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Social health insurance systems in western Europe – commonalities and variations

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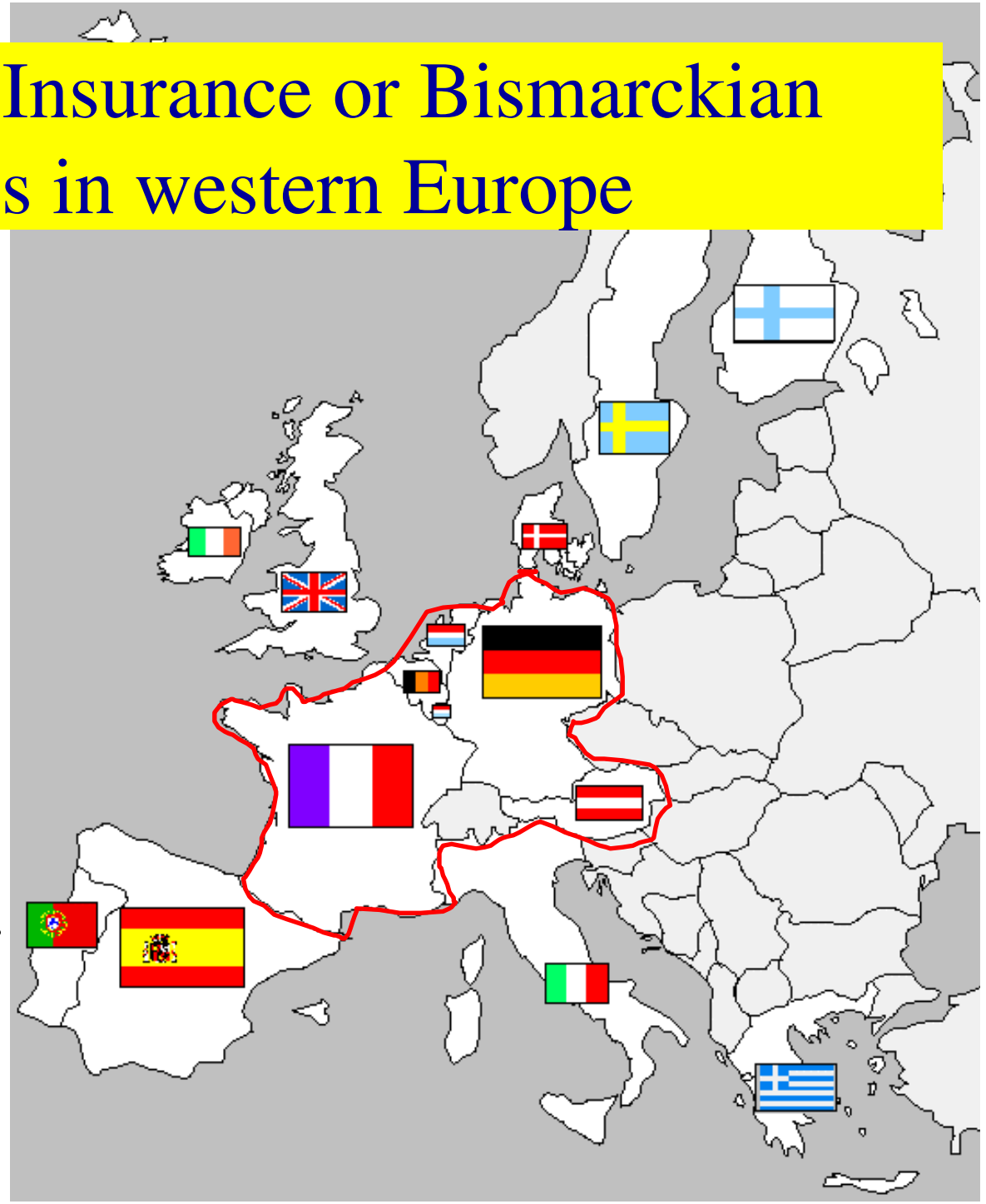
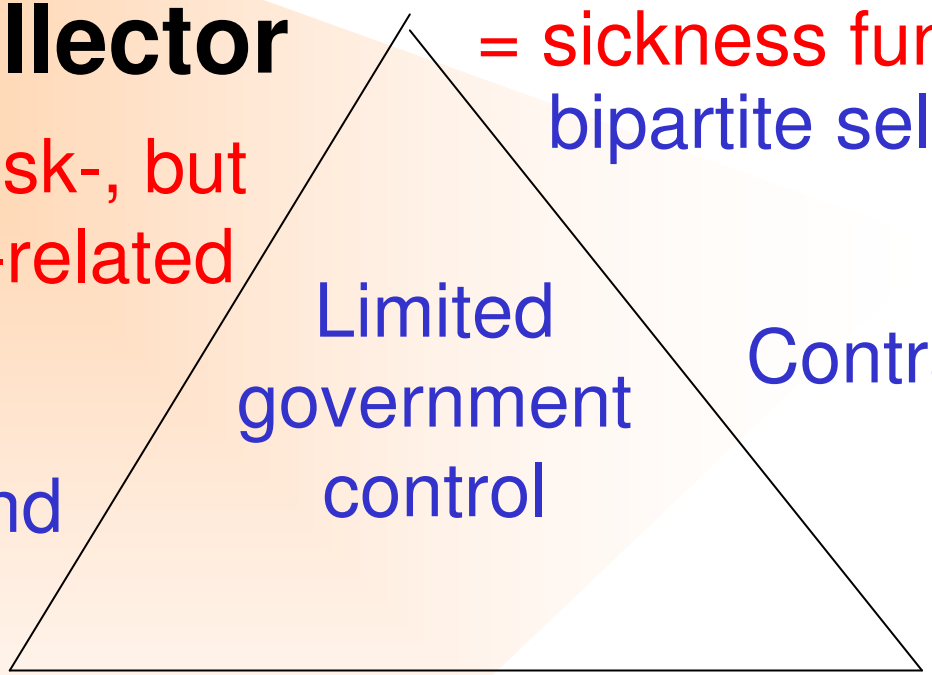
Social Health Insurance or Bismarckian countries in western Europe

