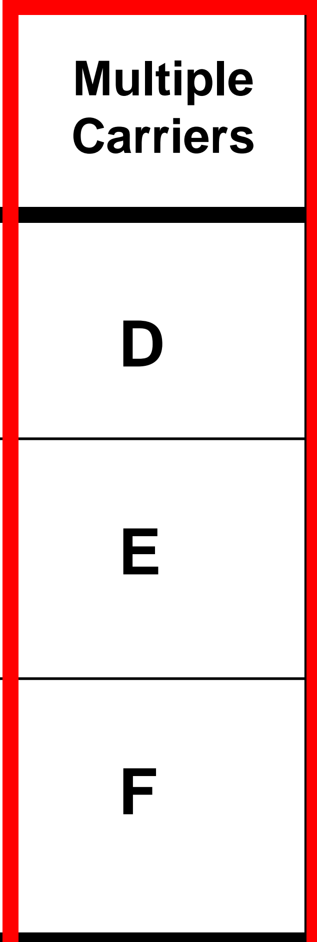
WWS 597 Reinhardt

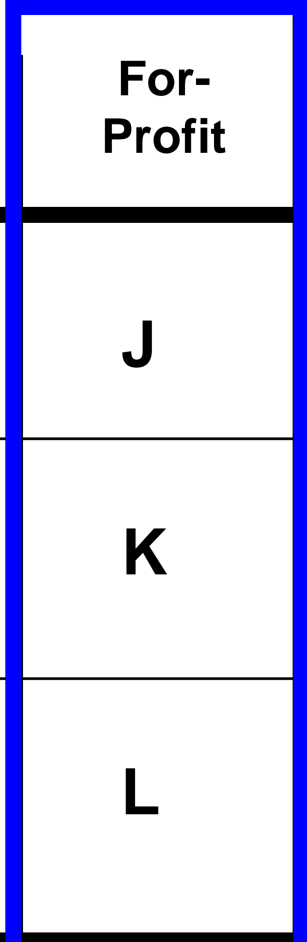
THE HEALTH CARE SYSTEMS OF GERMANY AND SWITZERLAND

Merely slouching towards “Regulated Competition”

