Technische Universität Berlin

Social health insurance actors, structures and regulation in western Europe – any lessons for CEE countries?

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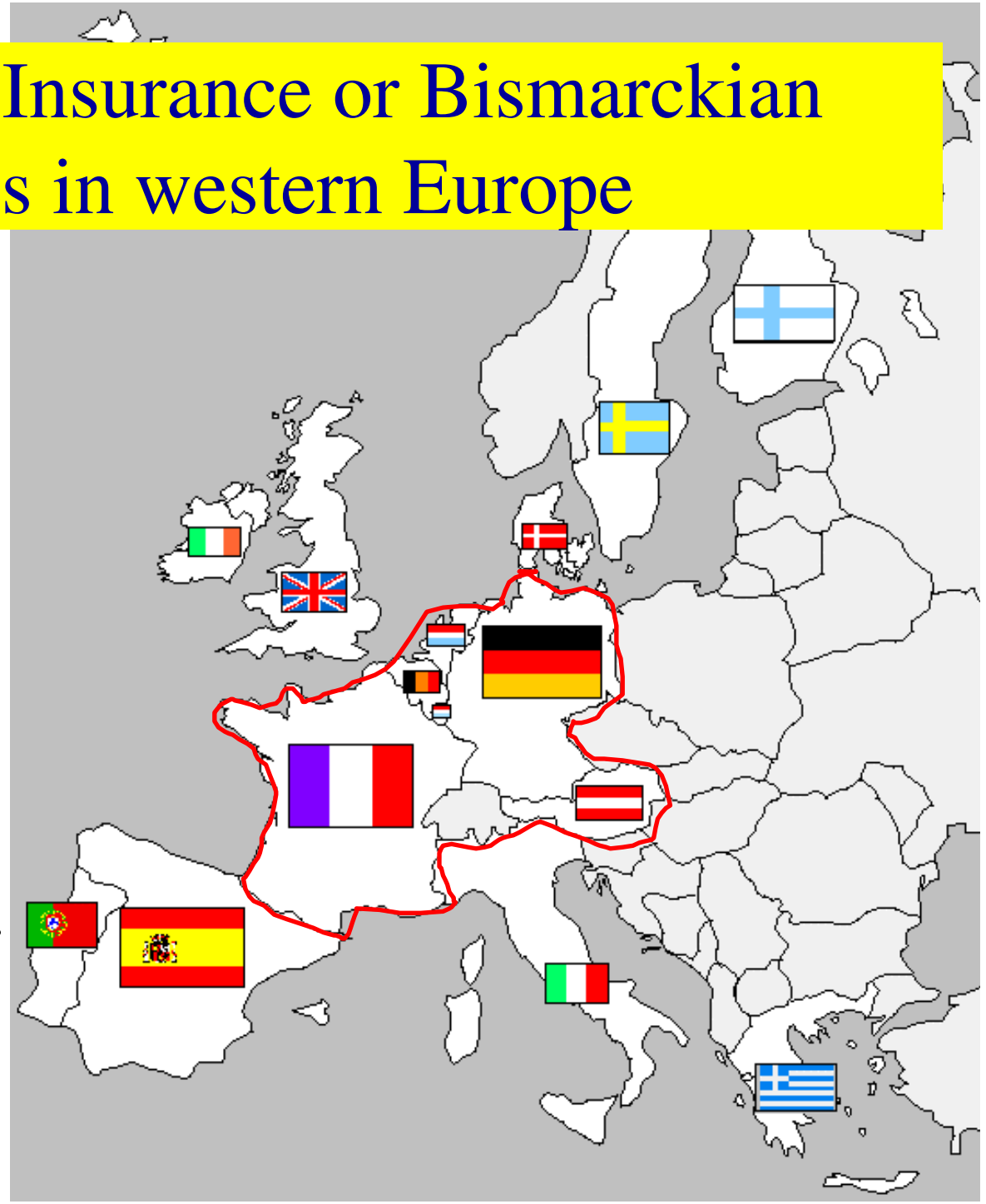
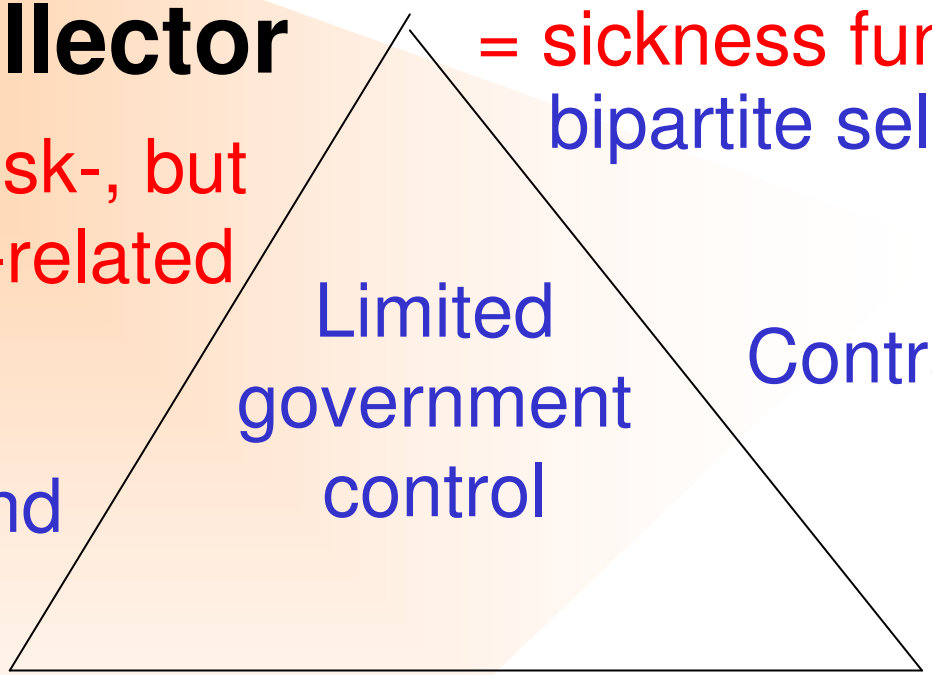
Social Health Insurance or Bismarckian countries in western Europe