- SHI definition
- Commonalities and variations between countries
- Analysis regarding impact on health status, efficiency, equity, satisfaction ...
- Future dynamics and challenges



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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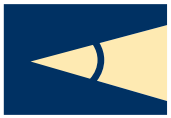
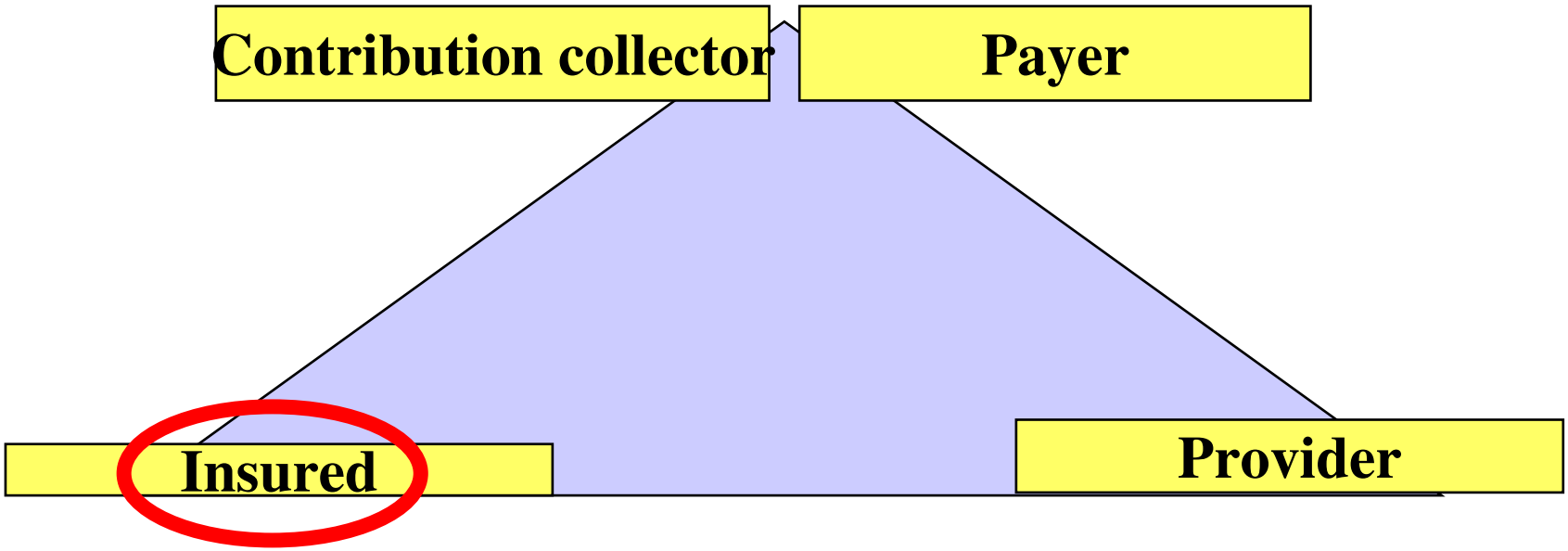
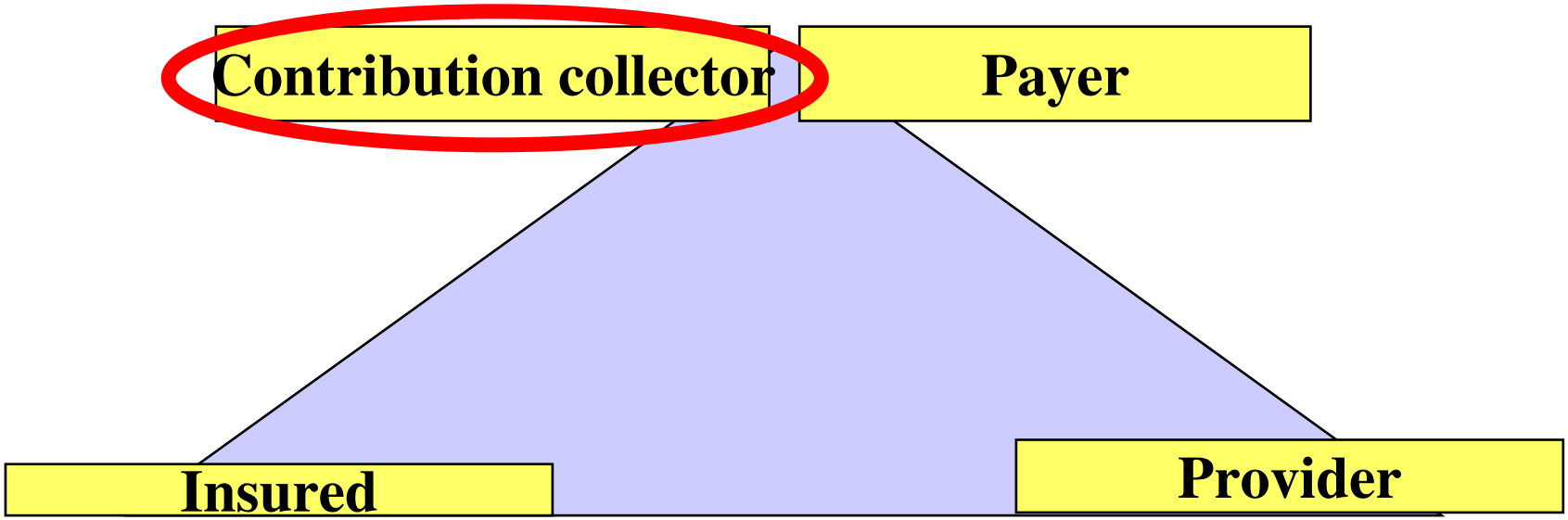
Other SHI system characteristics

- ***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.

