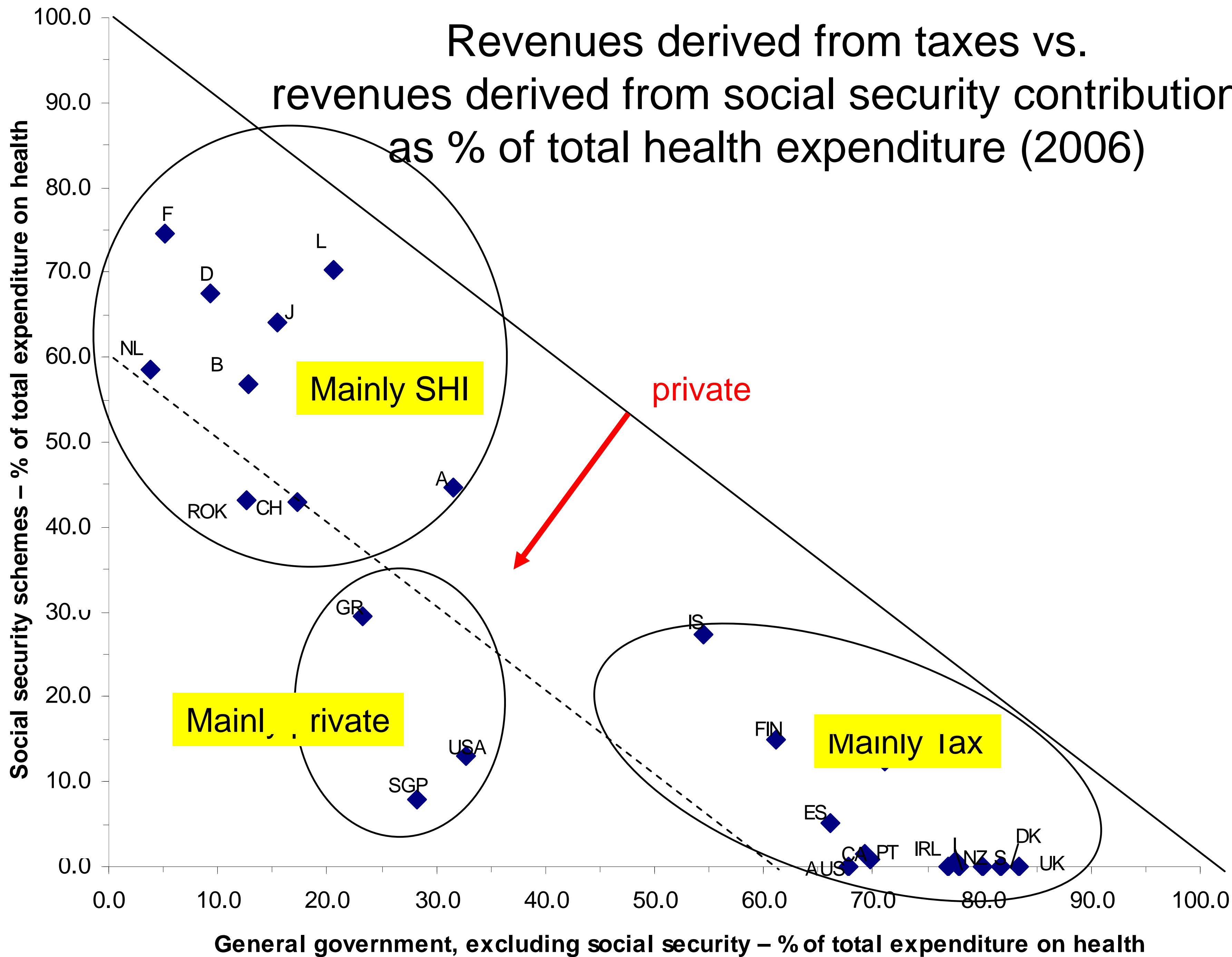
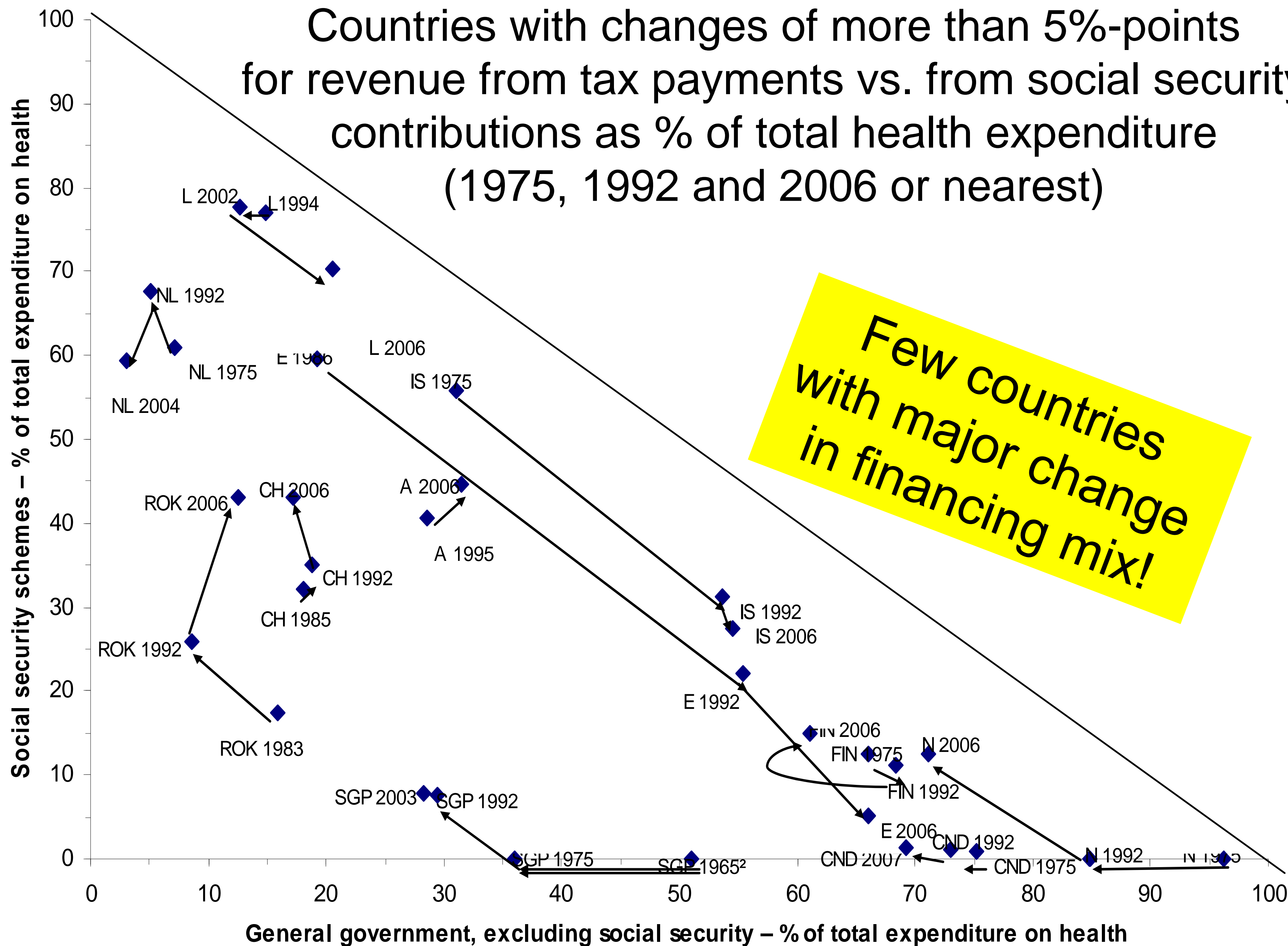