- SHI definition
- Commonalities and variations between countries
- Analysis regarding impact on health status, efficiency, equity, satisfaction ...
- Conclusions for CEE countries



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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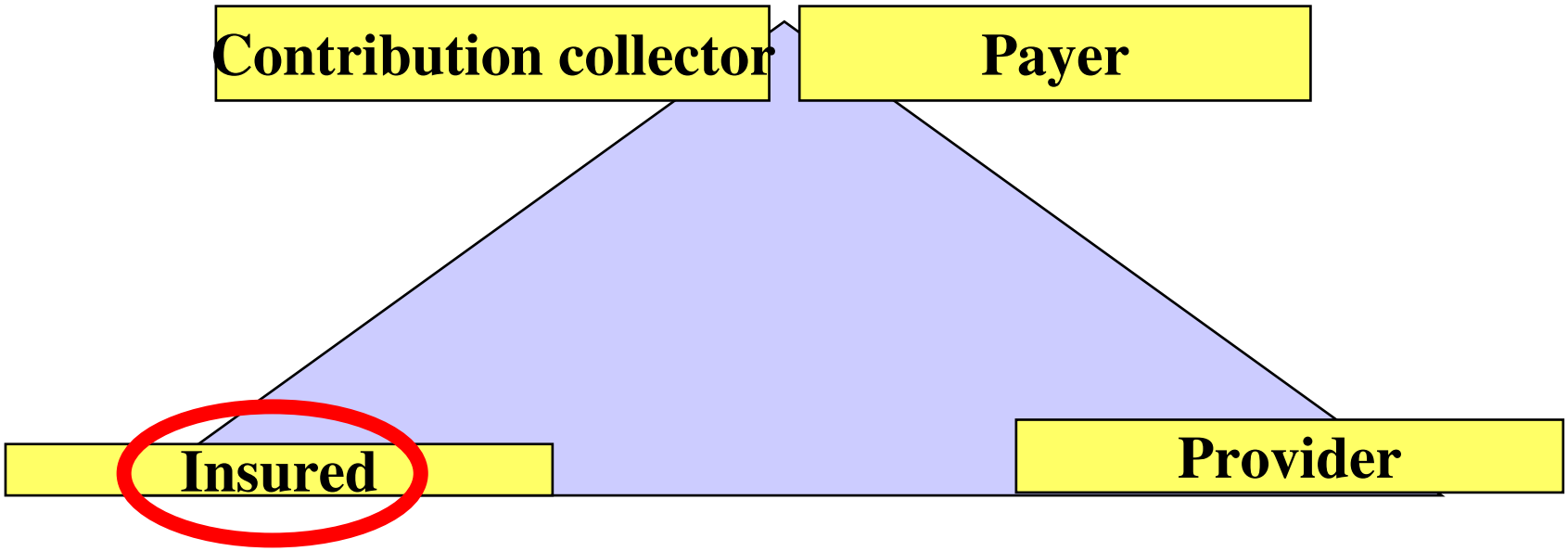
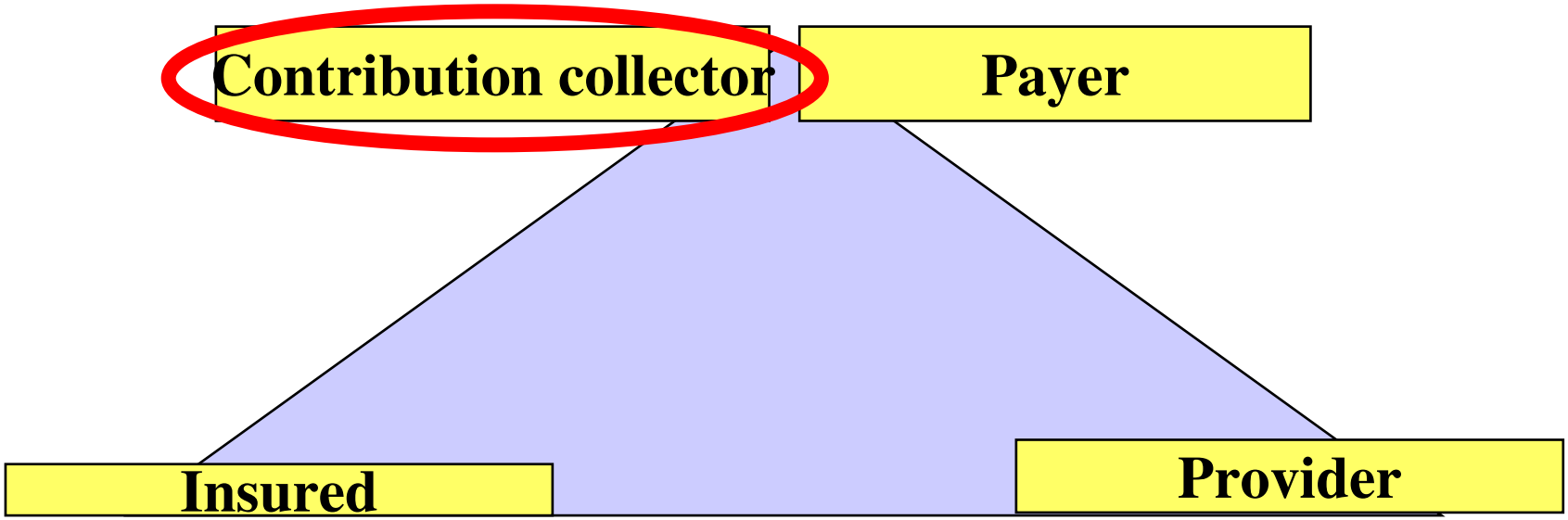
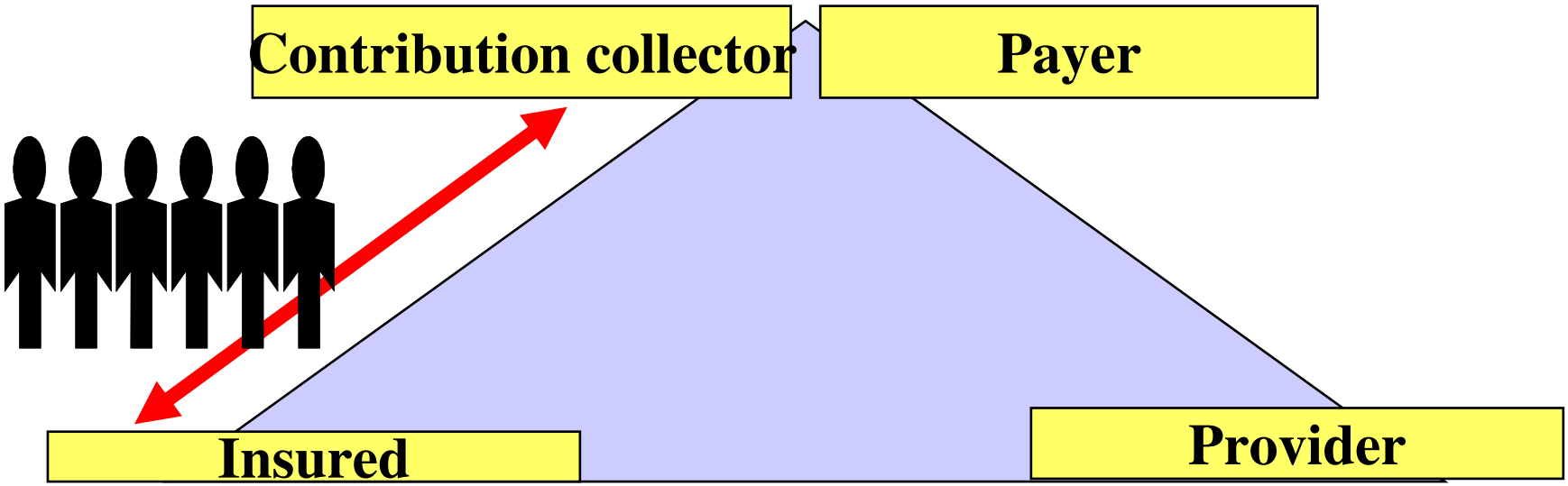


