

Künftige Anforderungen an Finanzierung und Vergütung im Gesundheitswesen

Verbreiterung der Finanzierungsbasis: Internationale Lösungsansätze

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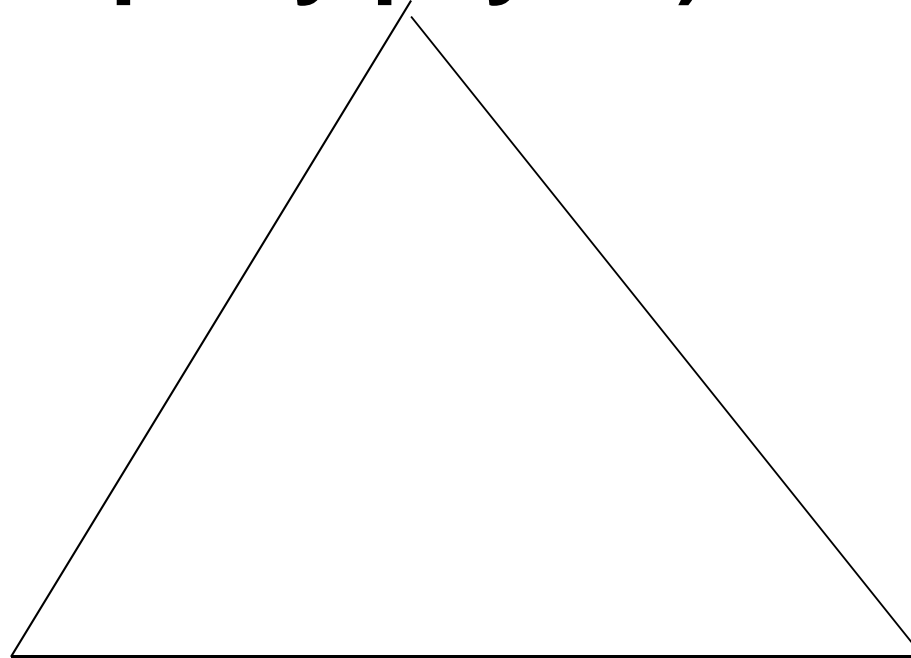
FG Management im Gesundheitswesen,
Technische Universität Berlin (WHO Collaborating Centre for Health
Systems Research and Management) &
European Observatory on Health Systems and Policies



Zahler (“Third-party payer”)