SOCIAL INSURANCE WITH PRIVATE PURCHASING

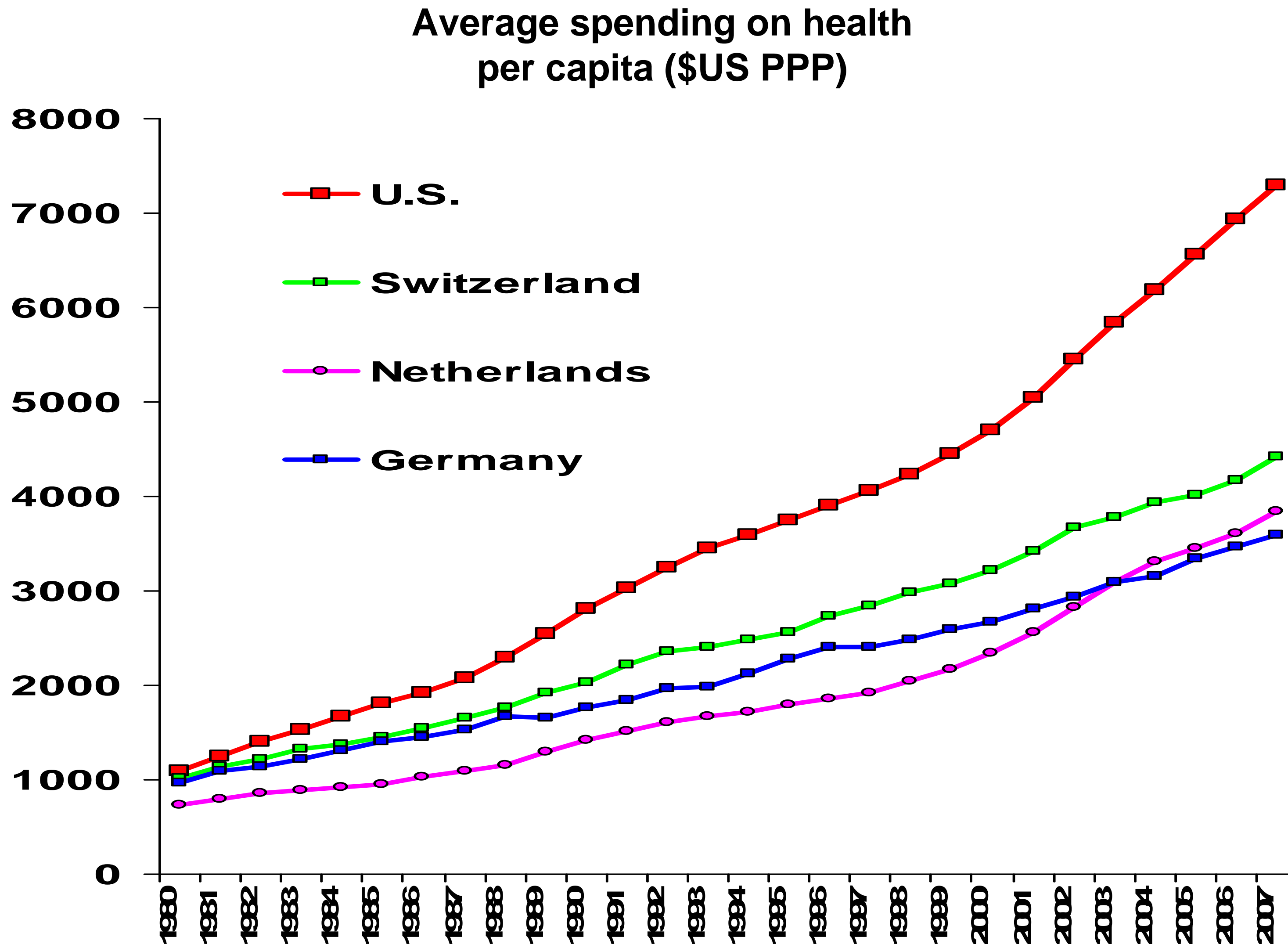
OWNERSHIP OF PROVIDERS	THE FINANCING OF HEALTH CARE				
	SOCIAL INSURANCE (Ability-to-Pay Financing)		PRIVATE INSURANCE (Actuarially fair premiums)		NO HEALTH INSURANCE
	Single Payer	Multiple Carriers	Non-Profit	For-Profit	Out-of-pocket
Government	A	D	G	J	M
Private, but non-profit	B	E	H	K	N
Private, and commercial	C	F	I	L	O