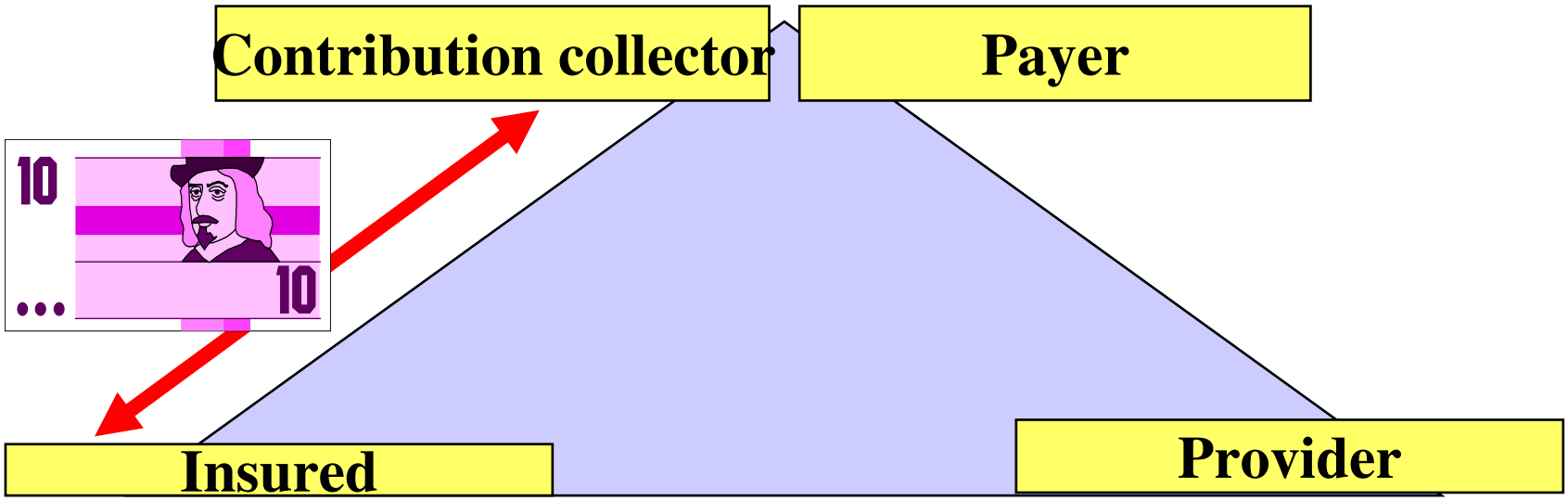
- 100% population coverage in Austria, Belgium, France, Luxembourg, Switzerland (since 1996!)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