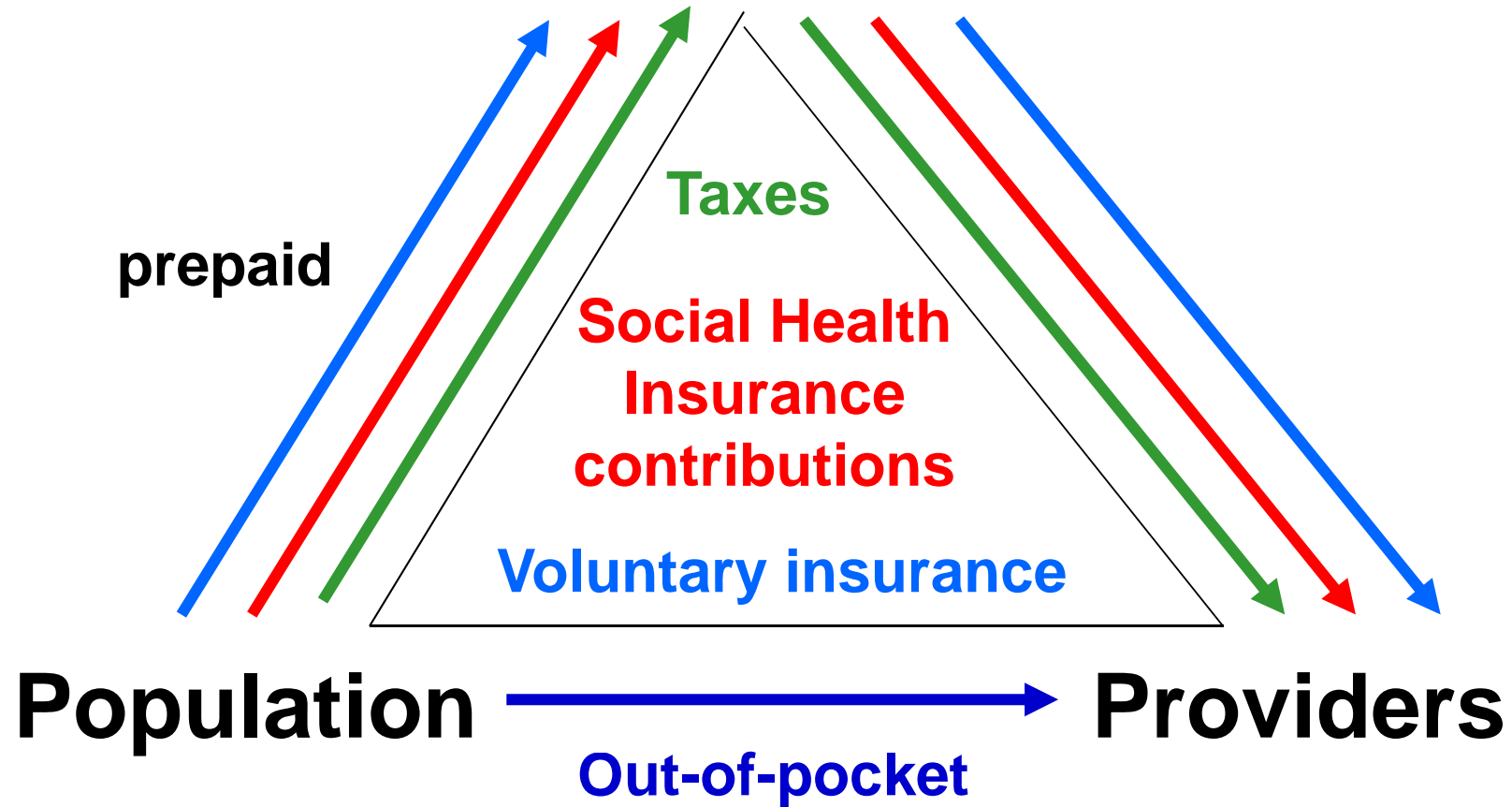
Bevölkerung

**Leistungs-
erbringer**

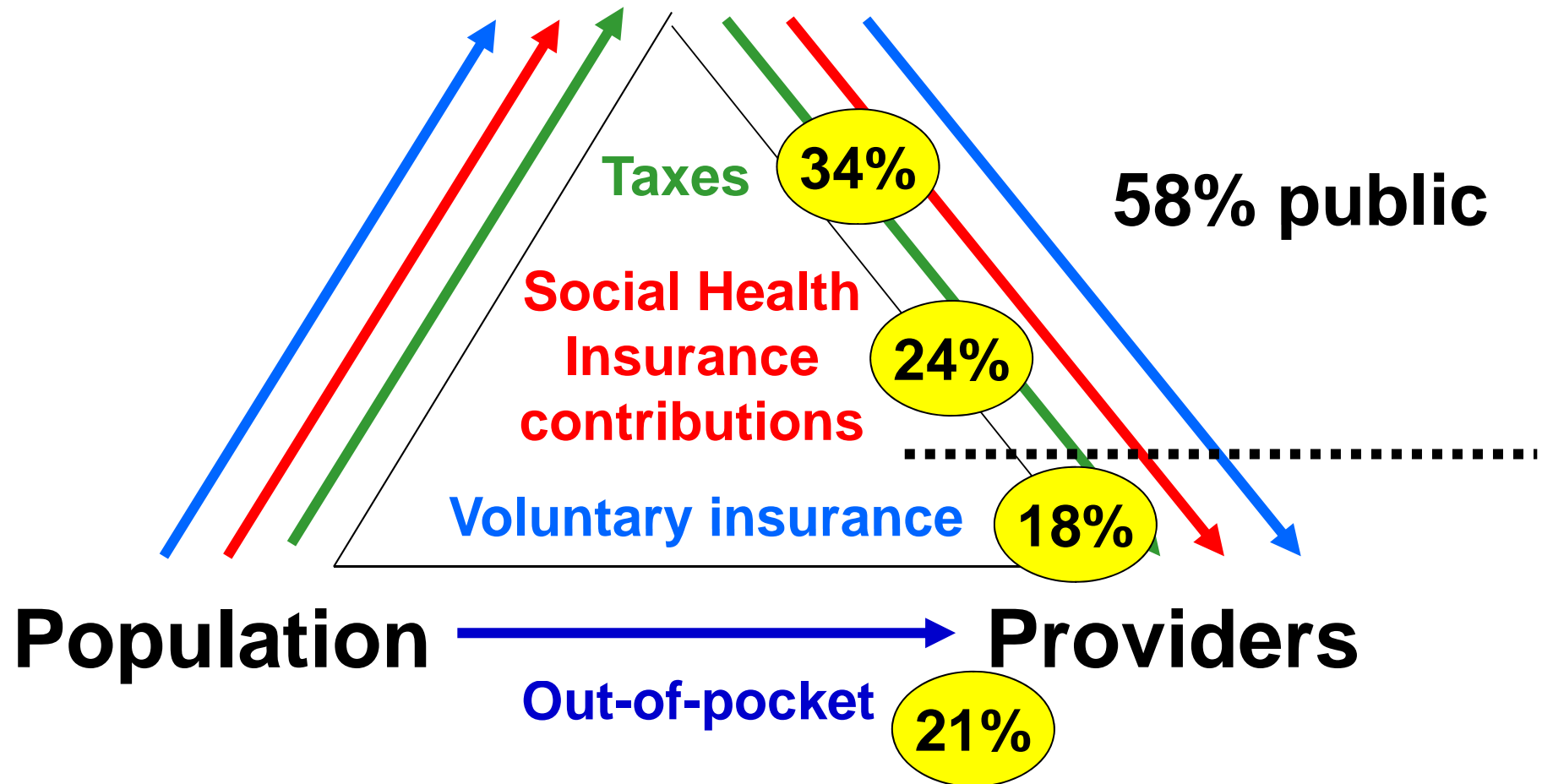


4 WESENTLICHE ARTEN VON FINANZIERUNG

Third-party Payer

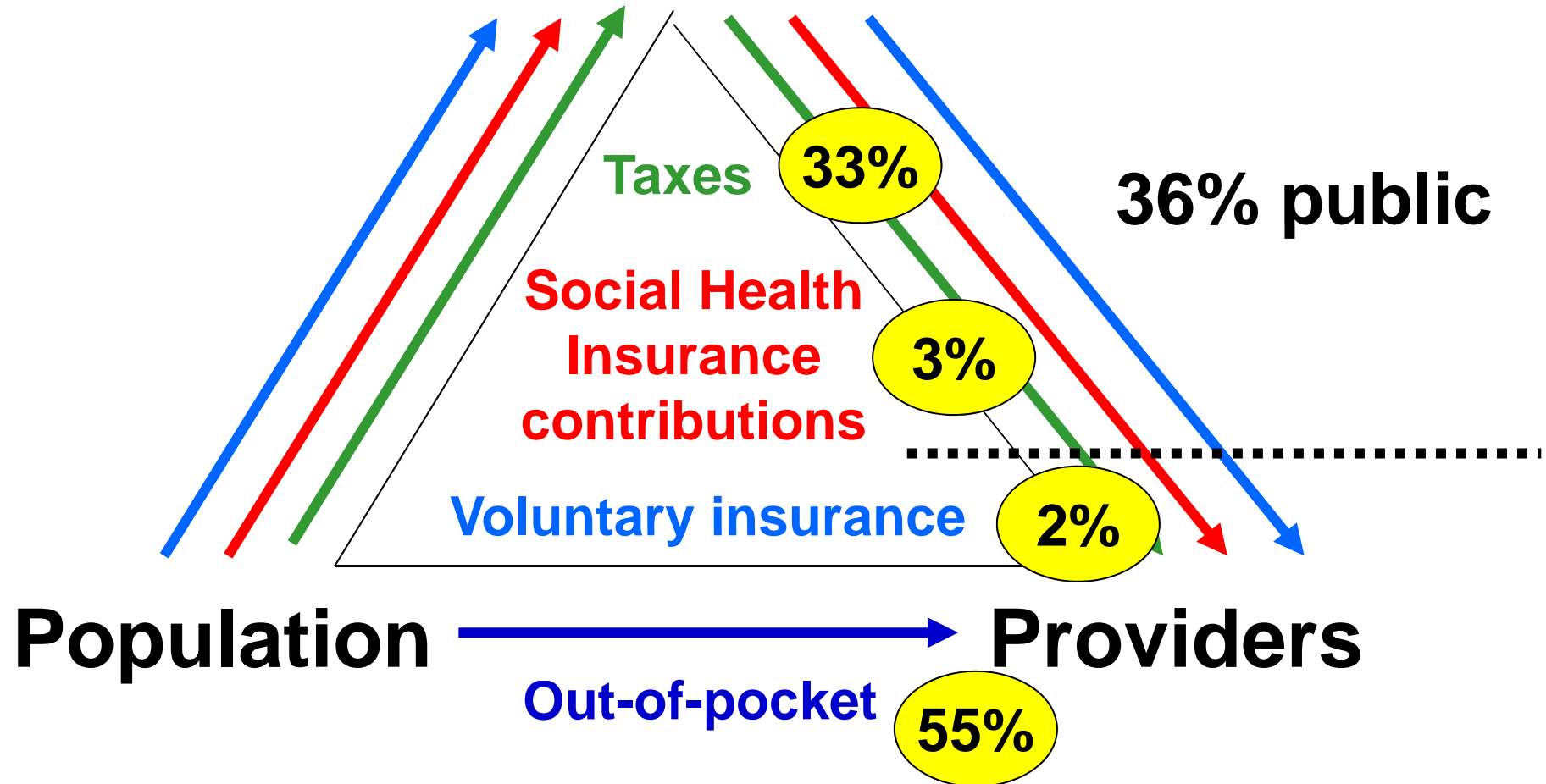


Third-party Payer



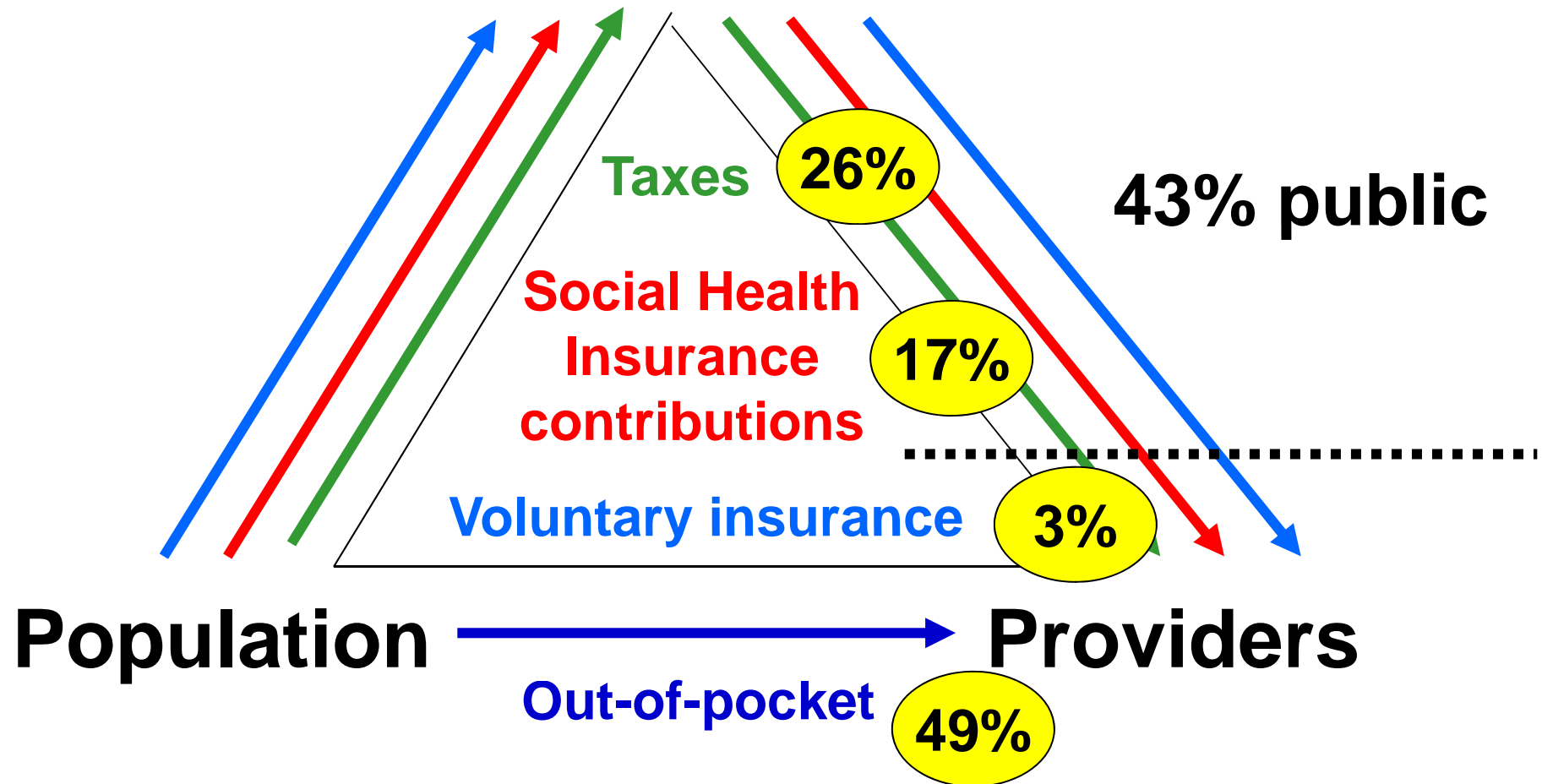
World-wide 2006 (*large US market!*)