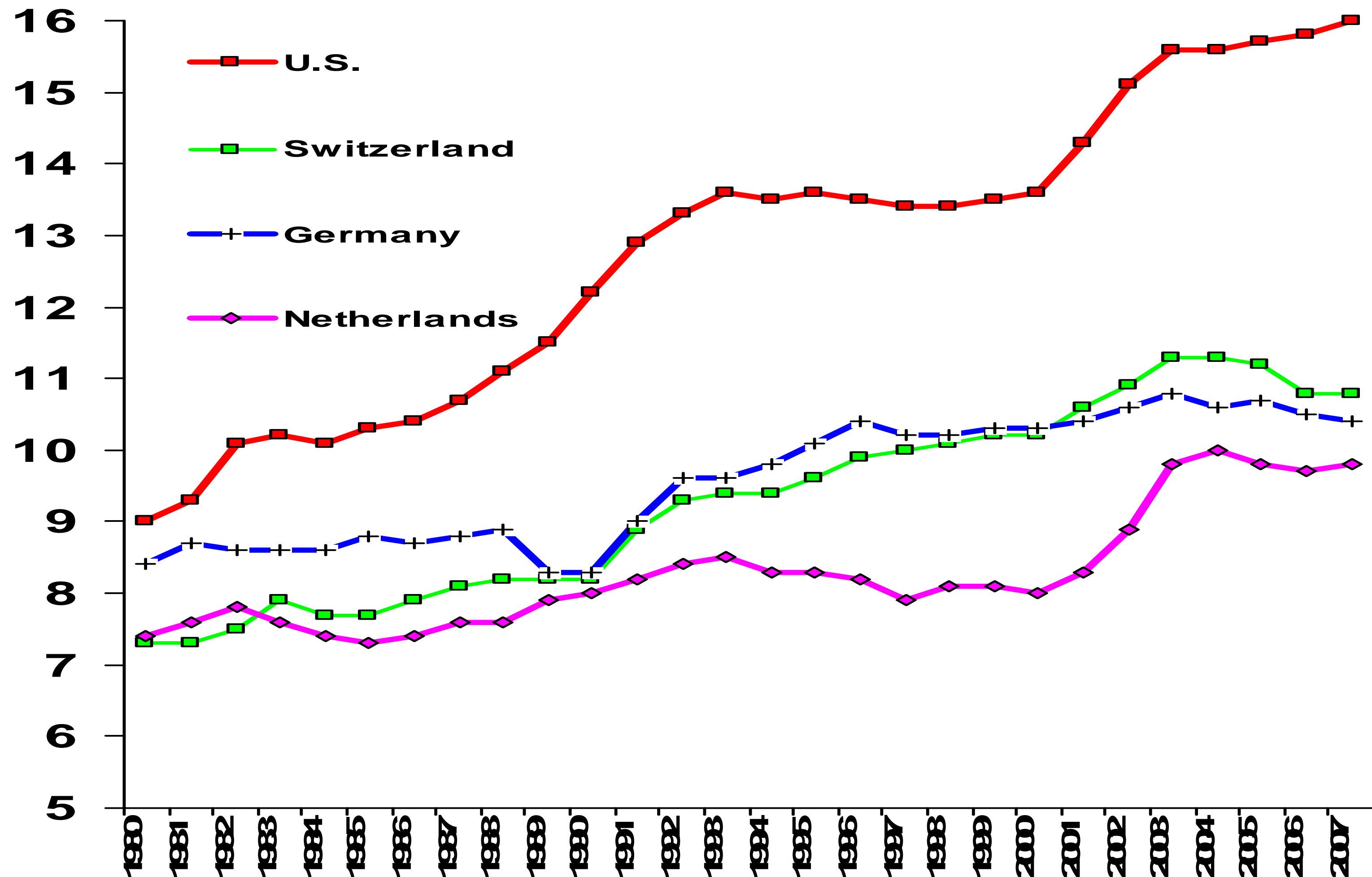
First, some comparative statistics

International Comparison of Spending on Health, 1980–2007



Source: OECD Health Data 2009 (June 2009) cited in http://www.commonwealthfund.org/Content/Publications/Chartbooks/2009/Multinational-Comparisons-of-Health-Systems-Data-2009.aspx