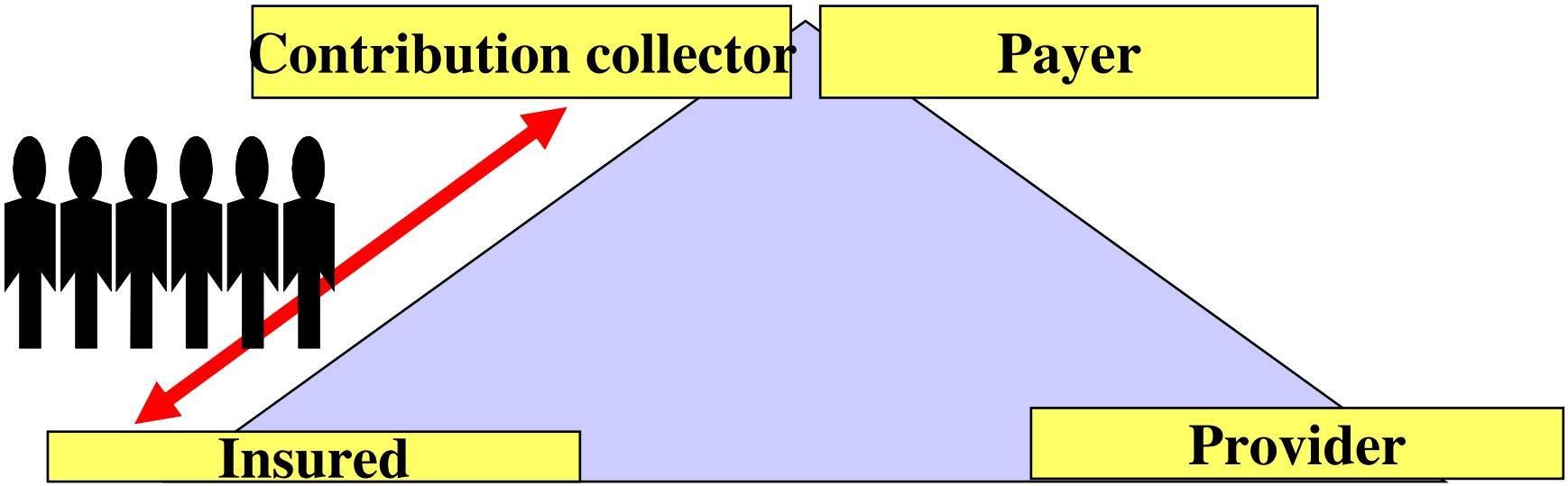




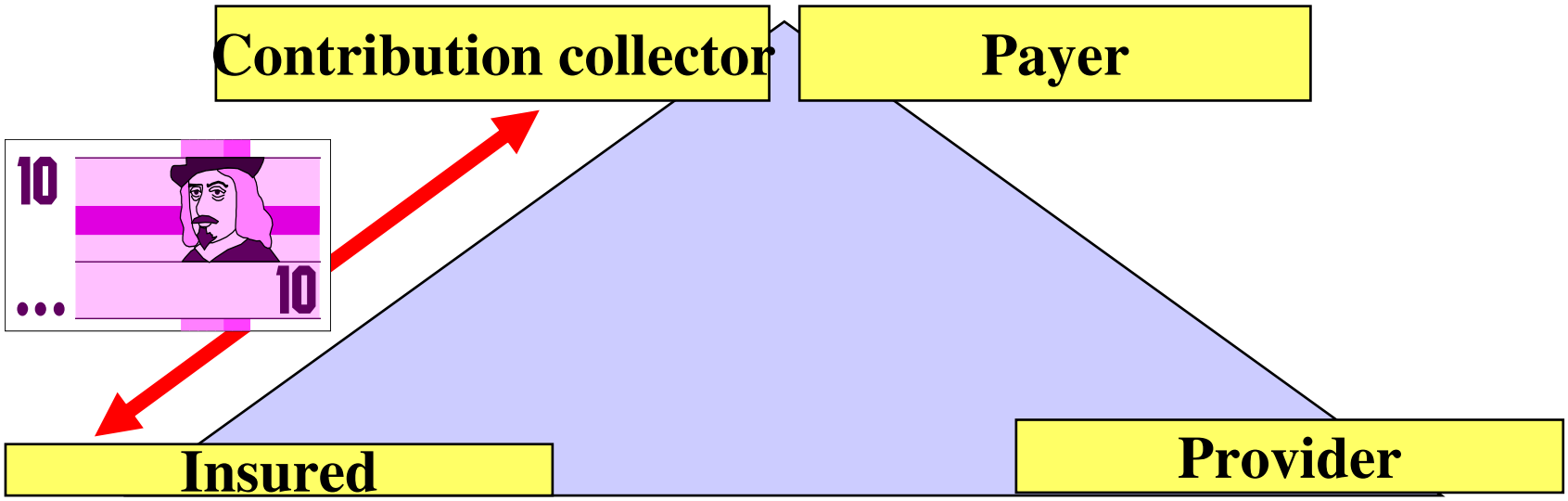
- 100% population coverage in Austria, Belgium, France, Luxembourg, Switzerland (since 1996!)
- 75% mandatory and 13% voluntary coverage in Germany (choice between SHI and PHI)
- 65% coverage in Netherlands (no choice!)