Third-party Payer



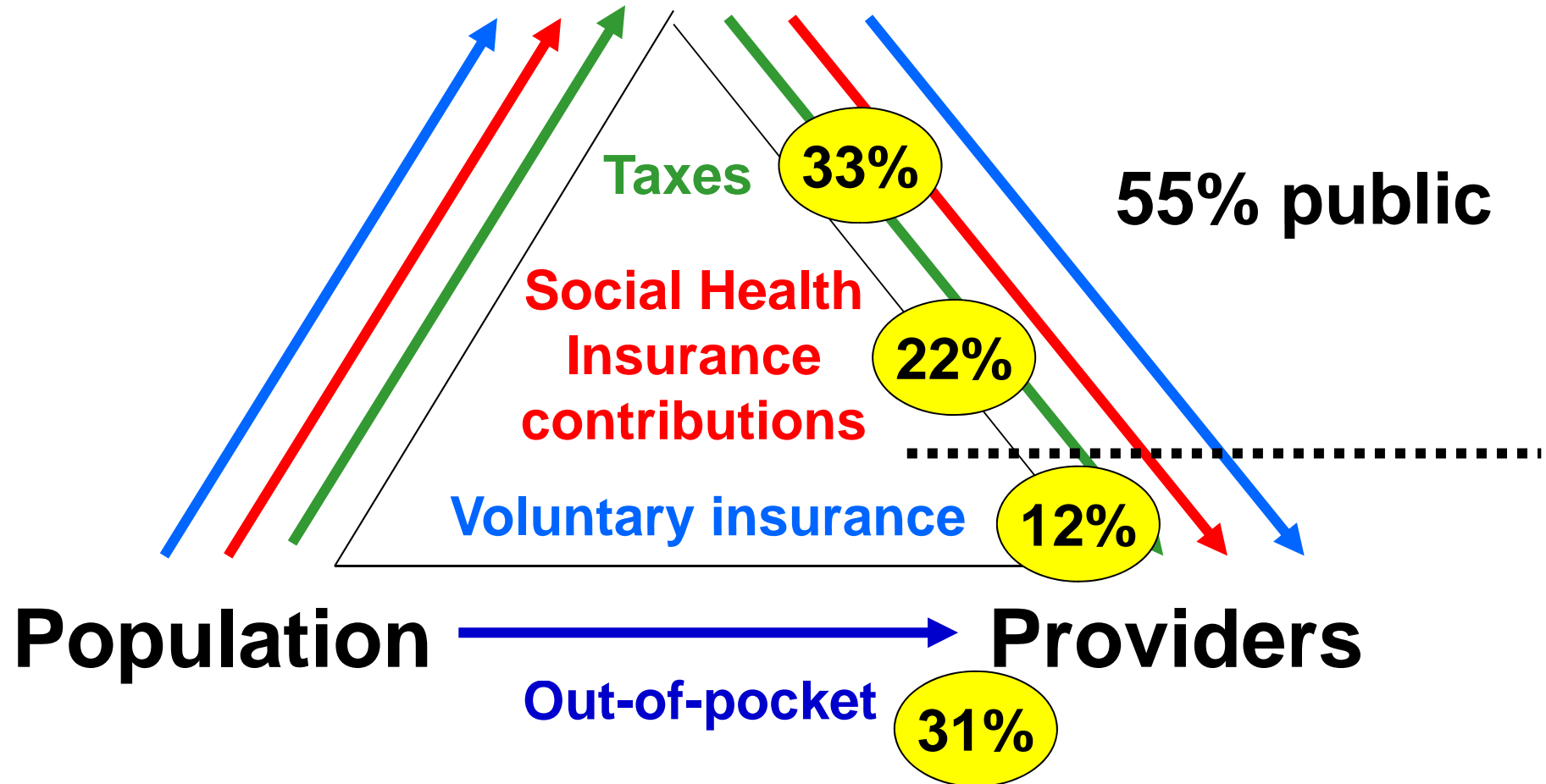
Low-income countries 2006

Third-party Payer



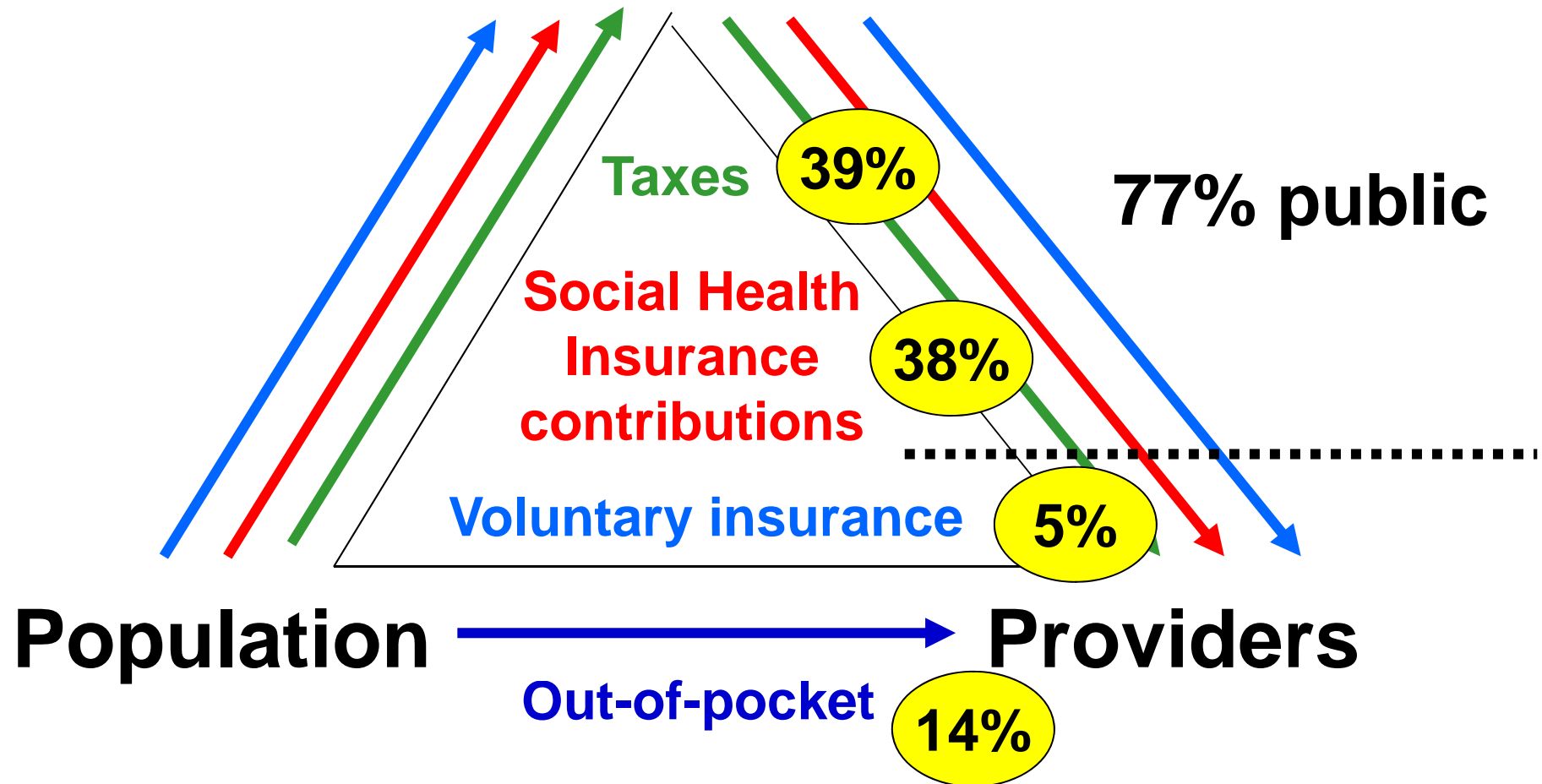
Lower middle income 2006

Third-party Payer



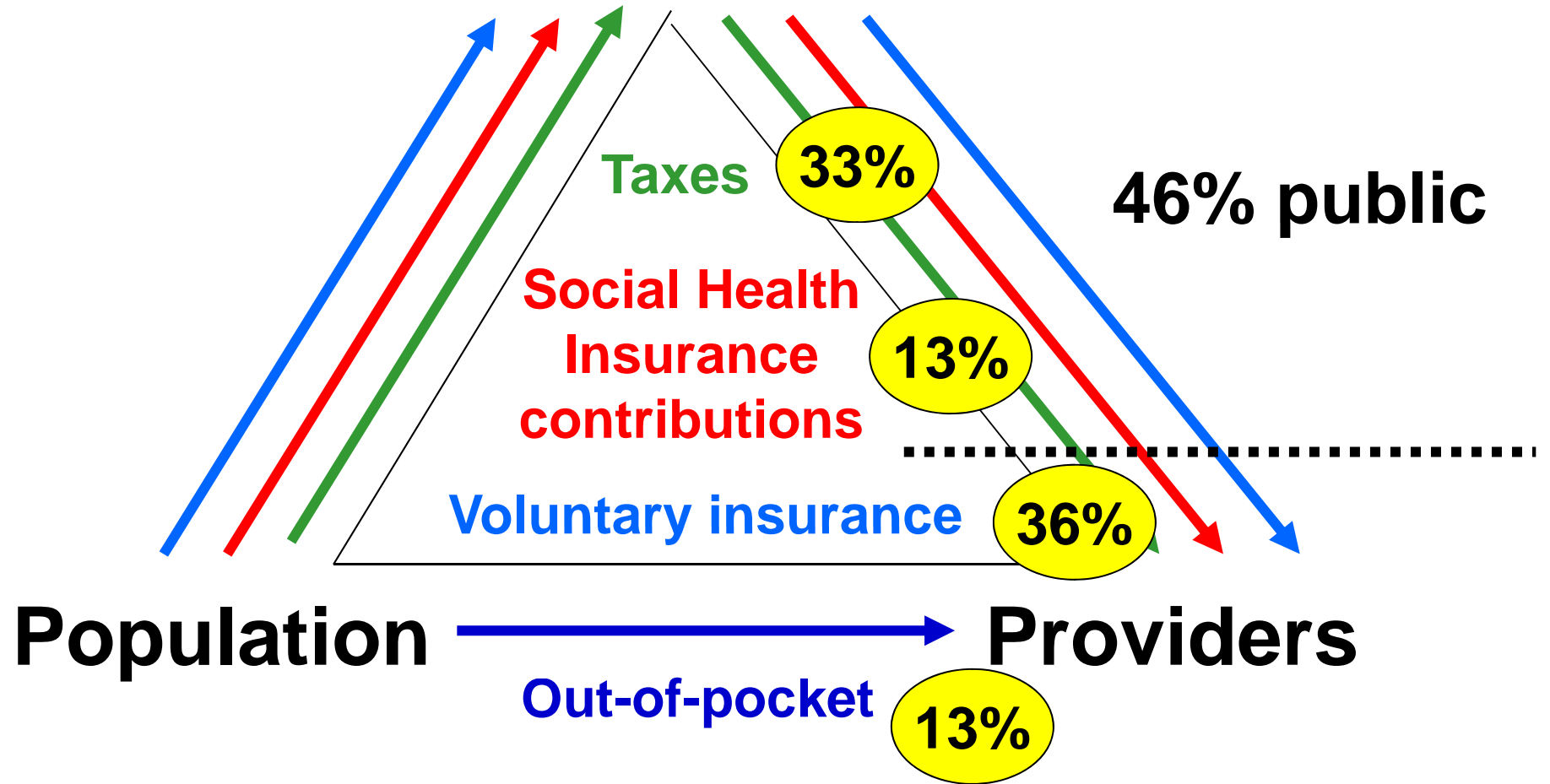
Upper middle income 2006

Third-party Payer



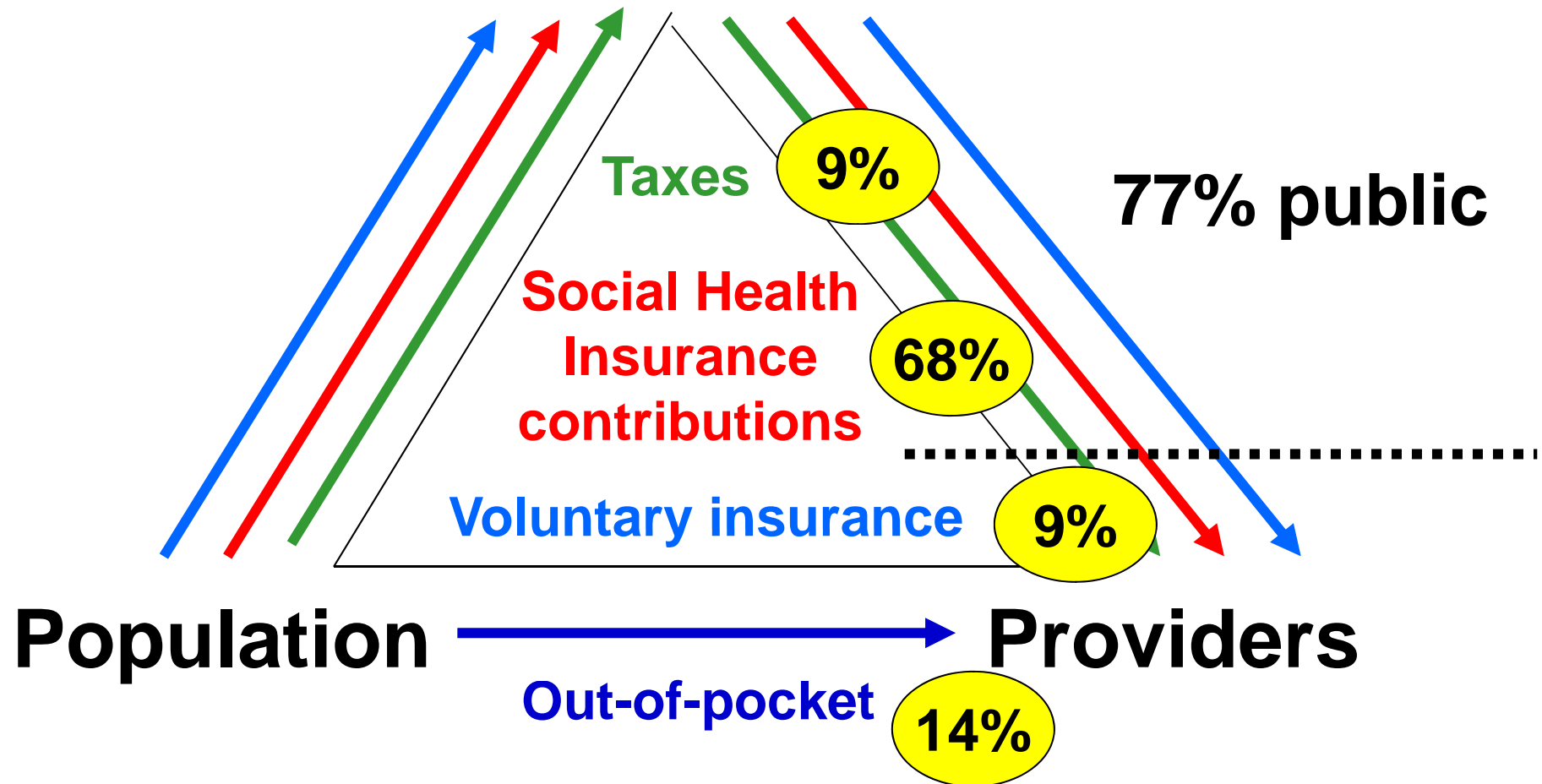
High income (excl. US) 2006

Third-party Payer



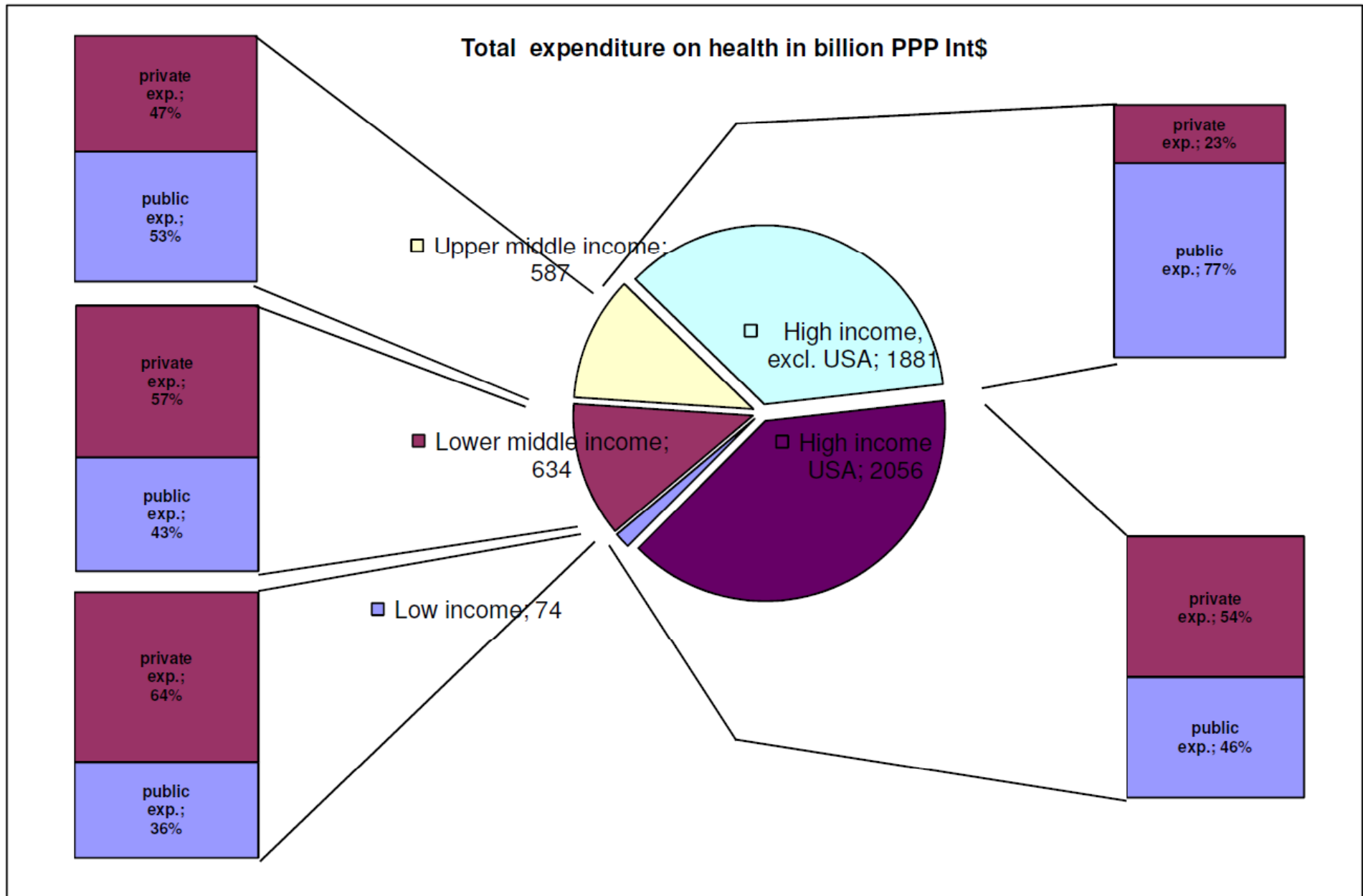
USA 2006

Third-party Payer



Germany 2006

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.