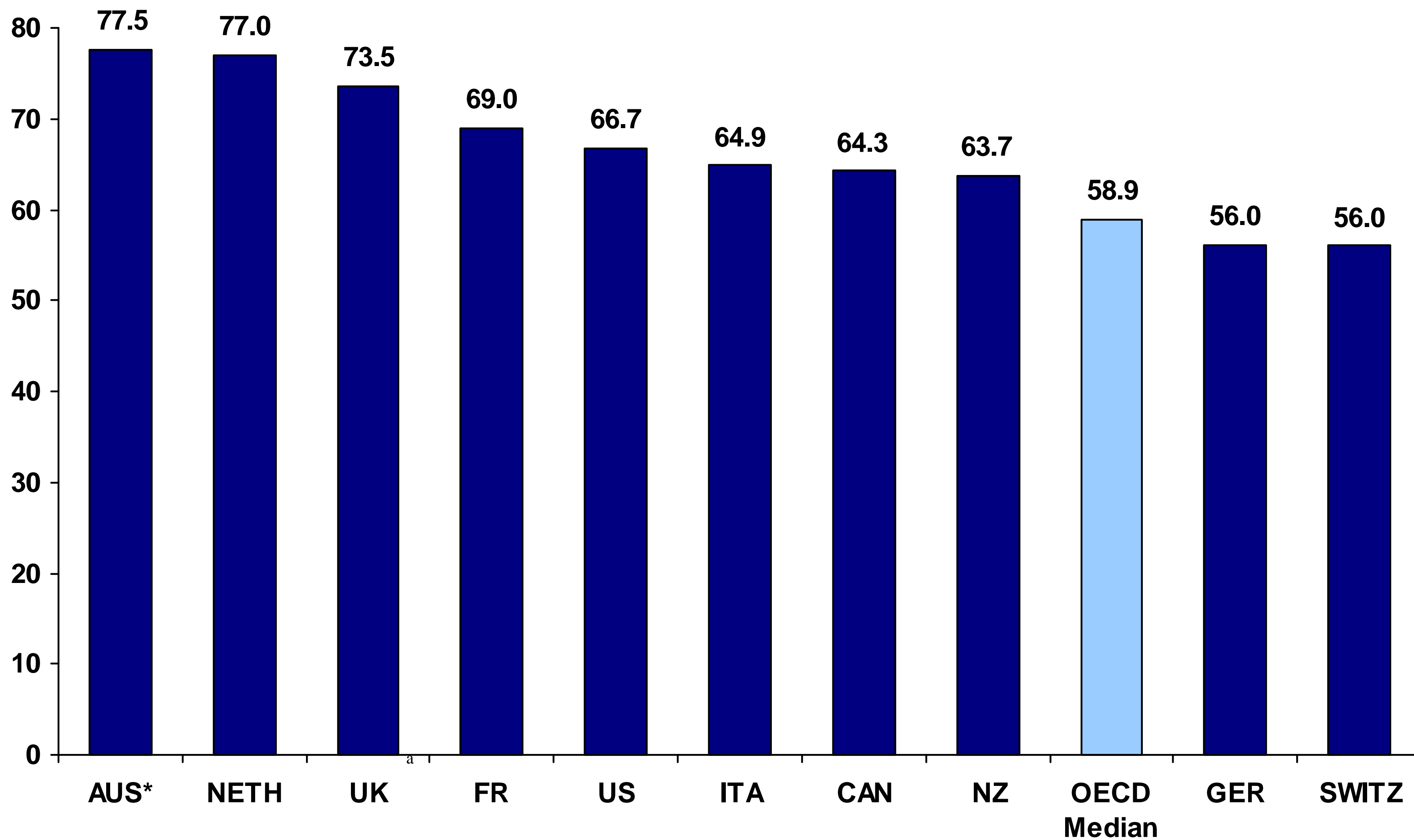
International Comparison of Spending on Health, 1980–2007



Source: OECD Health Data 2009 (June 2009) cited in http://www.commonwealthfund.org/Content/Publications/Chartbooks/2009/Multinational-Comparisons-of-Health-Systems-Data-2009.aspx