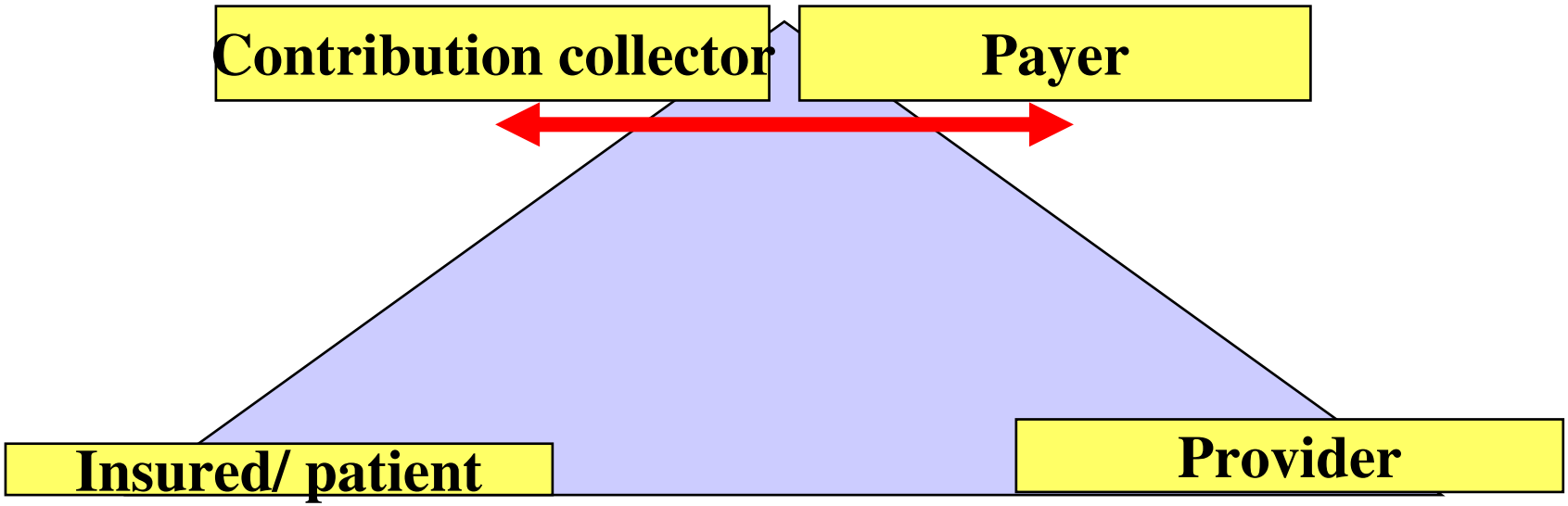
- Government (Netherlands)
- Social security agency (Belgium)
- Union of sickness funds (Luxembourg)
- One sickness fund for all (France)
- Individual sickness funds (Austria, Germany, Switzerland)