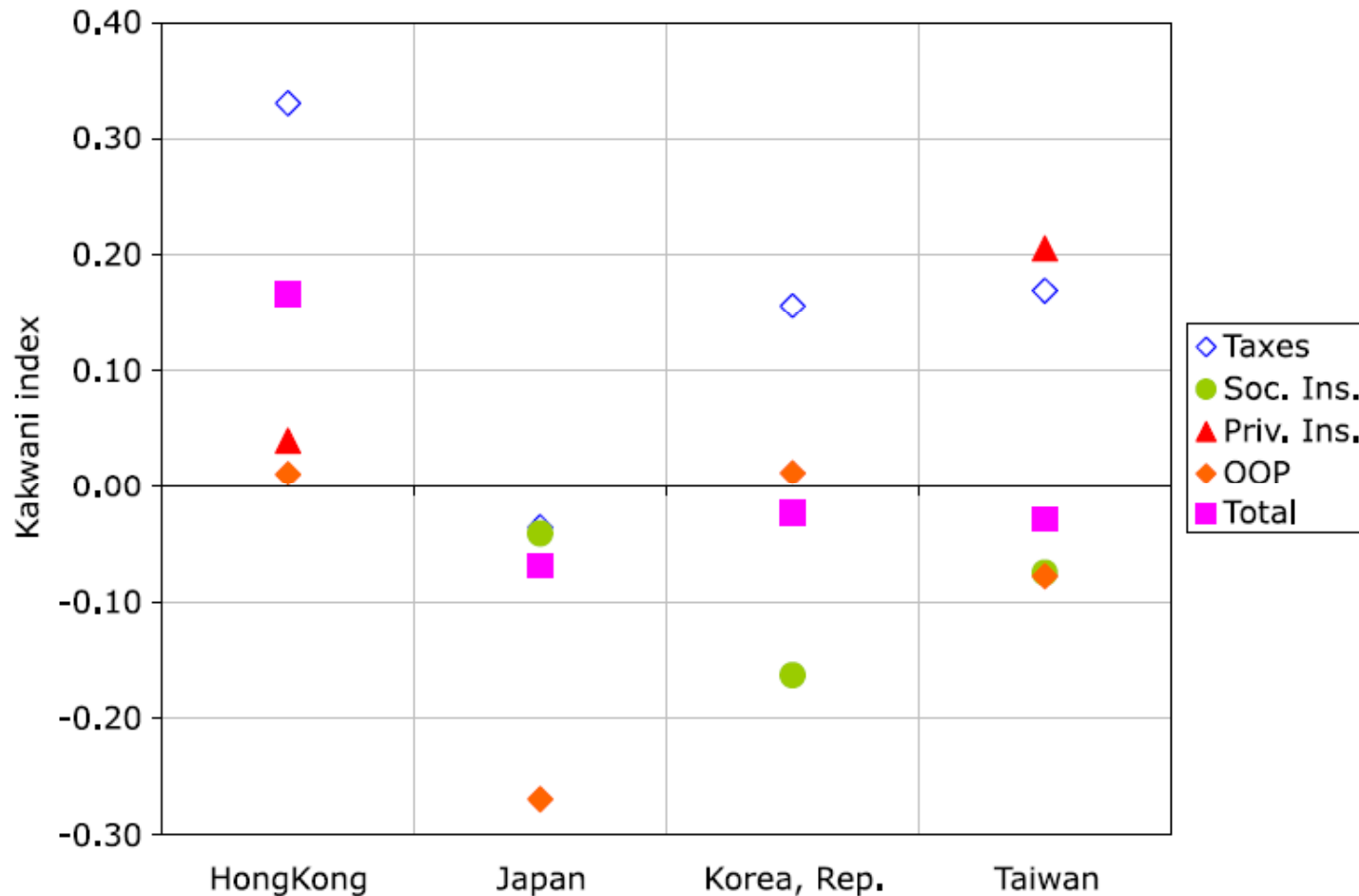
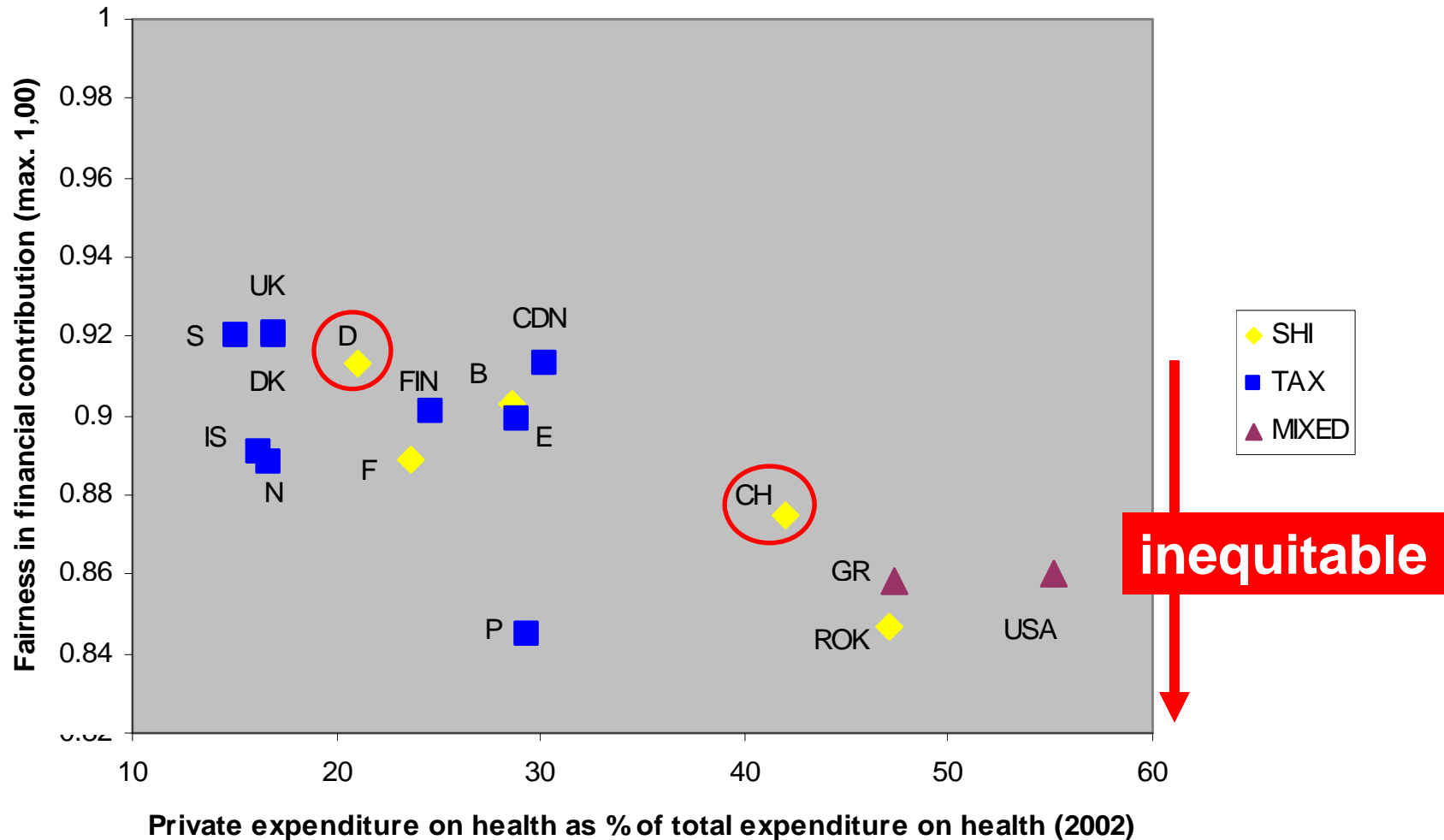
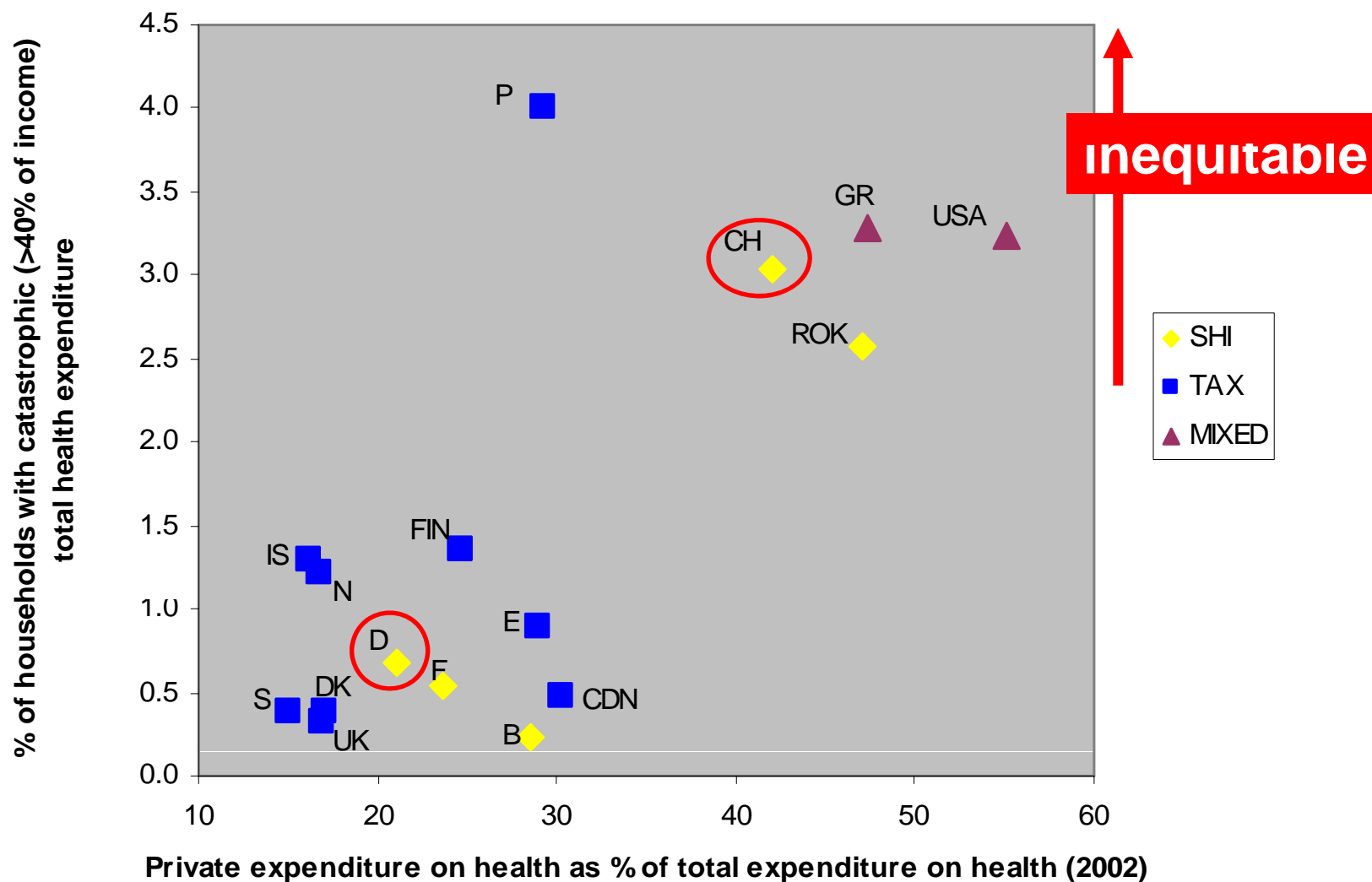


Figure 5. Progressivity of health financing sources in Japan and the Asian Tigers. A positive value of Kakwani's (1977) index indicates a progressive payment structure, a zero value proportional payments, and a negative value a regressive structure. The data shown are from O'Donnell *et al.* (2005)

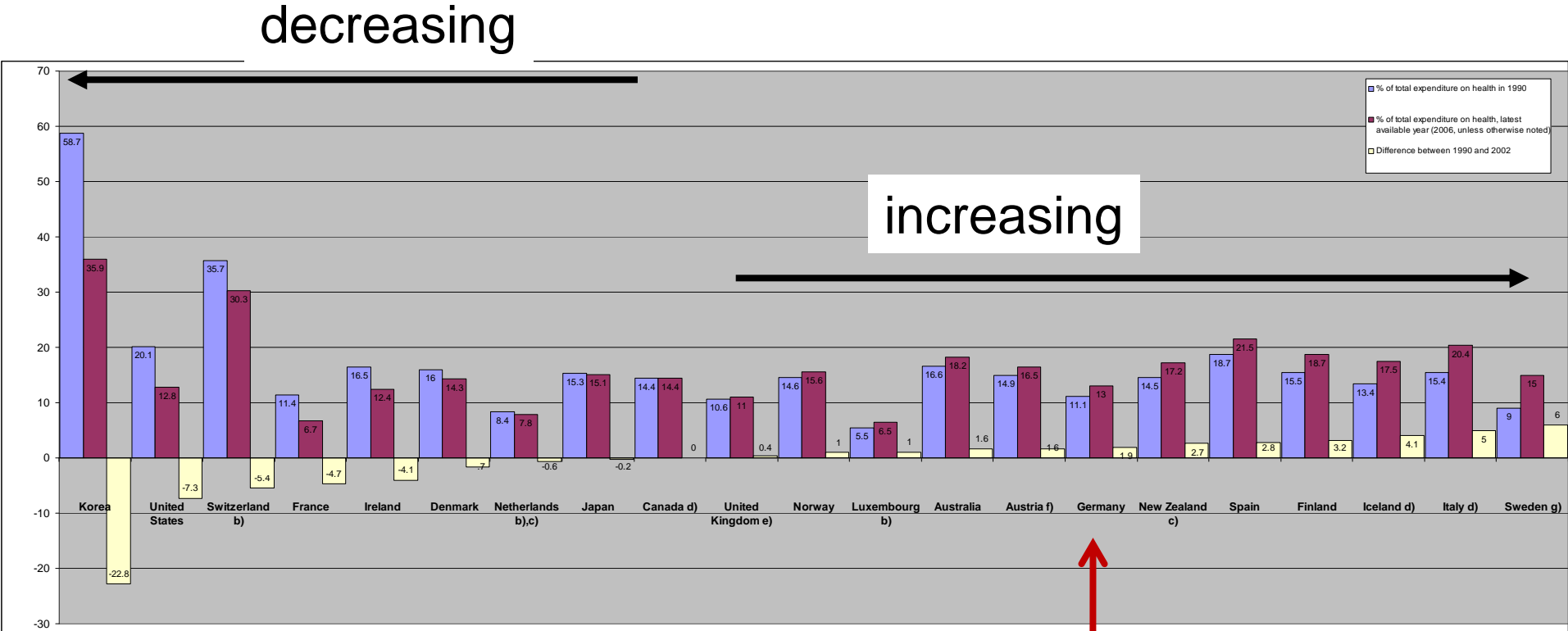
Correlation between private expenditure (as % of total health care expenditure) and the level of fairness in financing