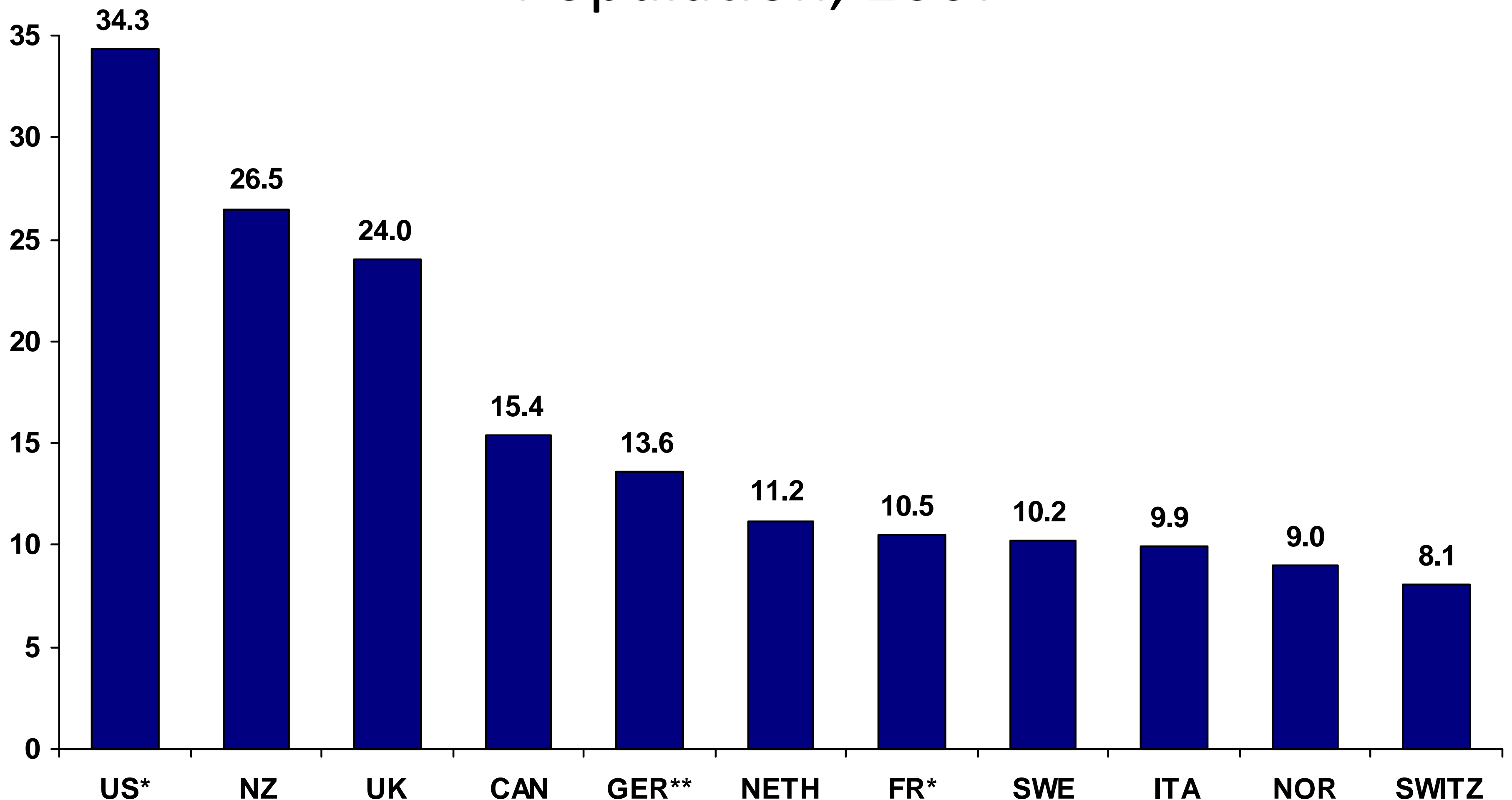
Percentage of Population over Age 65 with Influenza Immunization, 2007

Percent



* 2006
Source: OECD Health Data 2009 (June 2009).