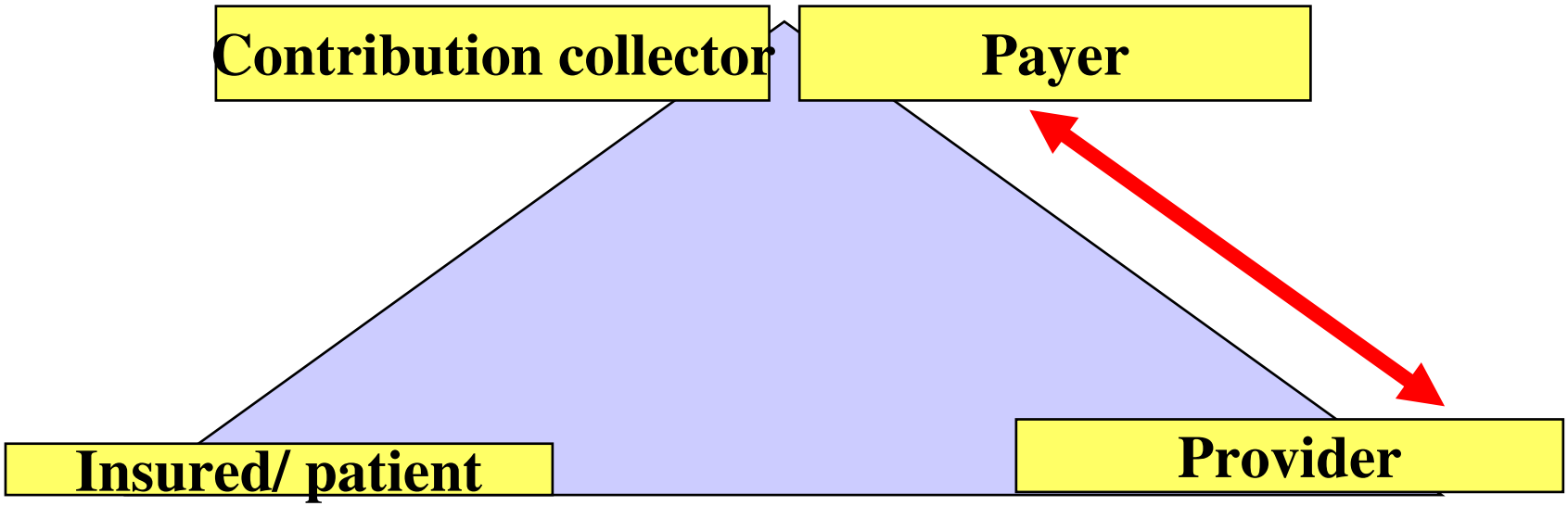
- Pre-determined membership in Austria, France, Germany (until 1995) and Luxembourg
- Free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland: *in Germany relatively high movement and de-mixing of risks!*



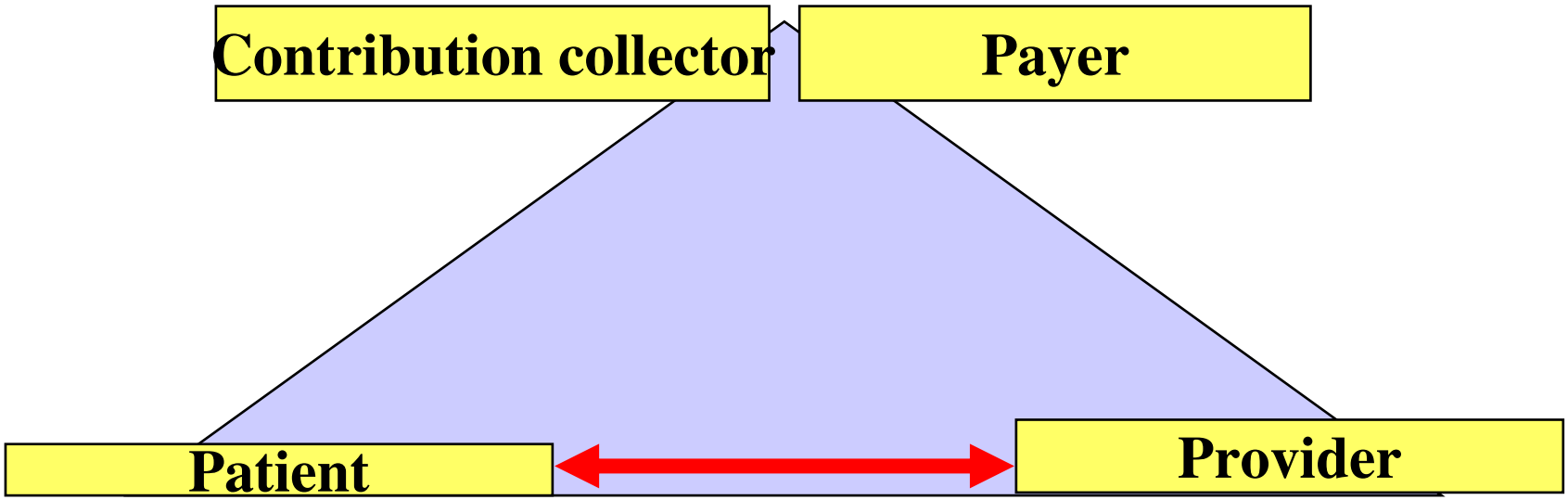
- Uniform rate in Austria, Belgium, France, Luxembourg and Netherlands (+ differing per-capita premium); differing rate in Germany; per-capita premium in Switzerland.
- Contribution cap in Austria and Germany but **not** in Belgium and France.
- France: change from income-related contribution (6.9%) to tax on total income (6%), *i.e. relief for wage-earners*.
- In the Netherlands, privately insured subsidise SHI, in Germany not.