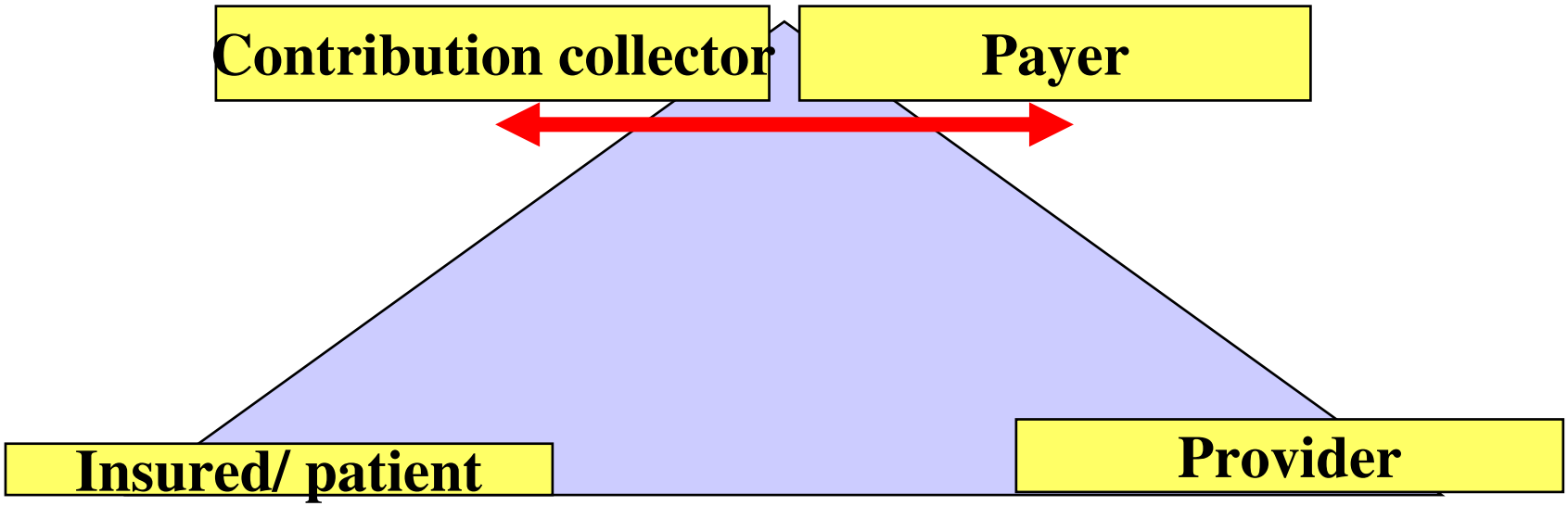
- Government (Belgium, France, Netherlands)
- Union of sickness funds (Luxembourg)
- Individual sickness funds (Austria, Germany, Switzerland)



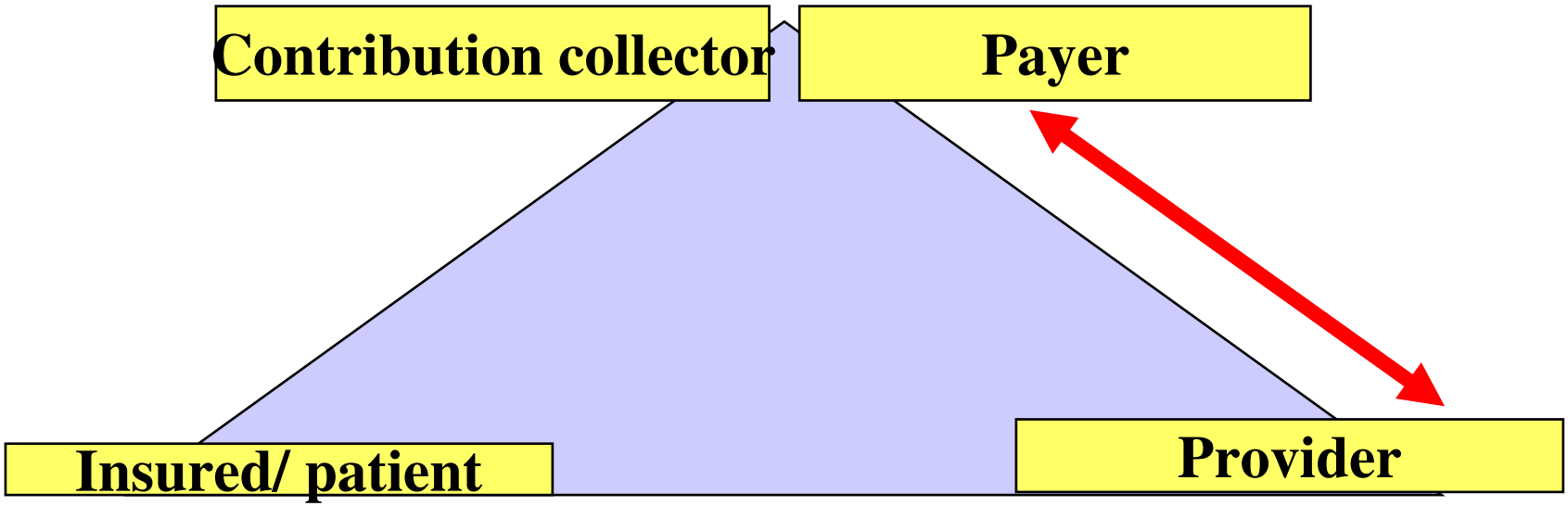
- Pre-determined membership in Austria, France, Germany (until 1995) and Luxembourg
- Free choice of fund in Belgium, Netherlands (1993-), Germany (1996-) and Switzerland