Obesity (BMI>30) Prevalence Among Adult Population, 2007



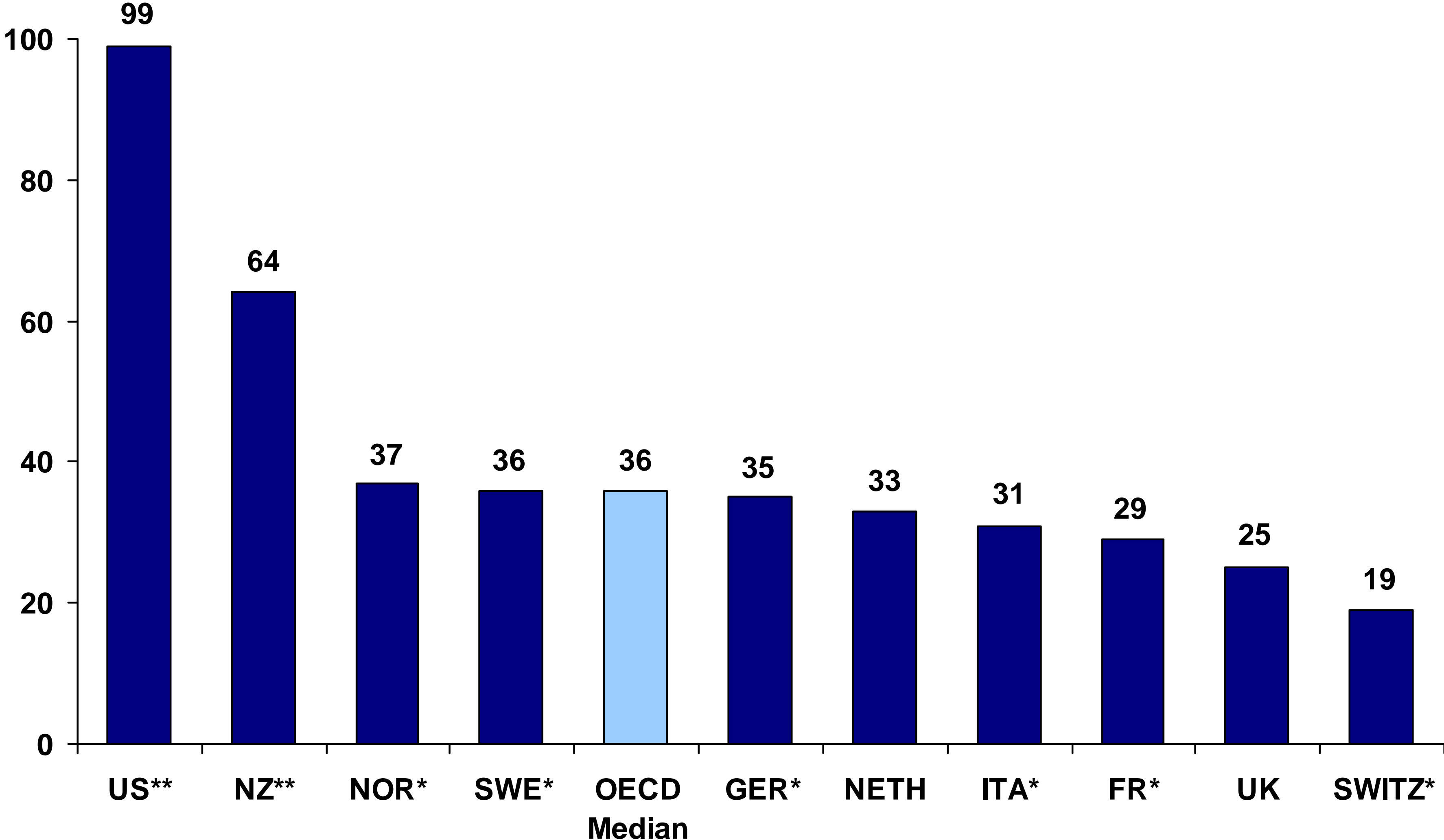
* 2006

** 2005

Note: BMI = body mass index. For most countries, BMI estimates are based on national health interview surveys (self-reported data). However, the estimates for the US, UK, and New Zealand are based on actual measurements of weight and height, and estimates based on actual measurements are usually significantly higher than those based on self-report.

Source: OECD Health Data 2009 (June 2009).