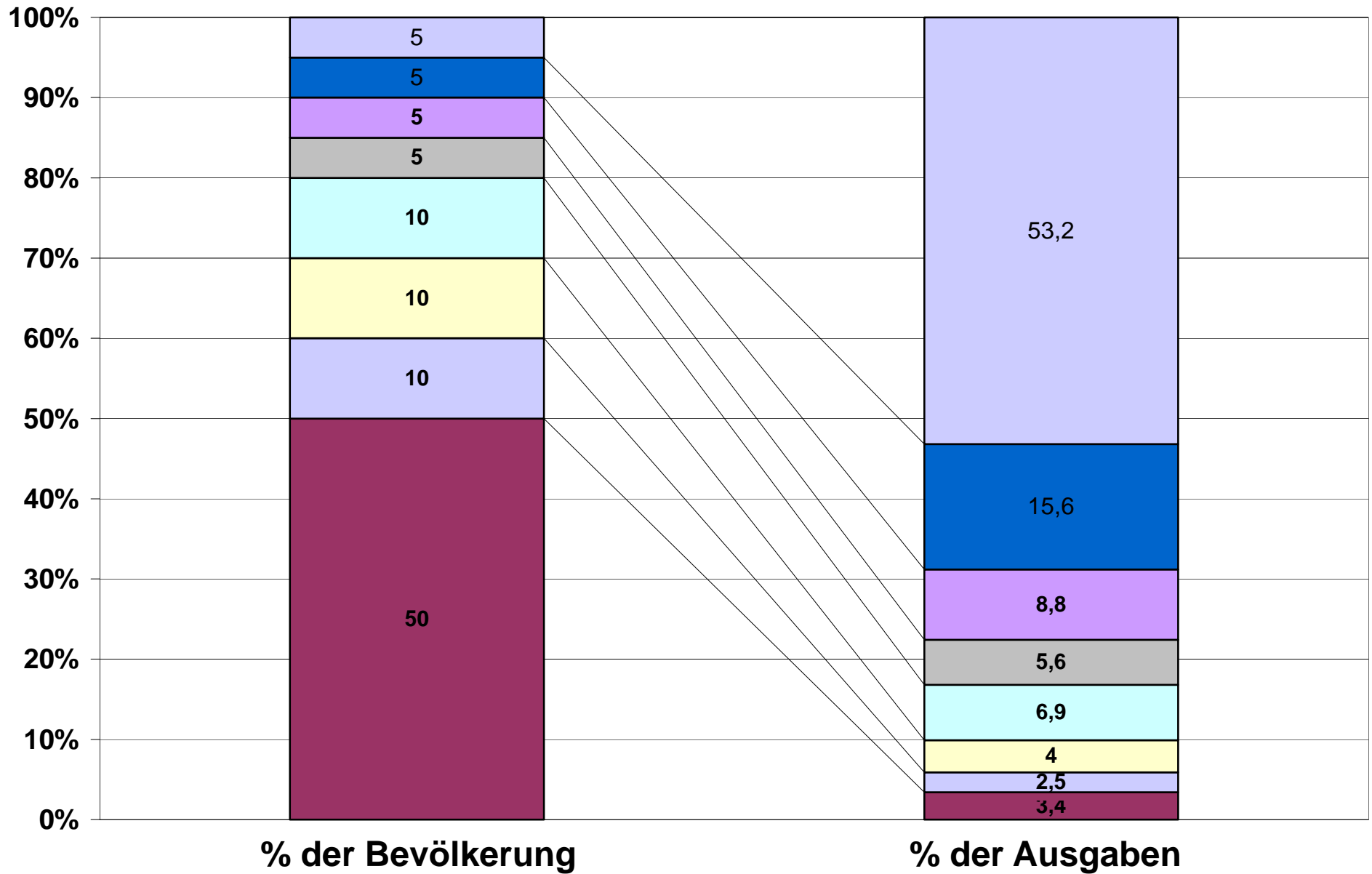
Correlation between private expenditure (as % of total health care expenditure) and the percentage of households with catastrophic health expenditure



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



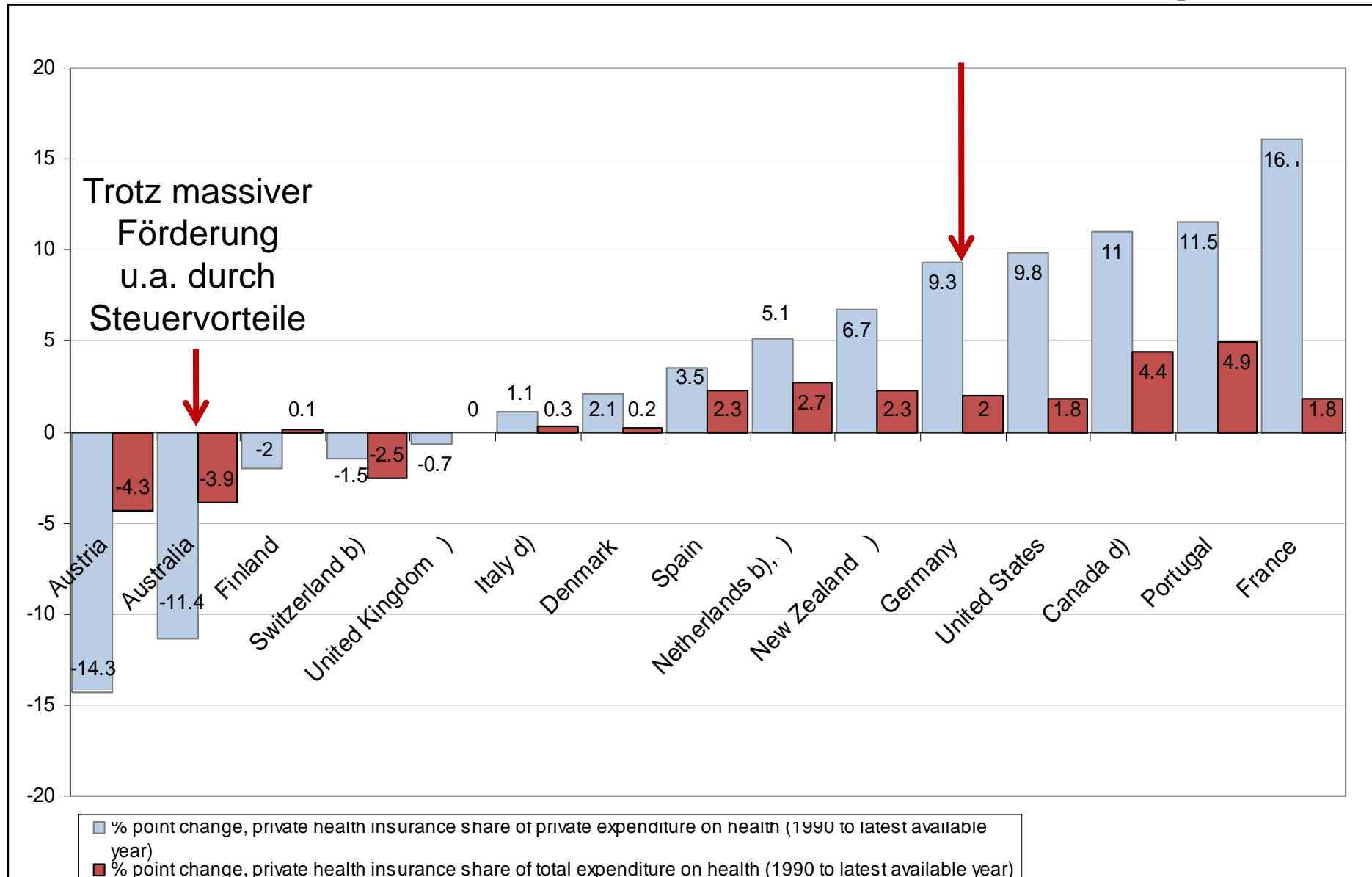
Die Verteilung von Leistungsausgaben auf Versicherte ist extrem konzentriert



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

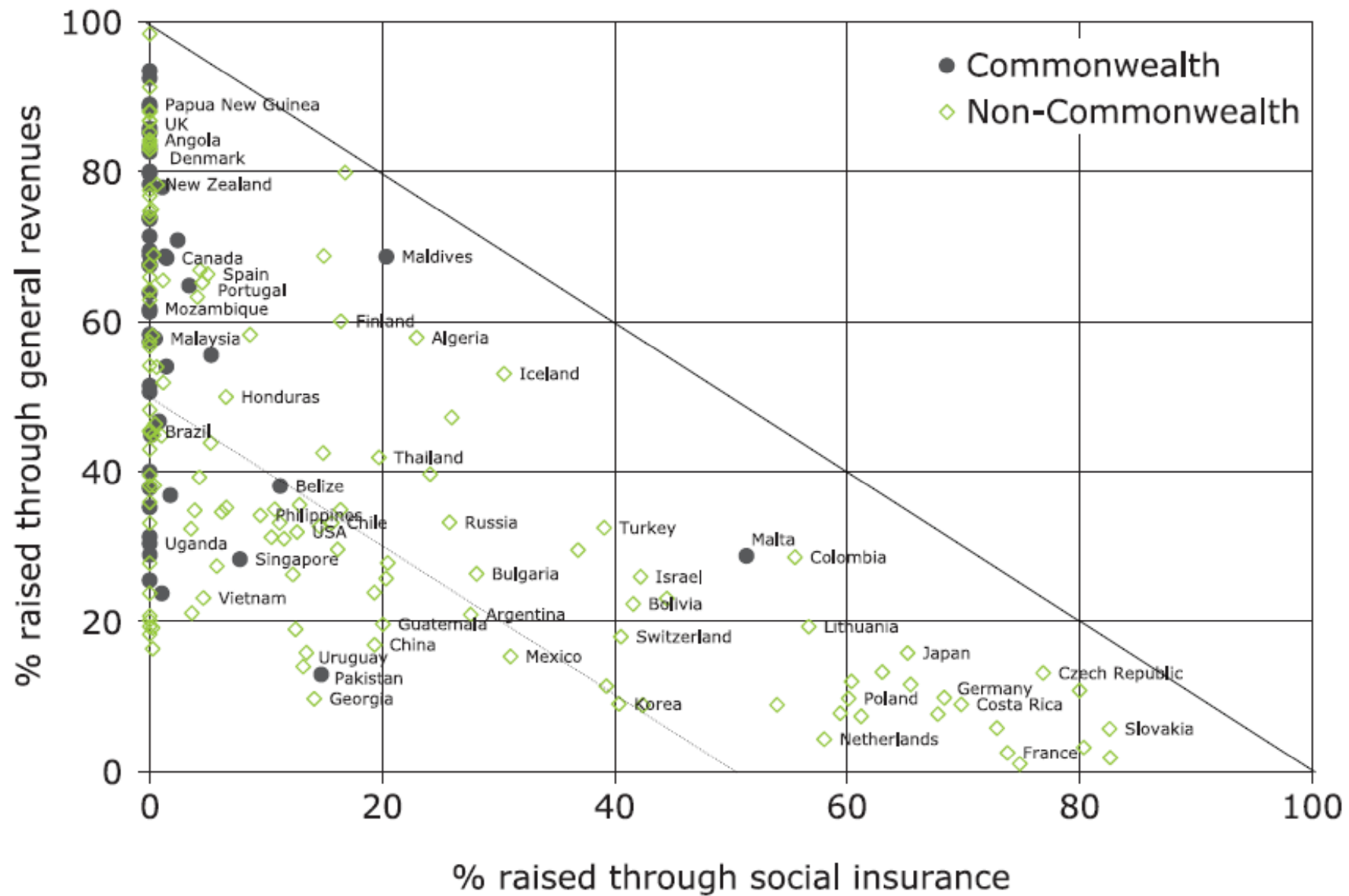


Figure 1. SHI vs taxes in health financing, 2003. *Source:* WHO World Health Report 2007

Revenues derived from taxes vs. revenues derived from social security contributions as % of total health expenditure (2006)