- allocation (Belgium, Netherlands) or re-allocation (Germany, Switzerland) *– the latter is more difficult as sickness funds view money as „theirs“*
- 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



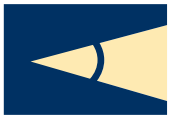
- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts will be illegal – but: funds hardly use selective contracts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



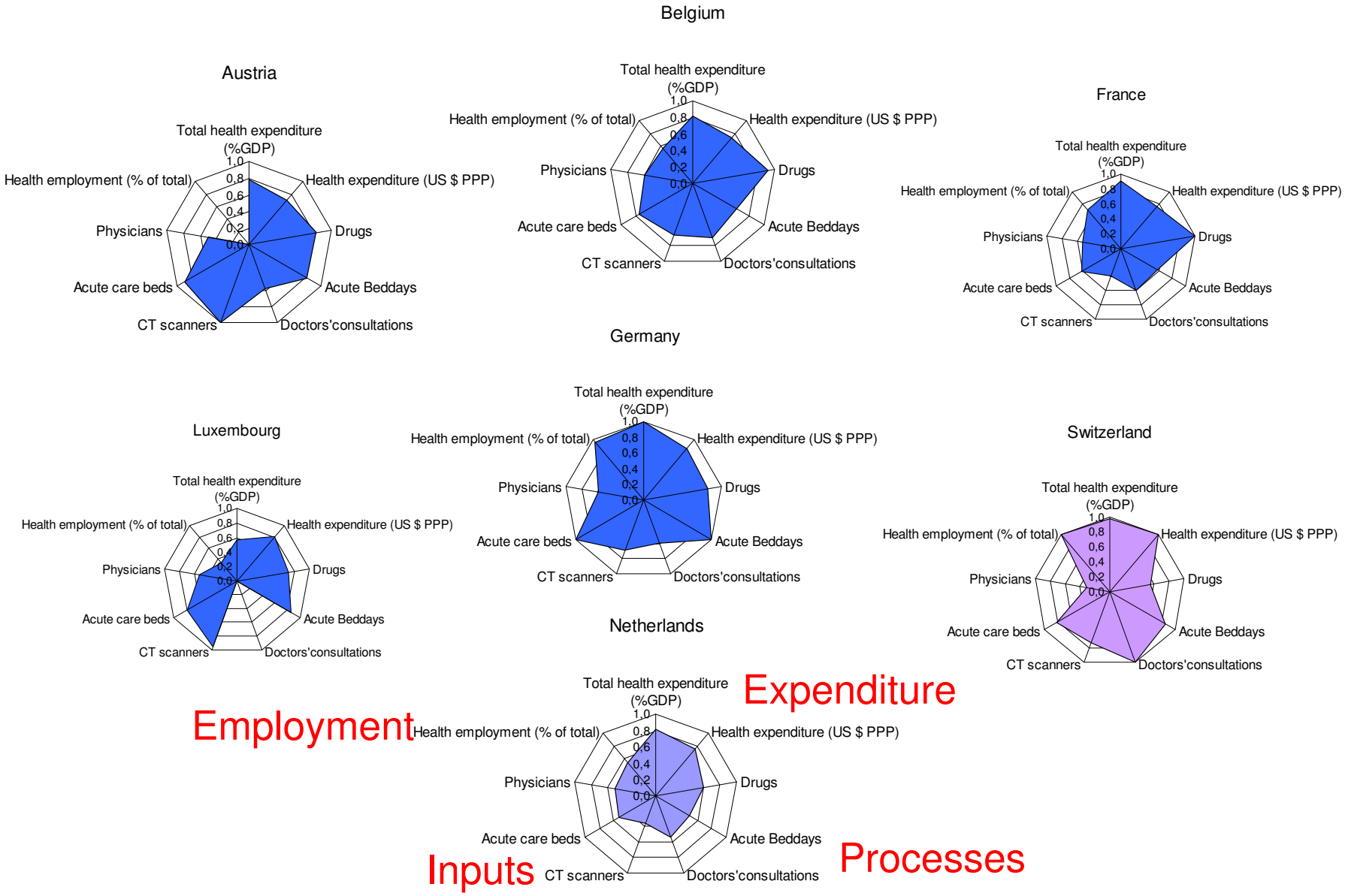
- Free access = feature of SHI systems (except NL): Gatekeeping = more effective, cheaper, but less popular?
- Attempts in the Netherlands to separate “core” benefits from others (to be paid for privately) has failed: dental care was partly re-introduced; not covered services make up only 3% of expenditure

Other SHI system characteristics

- ***Solidarity:*** set of four cross-subsidies on the funding side (healthy to sick, well-off to less-well-off, young to old, and individuals to families) that provide equal benefits on the entitlements side.
- ***Pluralism:*** a complex mix of different public, quasi-public, not-for-profit, and sometimes for-profit actors.
- ***Participation:*** shared governance among these actors, sometimes described as "self-regulation".
- ***Choice:*** insurees' ability to select among contracted providers and, in some countries, among different sickness funds.