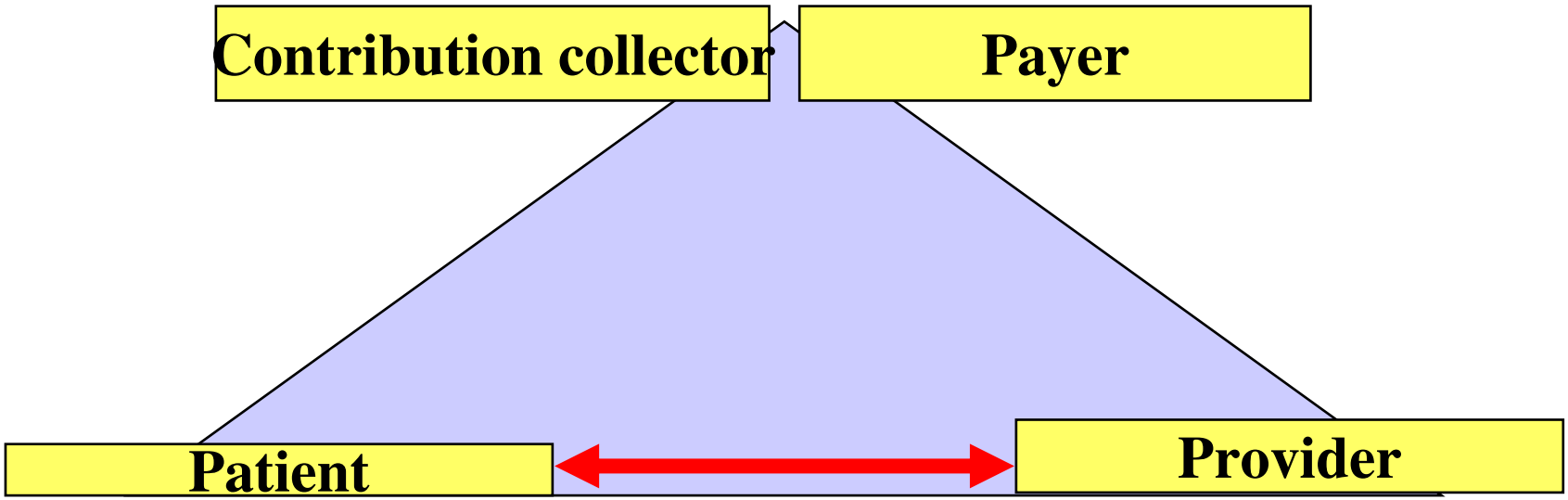
- Uniform rate in Austria, Belgium, France, Luxembourg and Netherlands (+ differing per-capita premium); differing rate in Germany; per-capita premium in Switzerland.
- Contribution cap in Austria and Germany but **not** in Belgium and France.
- France: in 1999 change from income-related contribution (8.9%) to tax on total income (8,25%)
- In the Netherlands, privately insured subsidise SHI, in Germany not.