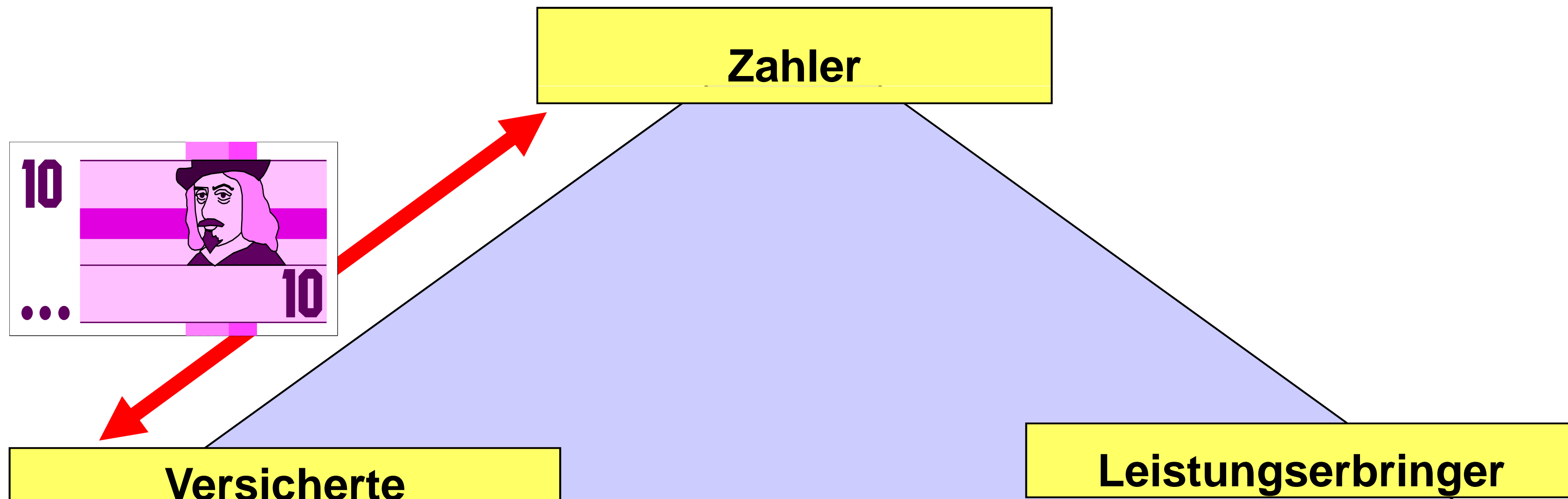