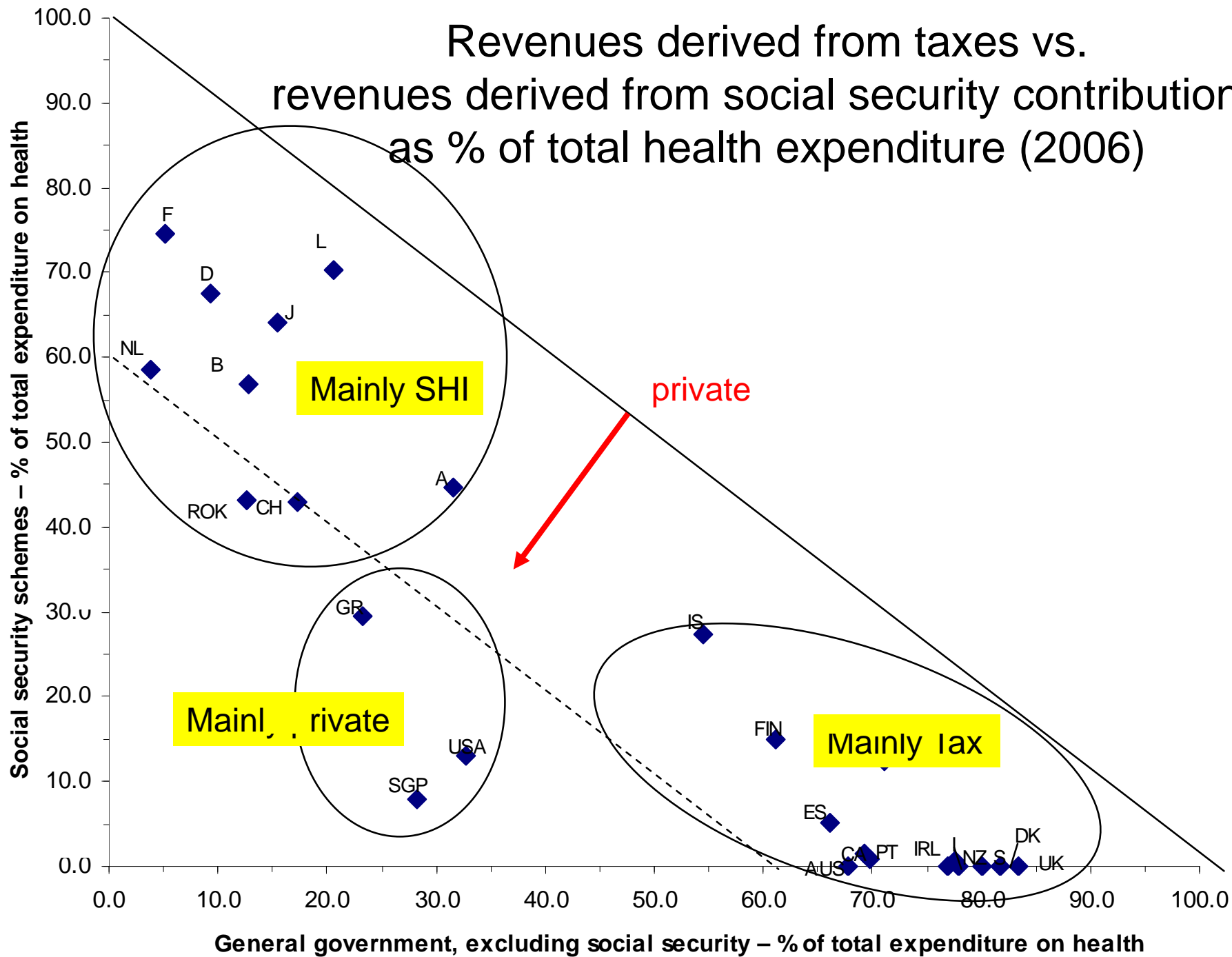
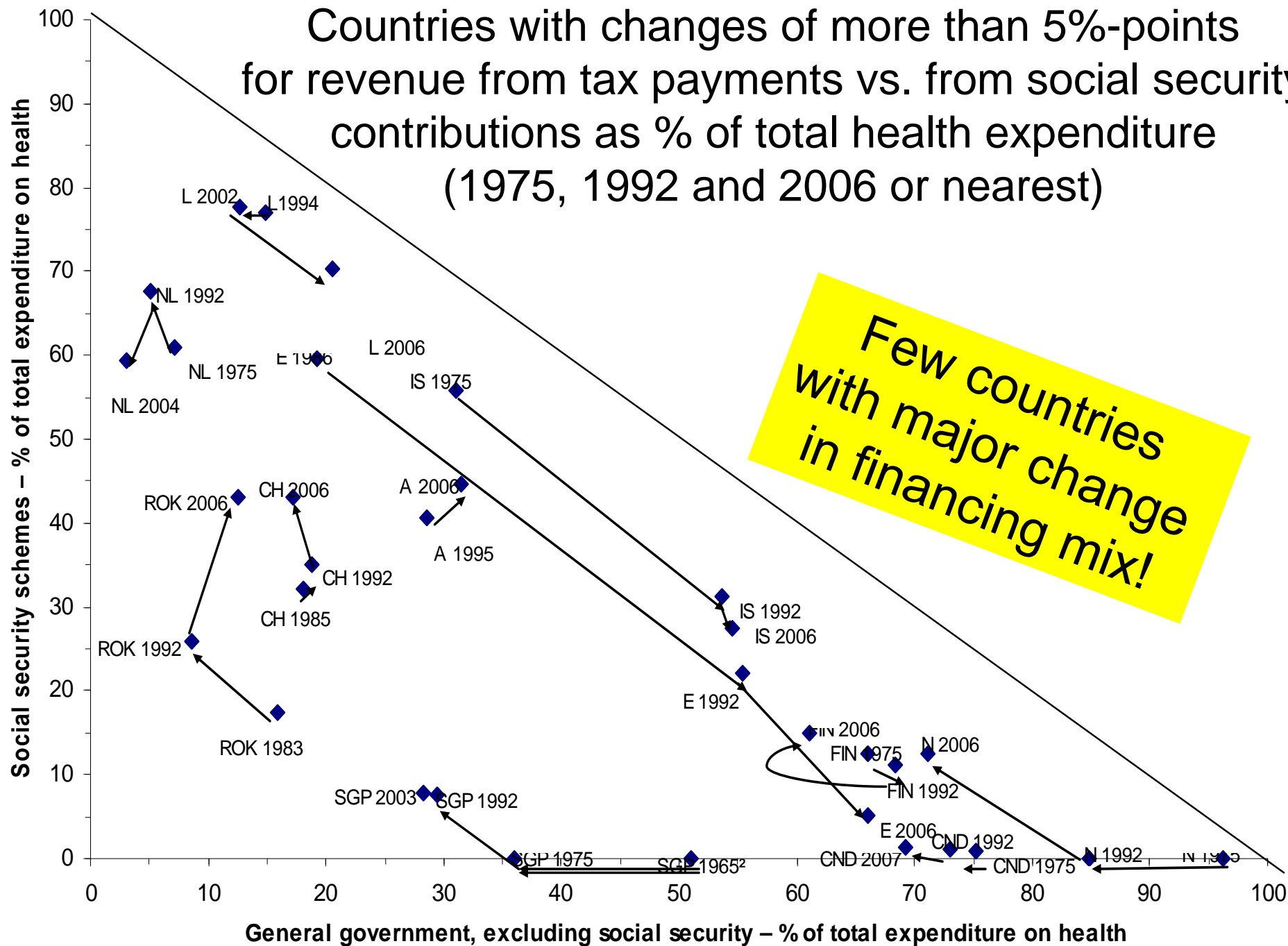


Figure 1: SHI systems in the OECD, 1960-2006



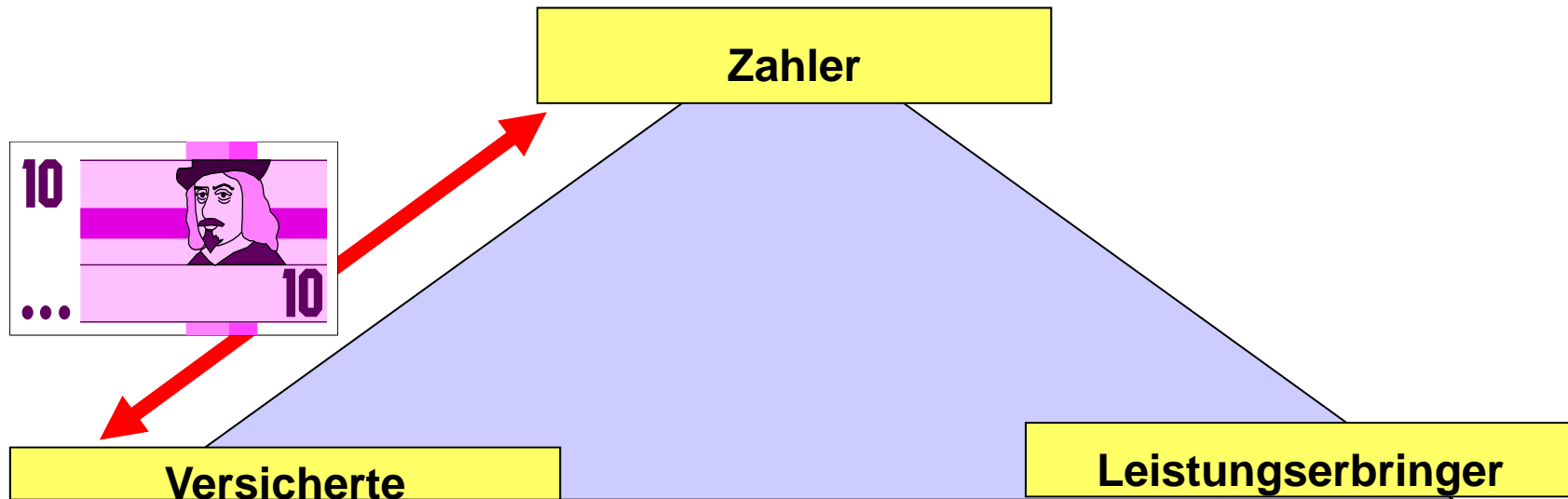
Sources: WHO Health in Transition series (HiTS) <http://www.euro.who.int/observatory/Hits/TopPage>, Saltman and Dubois (2004), Carrin and James (2005).

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)



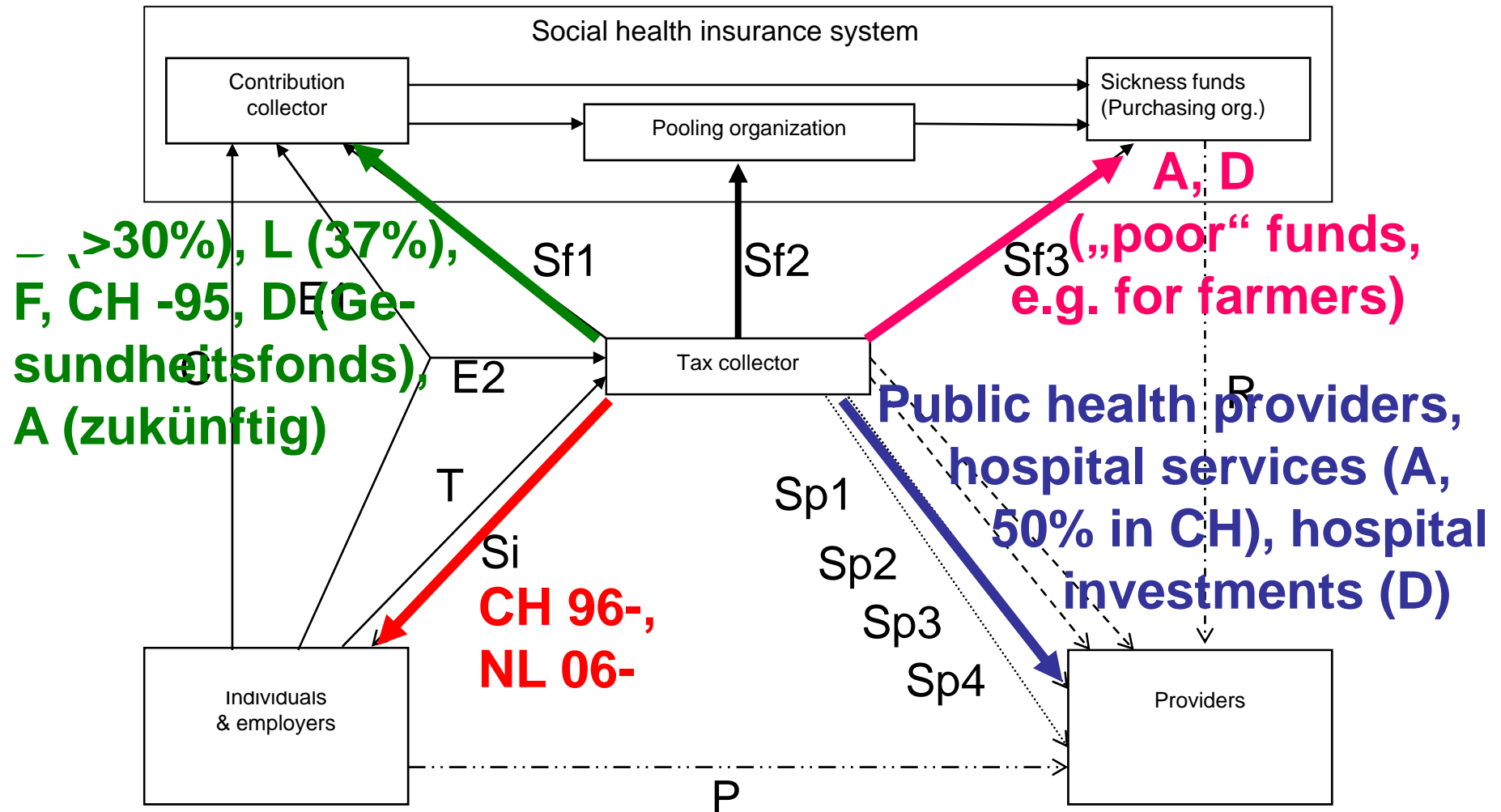
Few countries with major change in financing mix!