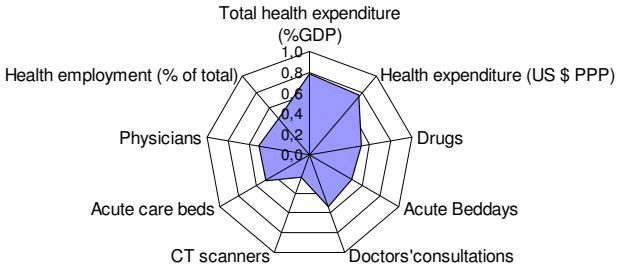


SHI: expensive and resource-intensive

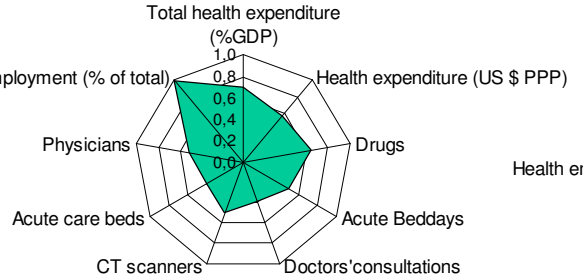


… at least in comparison to other EU countries

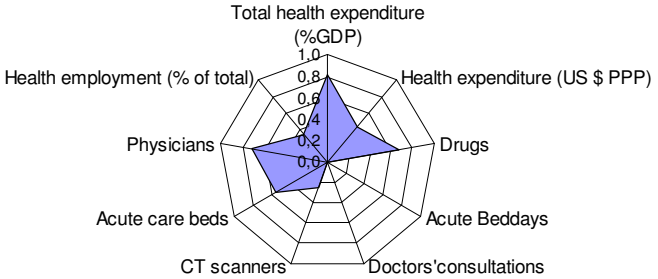
Denmark



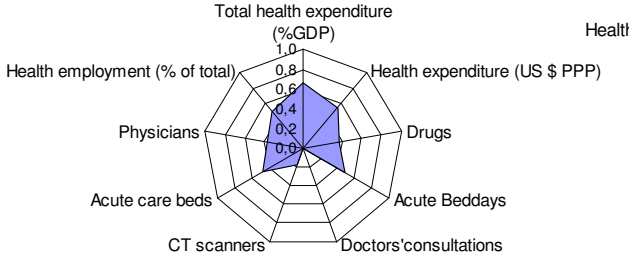
Finland



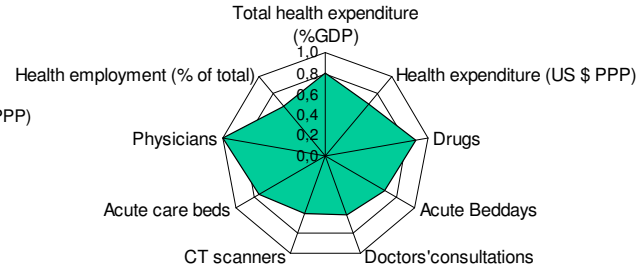
Greece



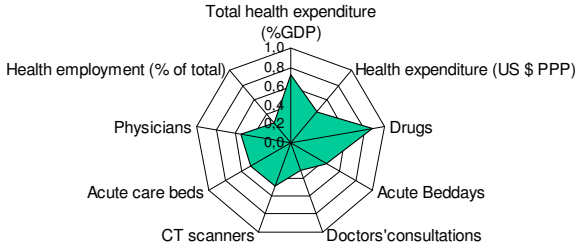
Ireland



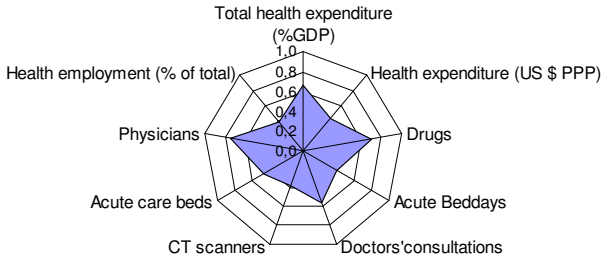
Italy



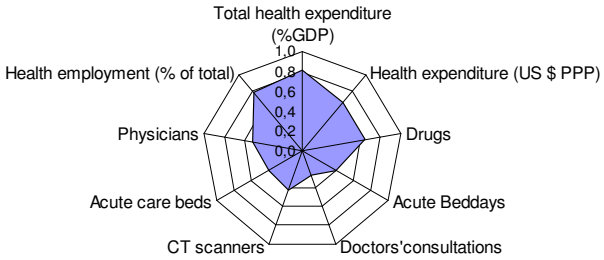
Portugal



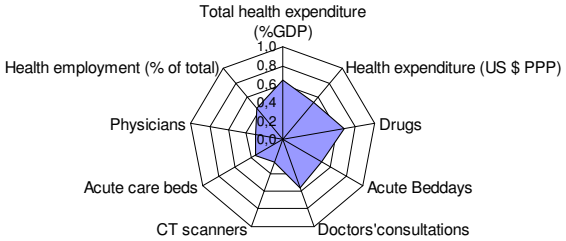
Spain



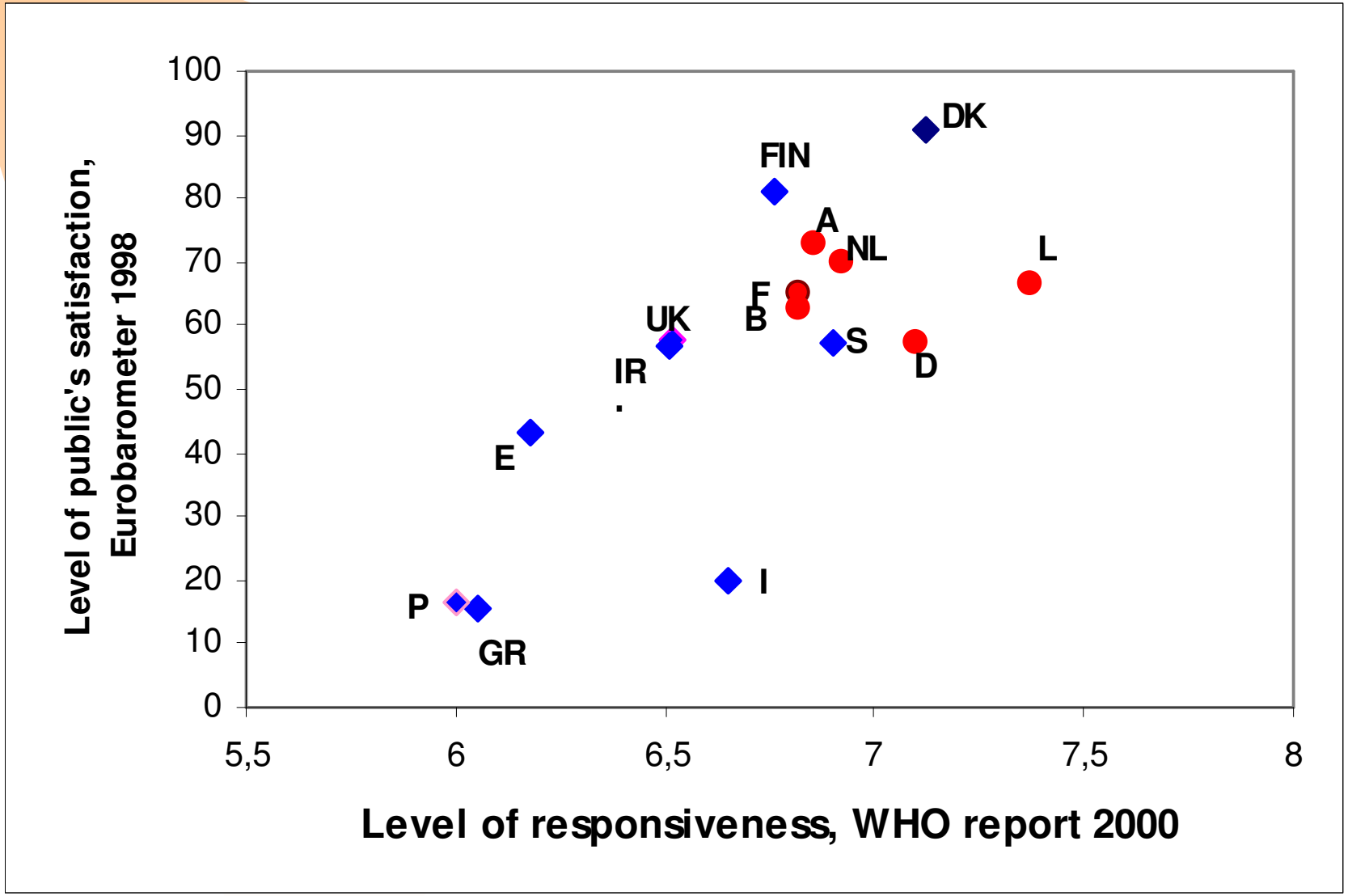
Sweden



U.K.



SHI more responsive and citizens more satisfied



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Efficiency: SHI = better outcomes for more money

	Health		Responsiveness		Faire financing (25%)	Goal attainment	Health expend./ capita	Efficiency („Performance“)	
	Level (25%)	Distrib. (25%)	Level (12,5%)	Distrib. (12,5%)				Level health	overall
A	17	8	12-13	3-38	12-15	10	6	15	9
B	16	26	16-17	3-38	3-5	13	15	28	21
DK	28	21	4	3-38	3-5	20	8	65	34
D	**22**	**20**	**5**	**3-38**	**6-7**	**14**	**3**	**41**	**25**
FIN	20	27	19	3-38	8-11	22	18	44	31
F	3	12	16-17	3-38	26-29	6	4	4	1
GR	7	6	36	3-38	41	23	30	11	14
GB	14	2	26-27	3-38	8-11	9	26	24	18
IRL	27	13	25	3-38	6-7	25	25	32	19
I	6	14	22-23	3-38	45-47	11	11	3	2
L	18	22	3	3-38	2	5	5	31	16
NL	13	15	9	3-38	20-22	8	9	19	17
P	29	34	38	53-57	58-60	32	28	13	12
E	5	11	34	3-38	26-29	19	24	6	7
S	4	28	10	3-38	12-15	4	7	21	23
SHI	14-15	17	10	20-21	12	9	7	23	**16-17**
other	16	17	24	24	24	20	20	24	**18**

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)

Conclusions for CEE countries

- SHI is clearly much more than a funding mechanism – it is "a way of life", needing a civil society with e.g. trade unions which is often not (yet) the case in CEE
- from a financial perspective, it is expensive, i.e. requires a certain level of health expenditure
- re outcomes such as responsiveness or satisfaction it is superior to other systems, re health gain similar – overall efficieny (inputs : outcomes) it is equal
- whether the tripartite self-government or the direct governmental control of funds can make it cheaper while retaining the advantages is doubtful

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