Revenues derived from taxes vs. revenues derived from social security contributions as % of total health expenditure (2006)
Social security schemes – % of total expenditure on health
General government, excluding social security – % of total expenditure on health
Mainly SHI
Mainly private
Mainly Tax
private
F
L
D
J
NL
B
A
ROK
CH
GR
USA
SGP
IS
FIN
ES
CA
PT
AUS
IRL
NZ
S
DK
UK
100.0
90.0
80.0
70.0
60.0
50.0
40.0
20.0
10.0
0.0
10.0
20.0
30.0
40.0
50.0
60.0
70.0
80.0
90.0
100.0

Figure 1: SHI systems in the OECD, 1960-2006

Sources: WHO Health in Transition series (HiTS) http://www.euro.who.int/observatory/Hits/TopPage, Saltman and Dubois (2004), Carrin and James (2005).

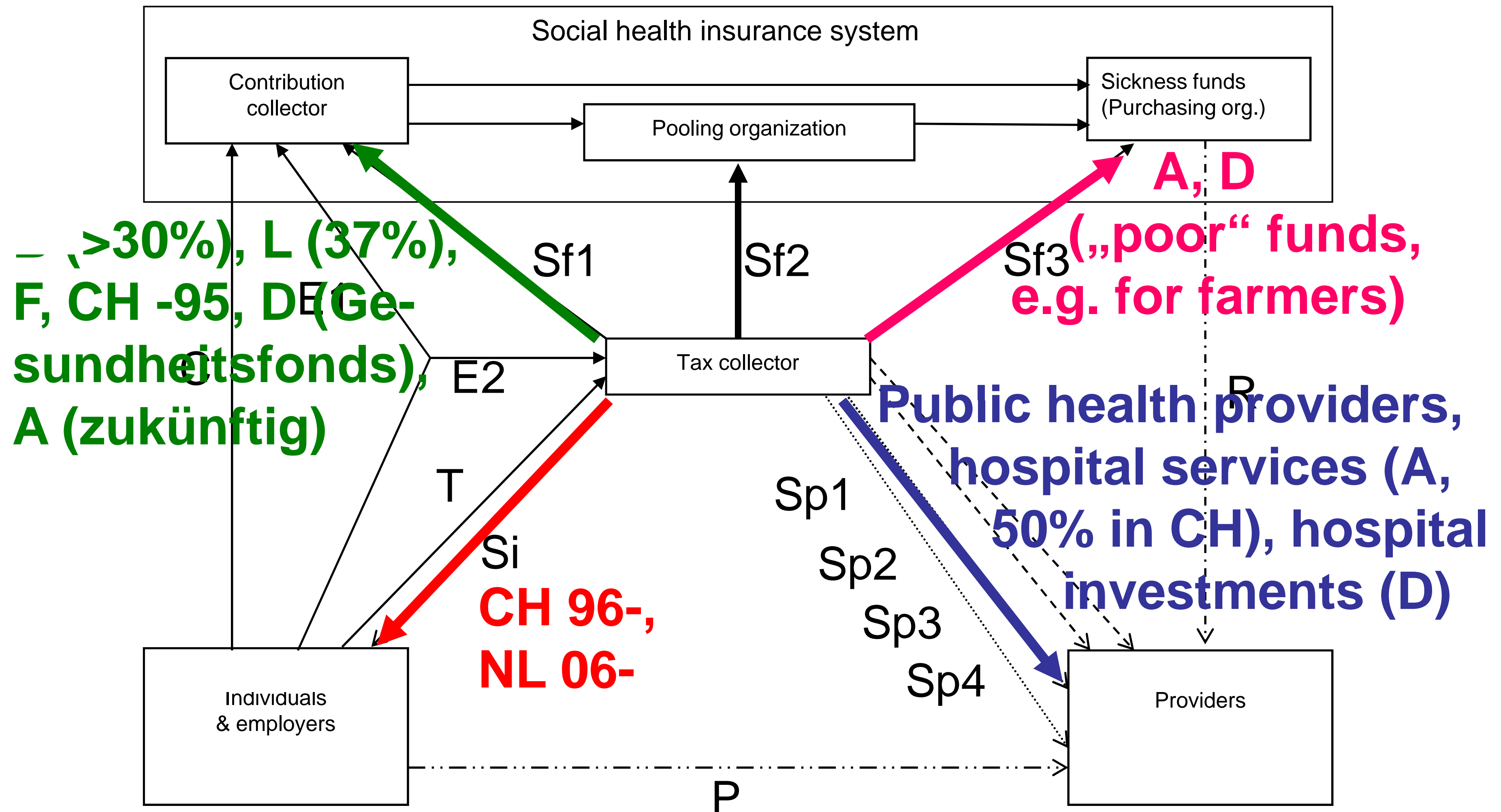

Countries with changes of more than 5%-points
for revenue from tax payments vs. from social security
contributions as % of total health expenditure
(1975, 1992 and 2006 or nearest)
Few countries
with major change
in financing mix!
Social security schemes – % of total expenditure on health
General government, excluding social security – % of total expenditure on health
L 2002
L 1994
L 2006
NL 1992
NL 1975
NL 2004
IS 1975
IS 1992
IS 2006
A 2006
A 1995
ROK 2006
ROK 1992
ROK 1983
CH 2006
CH 1992
CH 1985
E 1992
E 2006
FIN 1975
FIN 1992
N 2006
N 1992
SGP 2003
SGP 1992
CND 1992
CND 1975
0
10
20
30
40
50
60
70
80
90
100