GEÄNDERTE FINANZIERUNG IN GKV-LÄNDERN

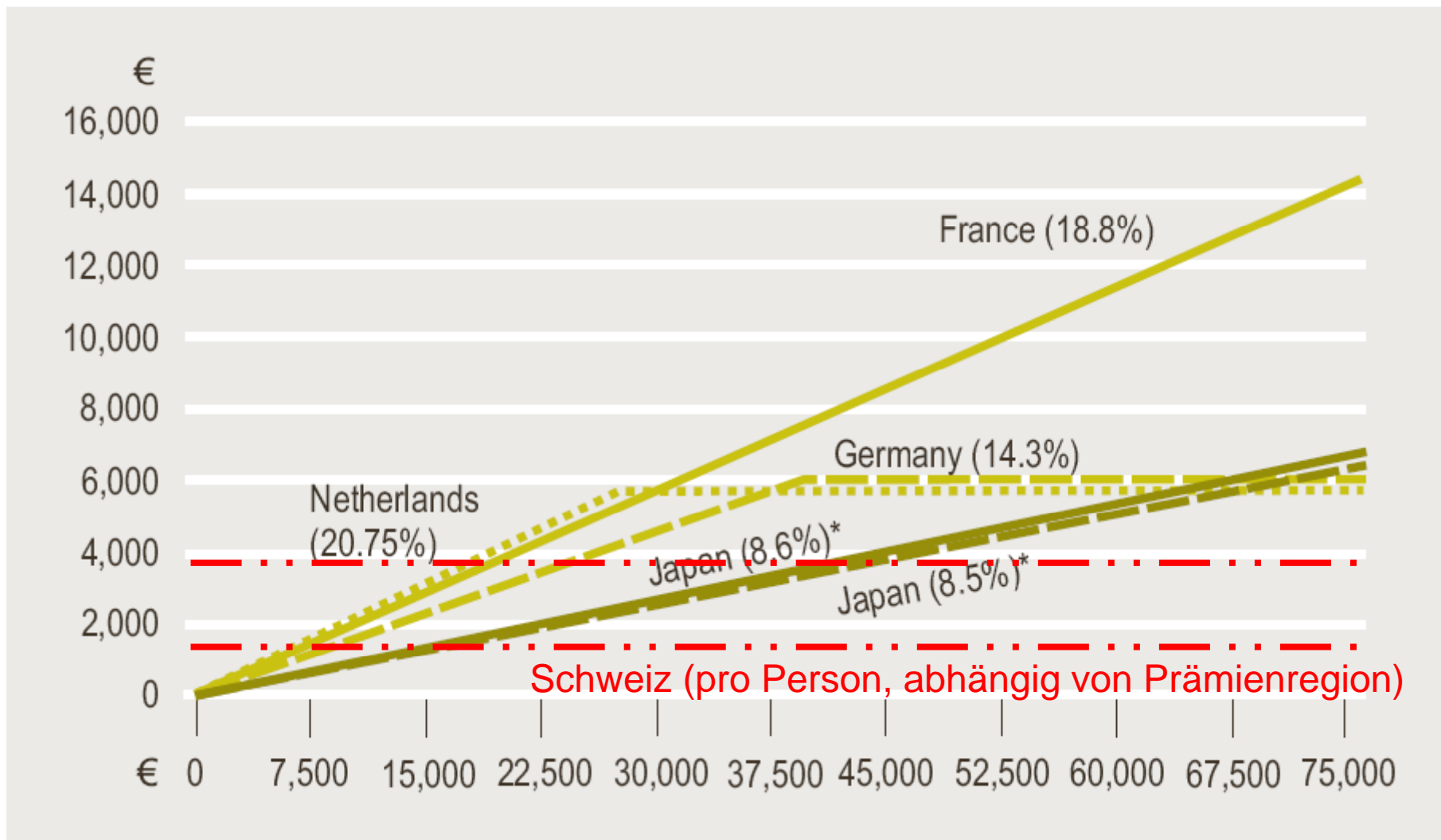


- Überwiegend lohnbezogene Beiträge (+ variabler Anteil Steuern) in Belgien, Deutschland, Frankreich, Luxemburg, Österreich
- Keine Beitragsmessungsgrenze in Belgien oder Frankreich
- Kopfpauschale/ Gesundheitsprämie in Schweiz
- Mischsystem (50% Beitrag, 45% Pauschale, 5% steuern) in den Niederlanden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

SHI countries: role of taxes increasing, but target varies

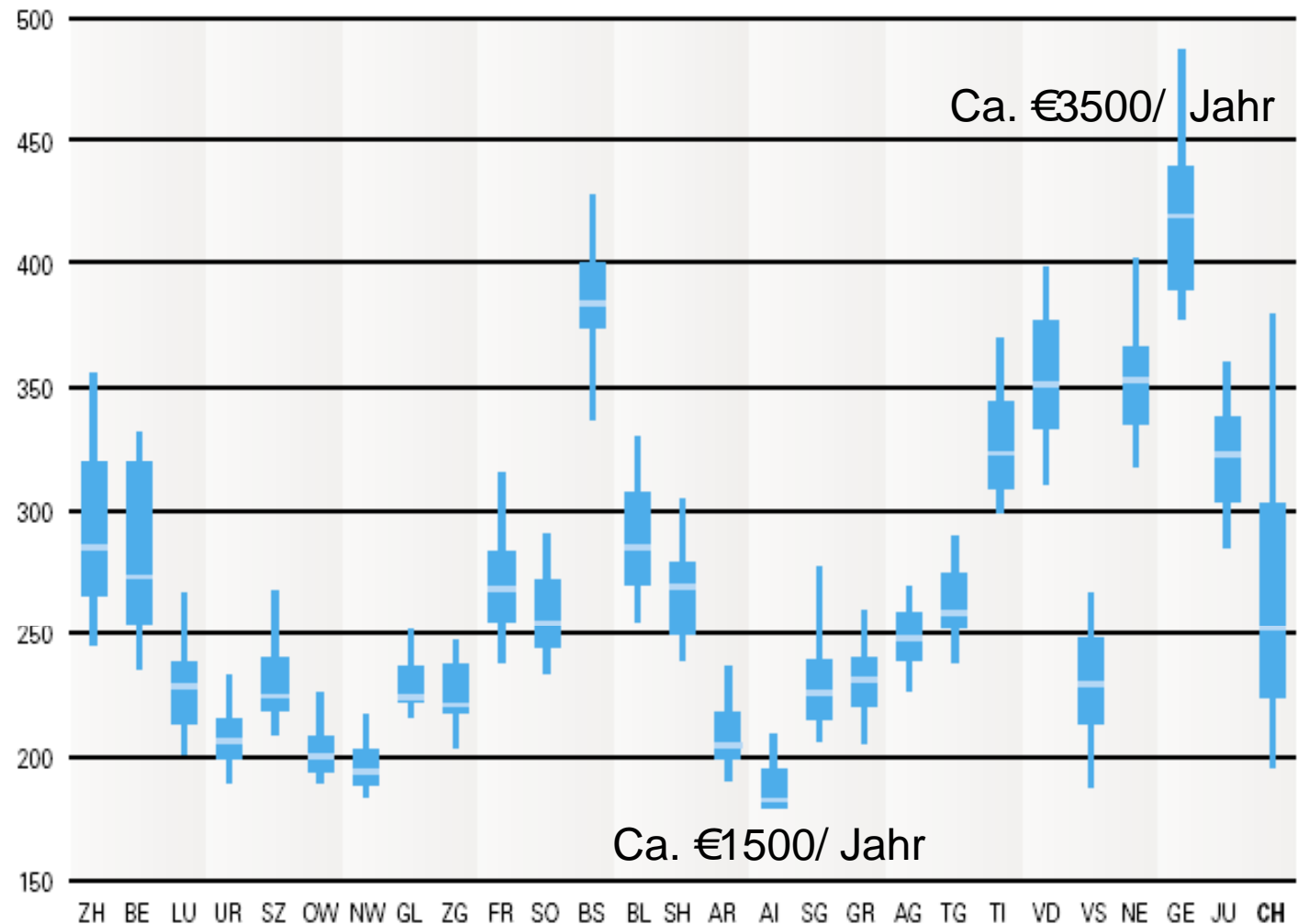


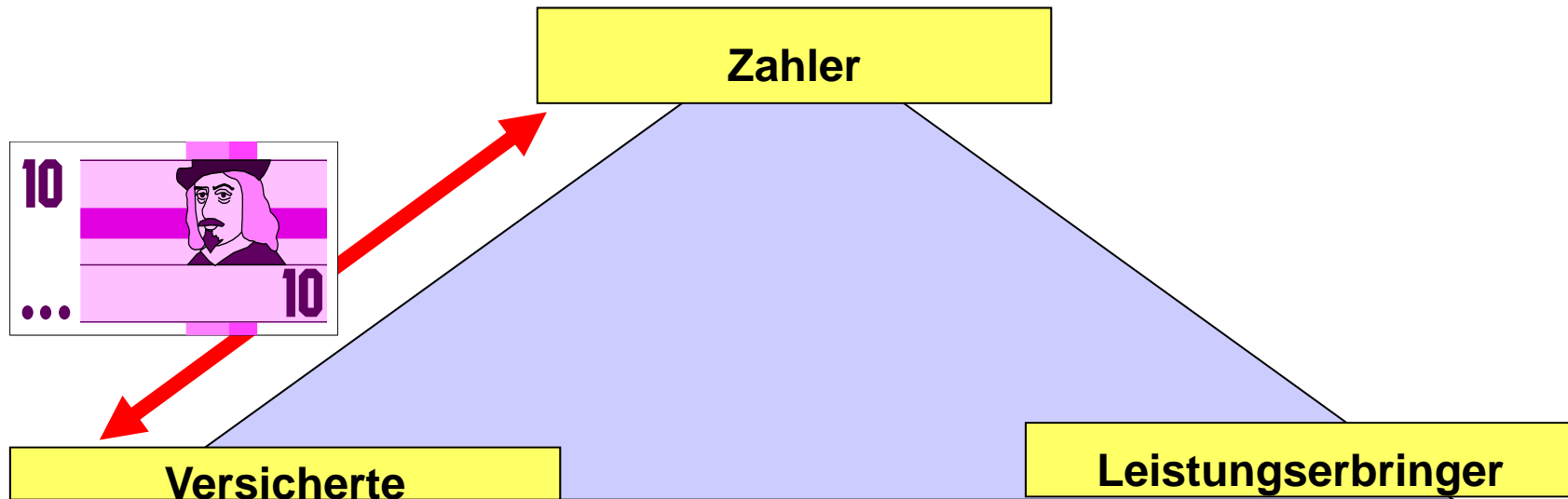
Krankenkassenbeiträge in Abhängigkeit vom Einkommen in verschiedenen GKV-Ländern



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

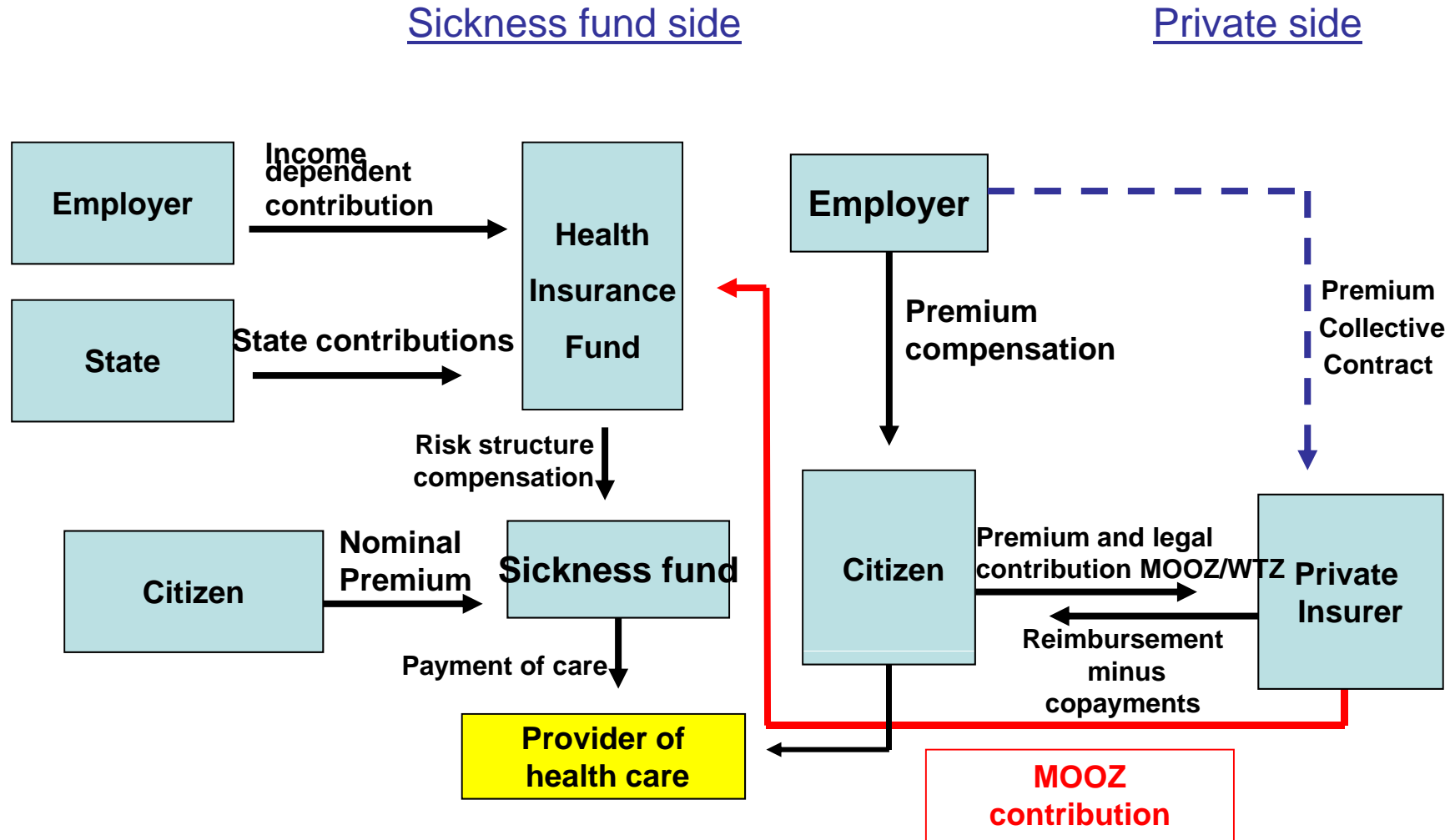
Grafik 3e: Verteilung der kantonalen monatlichen Durchschnittsprämien für Erwachsene (26 Jahre und mehr) in Franken für 2005 (mit ordentlicher Franchise und Unfalldeckung)