- allocation (Belgium, Netherlands) or re-allocation (Germany, Switzerland)
- 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

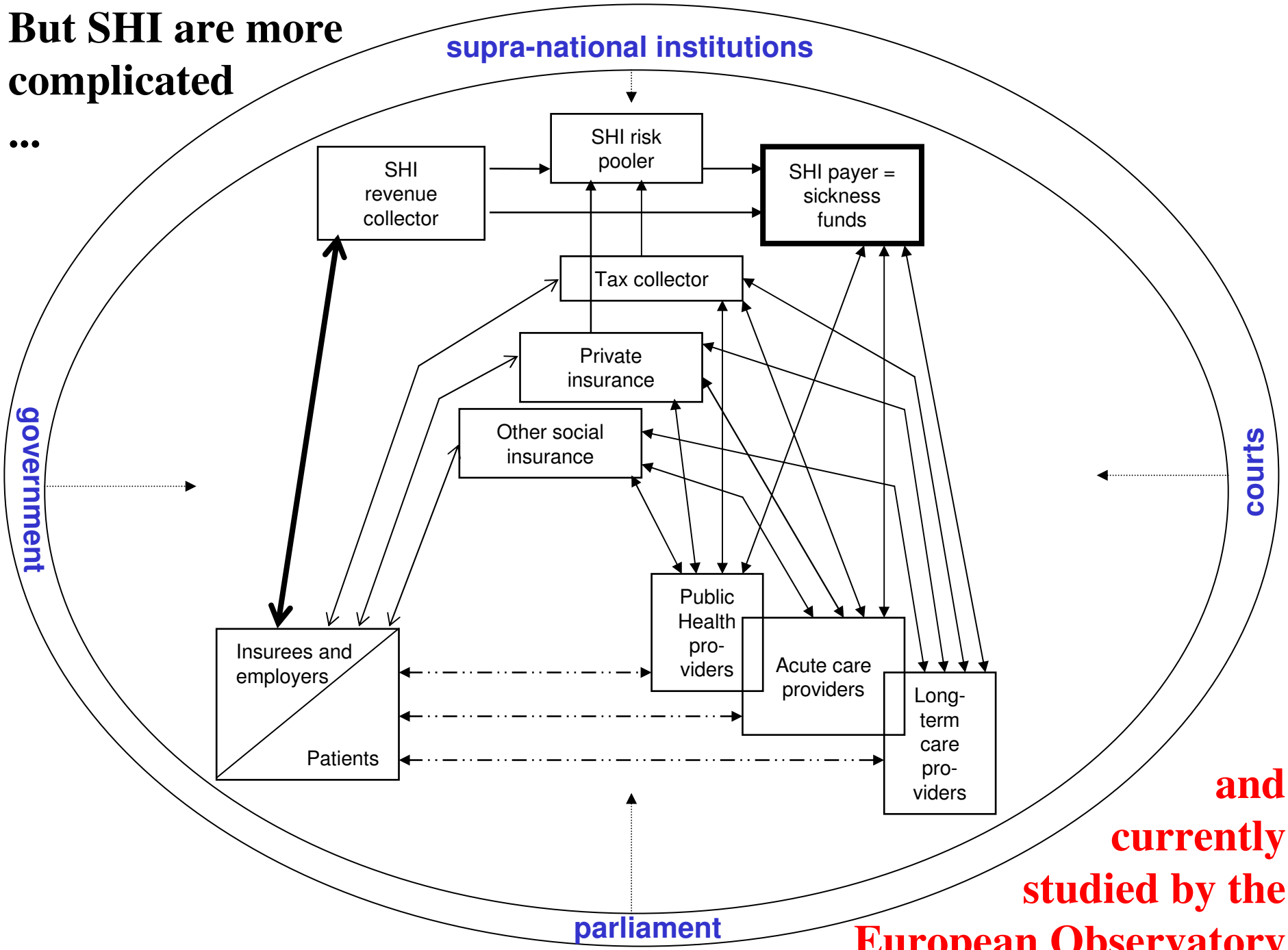


- all SHI systems are traditionally multi-payer systems – problem: weak cost-control
- solutions: budgets – via state (Austria, France) or collective contracts
  (problem: contradict competition between funds)
- Netherlands: collective contracts will be illegal – but: funds hardly use selective contracts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

But SHI are more complicated ...



and currently studied by the European Observatory