GEÄNDERTE FINANZIERUNG IN GKV-LÄNDERN

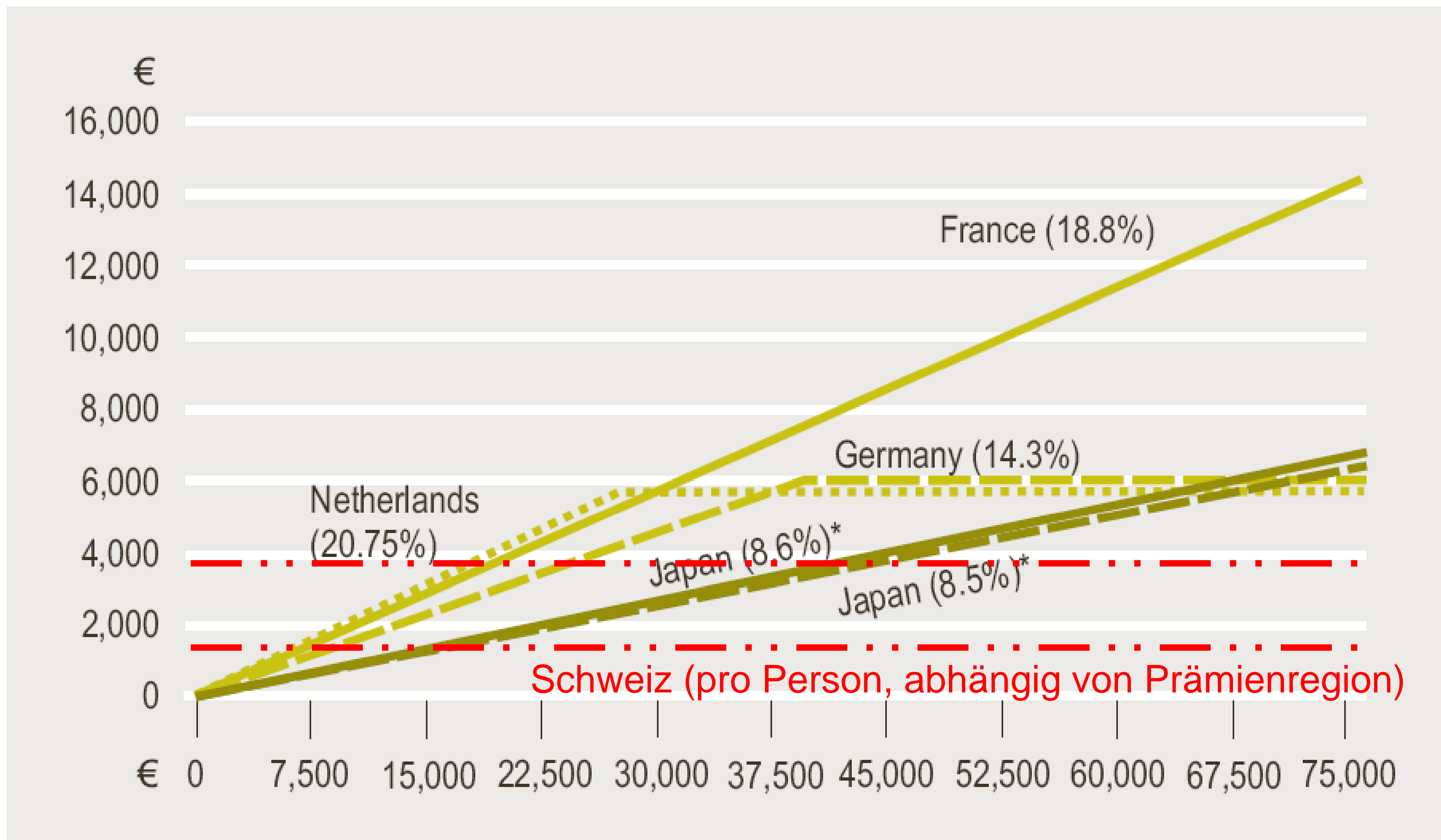


- Überwiegend lohnbezogene Beiträge (+ variabler Anteil Steuern) in Belgien, Deutschland, Frankreich, Luxemburg, Österreich
- Keine Beitragsmessungsgrenze in Belgien oder Frankreich
- Kopfpauschale/ Gesundheitsprämie in Schweiz
- Mischsystem (50% Beitrag, 45% Pauschale, 5% steuern) in den Niederlanden seit 2006