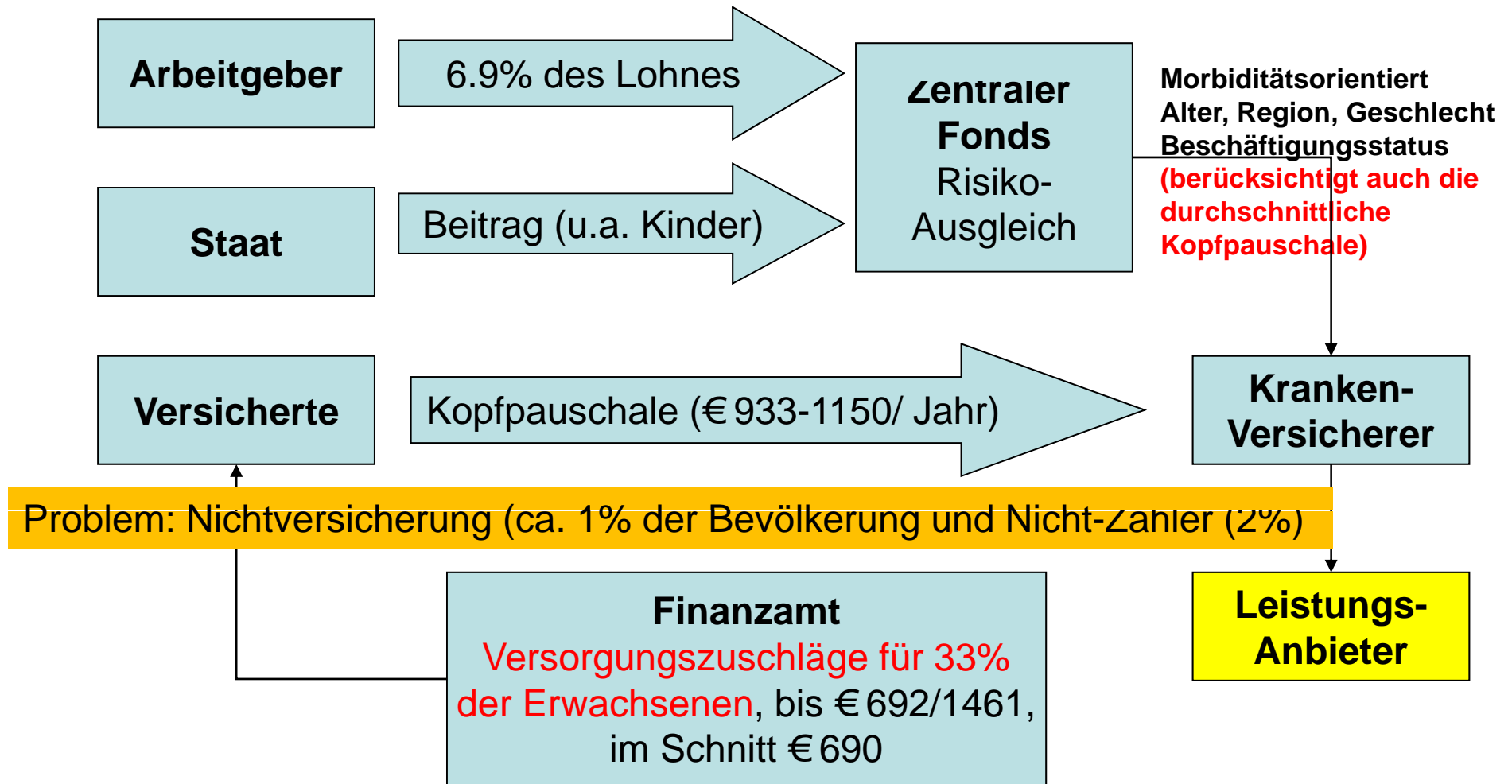
- Korea: Besitz wird bei der Veranlagung von Selbständigen berücksichtigt
- Niederlande: “MOOZ”-Abgabe von Privatversicherungen an GKV zwecks Risikoausgleich (bis 2005)

NL: Financial flows until 2005

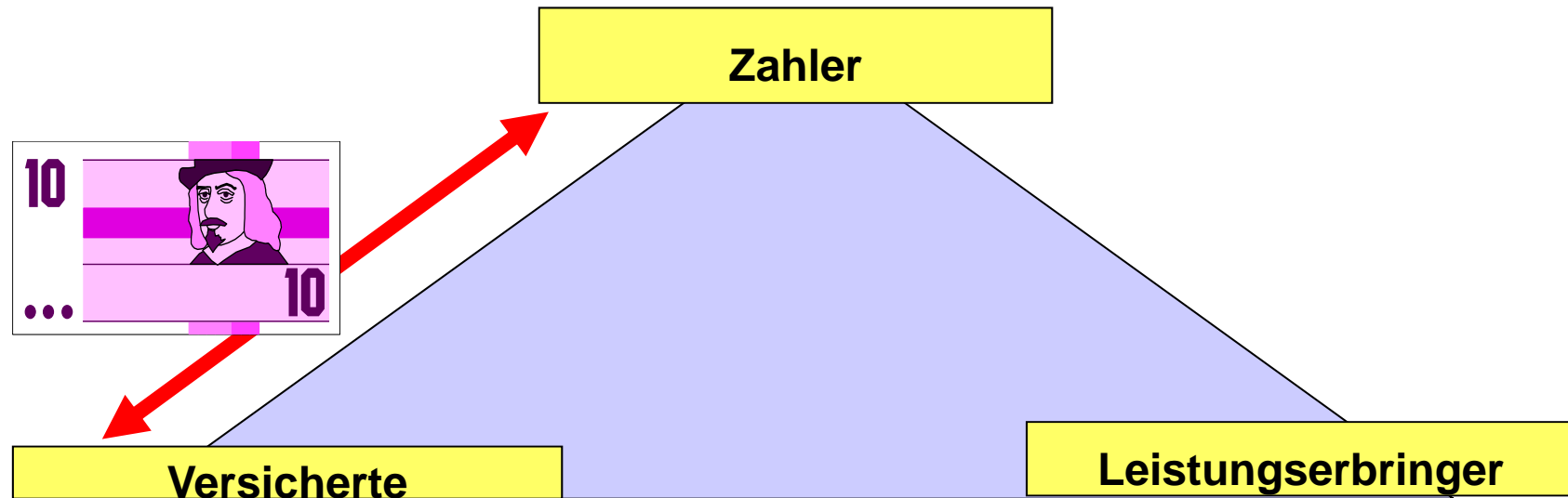


Source: Hamilton (2005)

Vereinfachte Darstellung des niederländischen Krankenversicherungssystems seit 2006



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

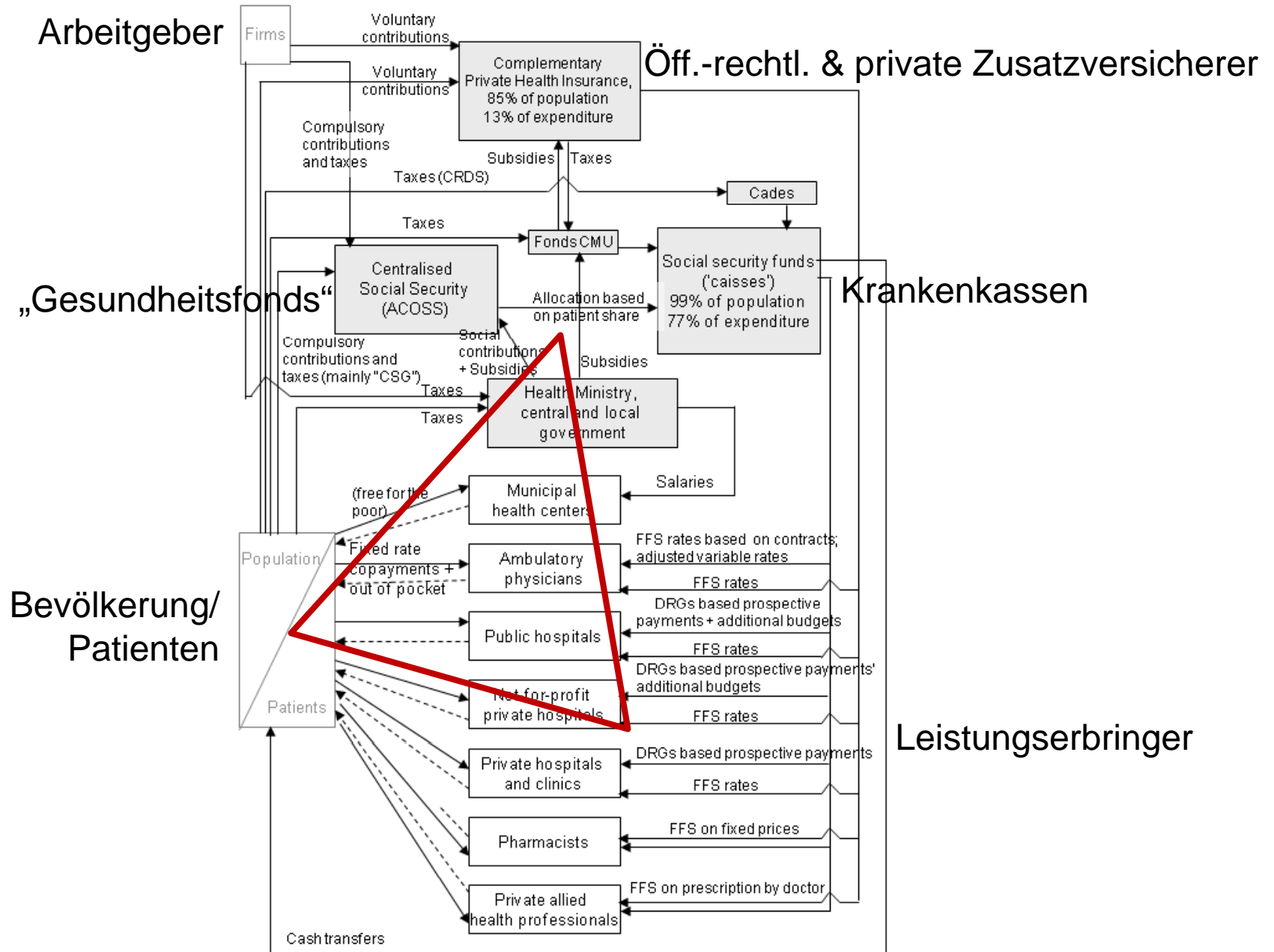


- Frankreich: 1998 Umstellung von Lohn-Beiträgen zu steuerähnlicheren Beiträgen (CSG) auf Löhne, Zinsen und Mieten
-> Verringerung von 6,8% auf 6,0% (5,25% CSG + 0,75% Beitrag)
- Zusätzliche Abgaben/Steuern auf Tabak, Alkohol, Kfz., Pharmawerbung, PKV-Prämien

Finanzierungsmix in Frankreich 1990 & 2000

	1990	2000
AG-Beiträge	63,1%	51,1%
AN-Beiträge	32,2%	3,1%
CSG	0%	34,6%
Spezifische Abgaben/ Steuern	1,6%	4,1%
Zuschuss aus all. Steuern (z.B. Kompensation AG-Beitragssenkung Niedri_verdiener,	0,5%	4,9%

France: Financing flows in the health care system, 2007
(excluding long-term care and prevention)



Source: OECD Secretariat 2001. Updated by Irdes in 2006, and Drees in 2007.
<http://www.ecosante.org/ocde.htm>



Präsentation, Literatur
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