SHI countries: role of taxes increasing, but target varies

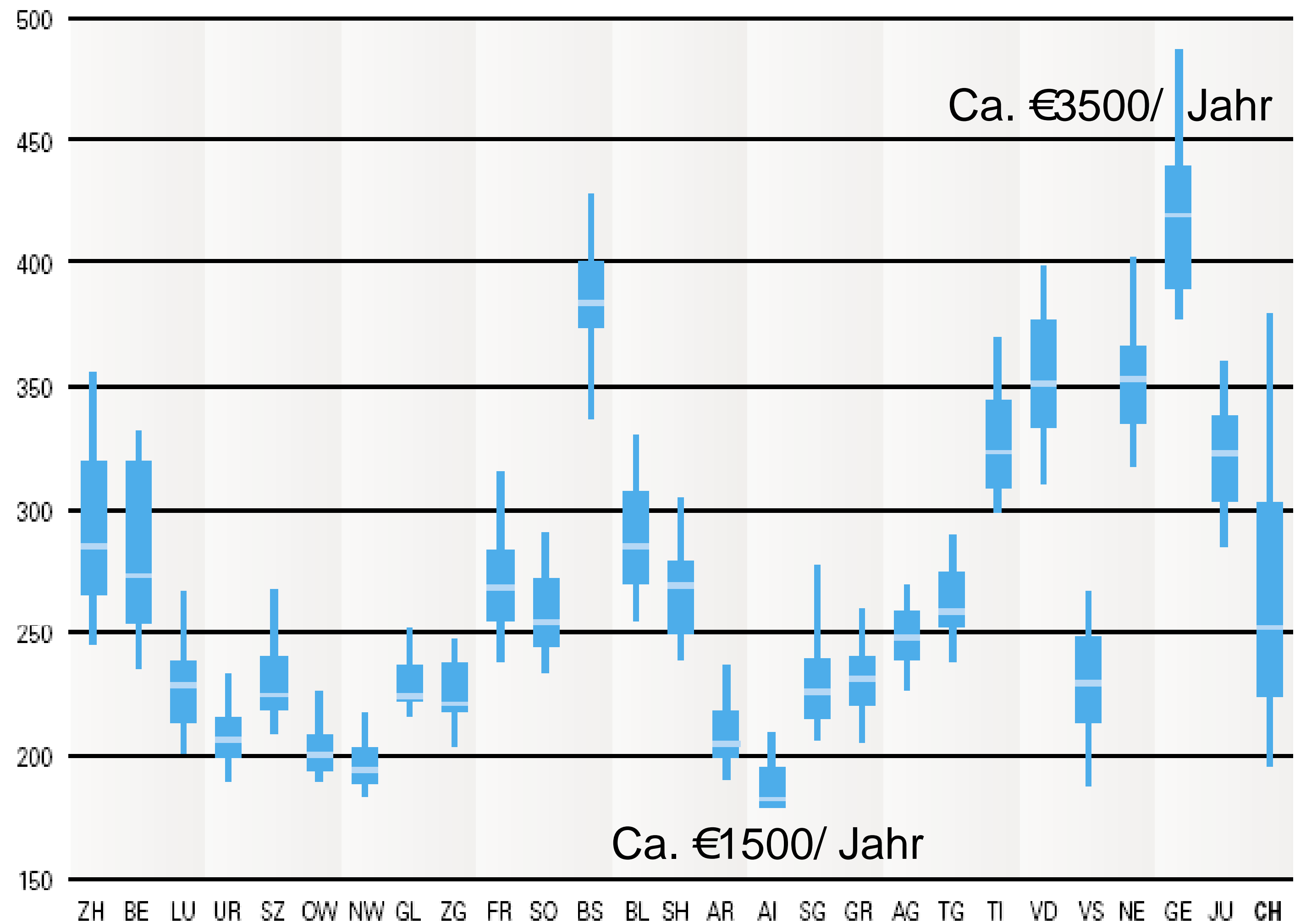


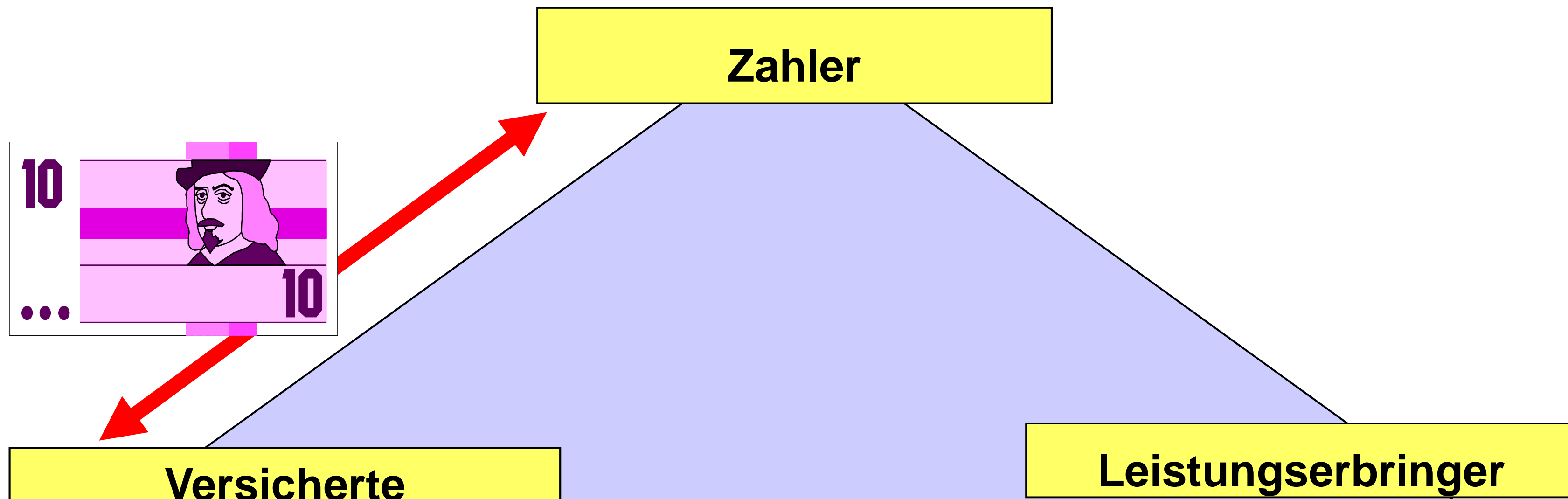
Krankenkassenbeiträge in Abhängigkeit vom Einkommen in verschiedenen GKV-Ländern



Schweiz: Steuerzuschuss für große Bevölkerungsteile bei z.T. sehr hohen Prämien notwendig (2005 in CHF/ Monat)

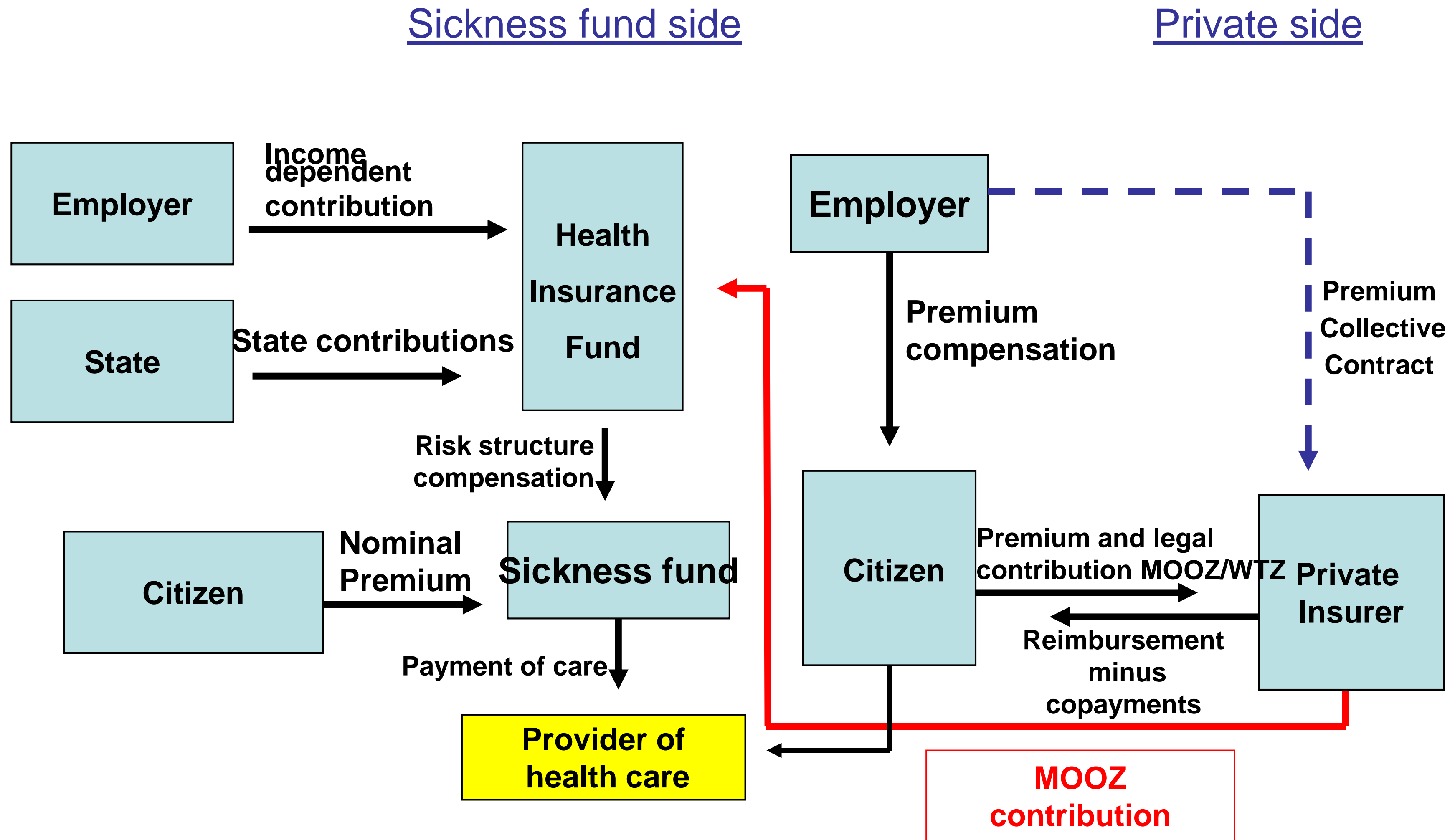
Grafik 3e: Verteilung der kantonalen monatlichen Durchschnittsprämien für Erwachsene (26 Jahre und mehr) in Franken für 2005 (mit ordentlicher Franchise und Unfalldeckung)





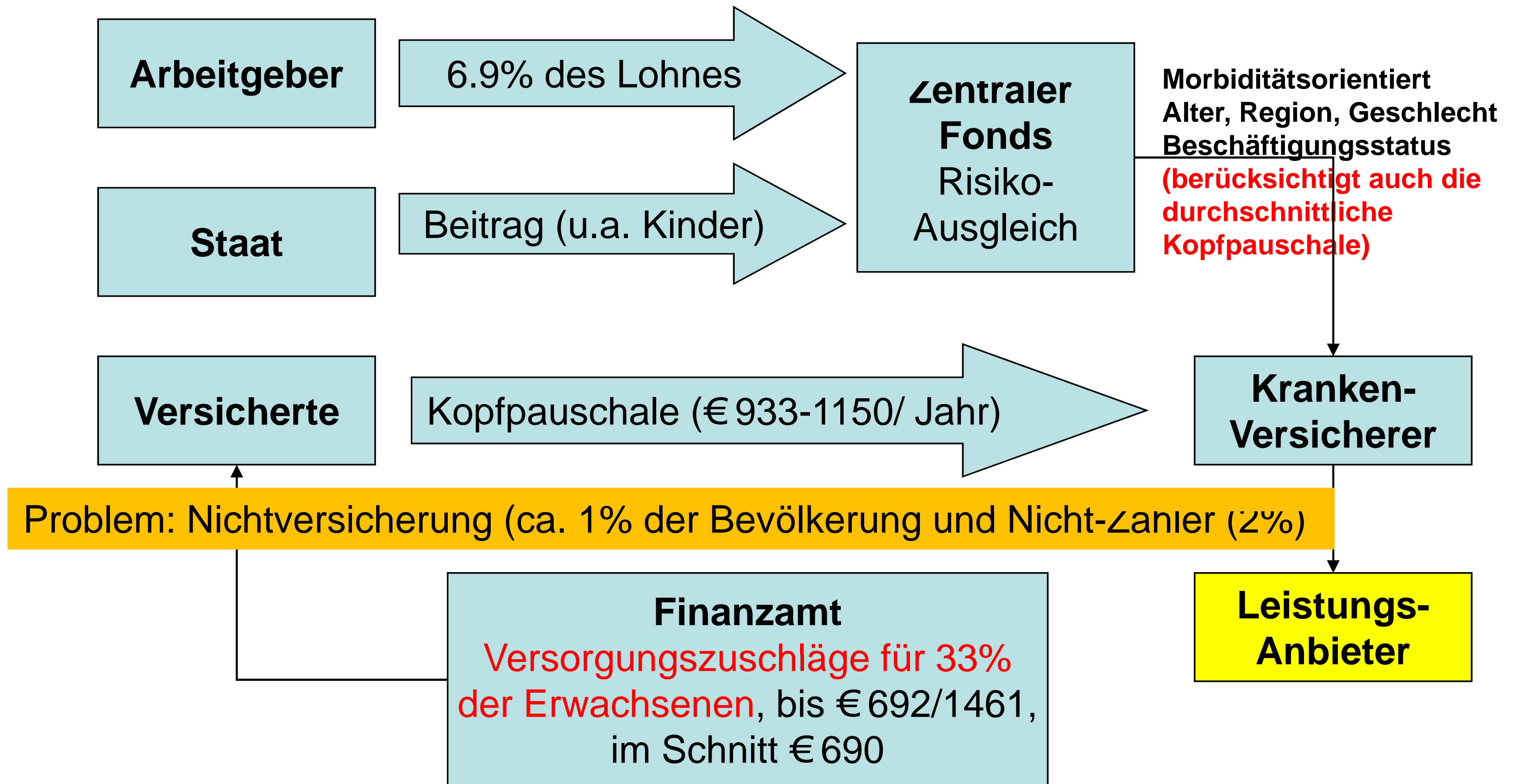
- Korea: Besitz wird bei der Veranlagung von Selbständigen berücksichtigt
- Niederlande: “MOOZ”-Abgabe von Privatversicherten an GKV zwecks Risikoausgleich (bis 2005)

NL: Financial flows until 2005

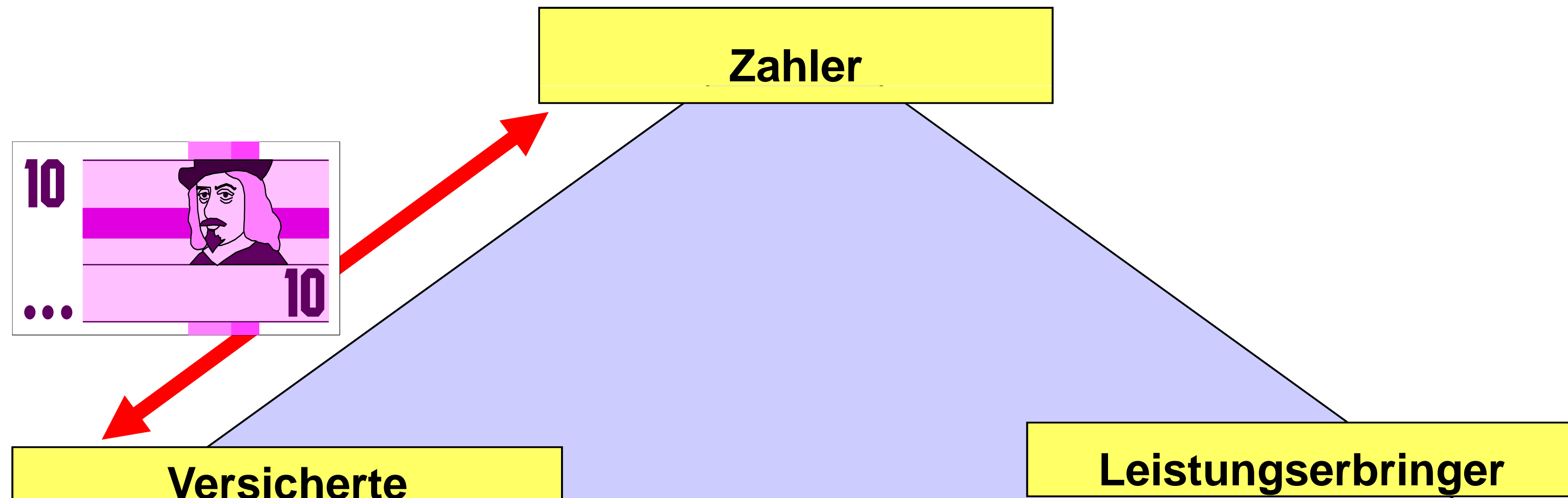


Source: Hamilton (2005)

Vereinfachte Darstellung des niederländischen Krankenversicherungssystems seit 2006



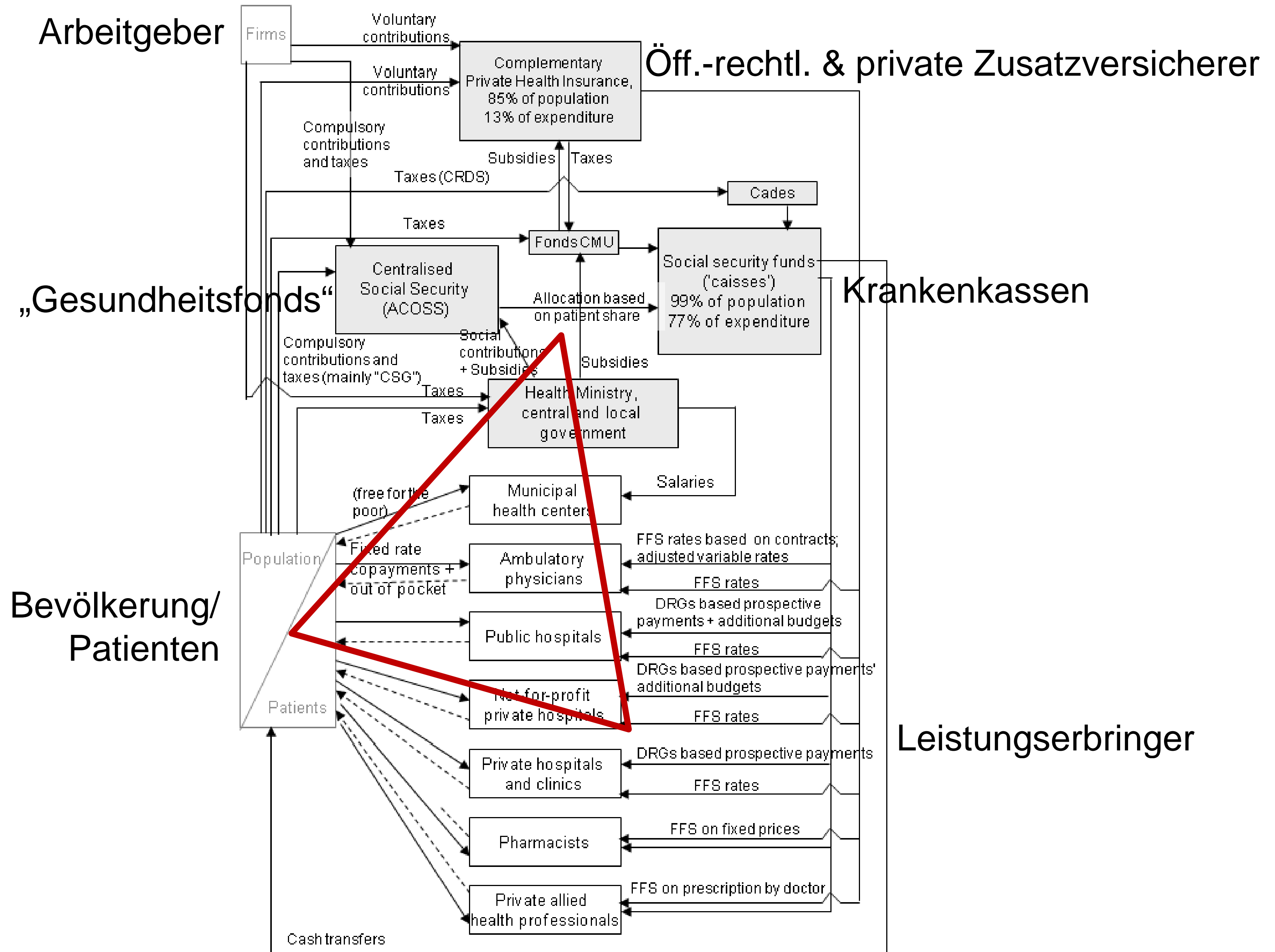
Quelle: mod. und akt. Van Ginneken et al. (2006)



- Frankreich: 1998 Umstellung von Lohn-Beiträgen zu steuerähnlicheren Beiträgen (CSG) auf Löhne, Zinsen und Mieten
  -> Verrin erun von 6,8% auf 6,0% 5,25% CSG + 0,75% Beitrag)
- Zusätzliche Abgaben/Steuern auf Tabak, Alkohol, Kfz., Pharmawerbung, PKV-Prämien

Finanzierungsmix in Frankreich 1990 & 2000

	1990	2000
AG-Beiträge	63,1%	51,1%
AN-Beiträge	32,2%	[illegible]
CSG	0%	34,6%
Spezifische Abgaben/ Steuern	1,6%	4,1%
Zuschuss aus all. Steuern (z.B. Kompensation AG-Beitragssenkung Niedri[illegible]verdiener[illegible]	0,5%	4,9%


France: Financing flows in the health care system, 2007
(excluding long-term care and prevention)
Arbeitgeber
Firms
Voluntary contributions
Voluntary contributions
Complementary Private Health Insurance, 85% of population 13% of expenditure
Öff.-rechtl. & private Zusatzversicherer
Compulsory contributions and taxes
Subsidies
Taxes
Taxes (CRDS)
Cades
Taxes
Fonds CMU
Social security funds ('caisses') 99% of population 77% of expenditure
Krankenkassen
„Gesundheitsfonds“
Centralised Social Security (ACOSS)
Allocation based on patient share
Compulsory contributions and taxes (mainly "CSG")
Social contributions + Subsidies
Subsidies
Taxes
Taxes
Health Ministry, central and local government
Salaries
(free for the poor)
Municipal health centers
Fixed rate copayments + out of pocket
Ambulatory physicians
FFS rates based on contracts; adjusted variable rates
FFS rates
Population
Bevölkerung/ Patienten
Public hospitals
DRGs based prospective payments + additional budgets
FFS rates
Not-for-profit private hospitals
DRGs based prospective payments' additional budgets
FFS rates
Patients
Leistungserbringer
Private hospitals and clinics
DRGs based prospective payments
FFS rates
Pharmacists
FFS on fixed prices
Private allied health professionals
FFS on prescription by doctor
Cash transfers
Source: OECD Secretariat 2001. Updated by Irdes in 2006, and Drees in 2007.
http://www.ecosante.org/ocde.htm

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