Potential Years of Life Lost Because of Diabetes per 100,000 Population, 2007

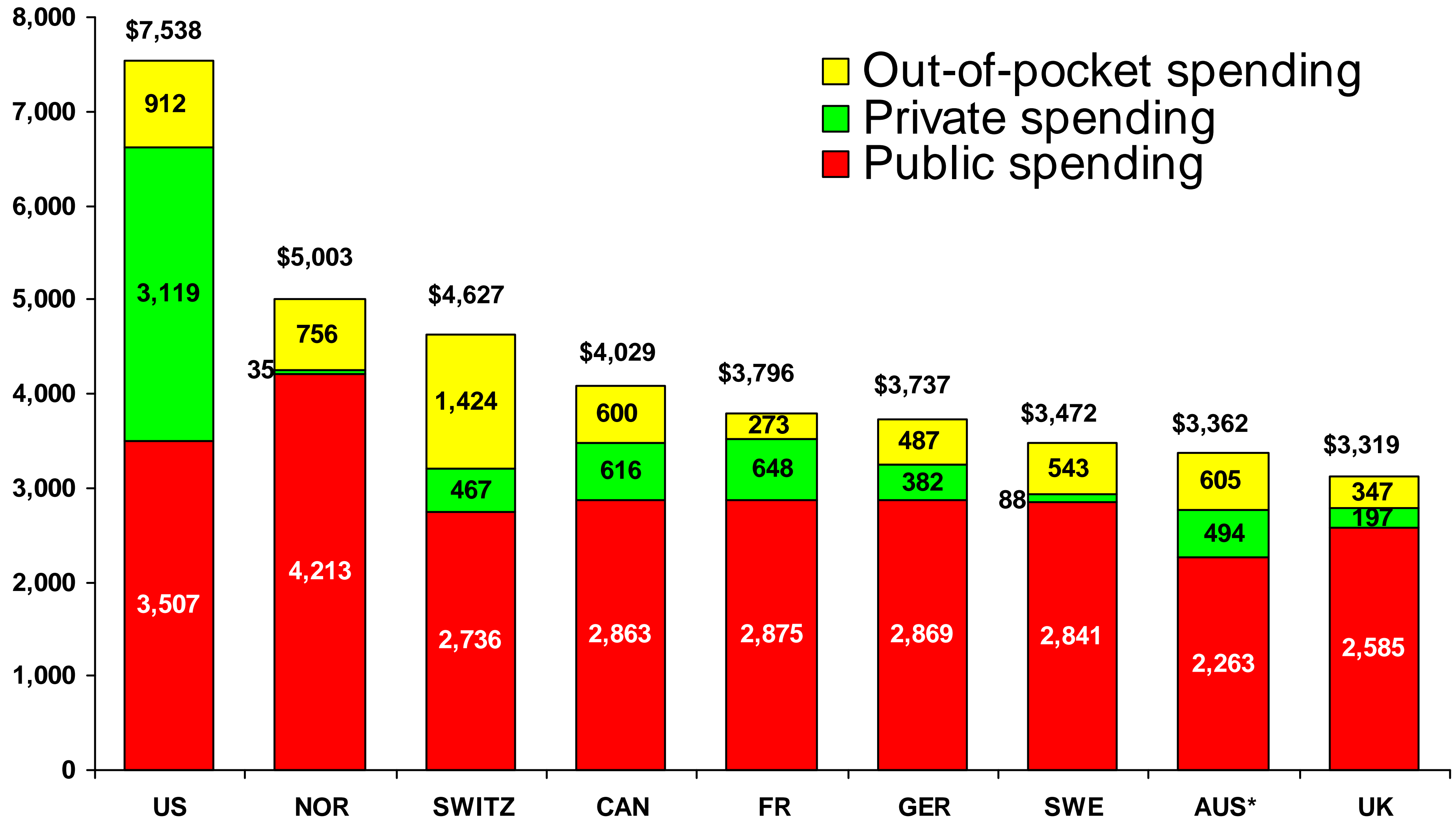


* 2006
** 2005
Source: OECD Health Data 2009 (June 2009).

Health Care Expenditure per Capita by Source of Funding, 2008

In Purchasing-Power Parity Dollars (PPP $s)

Dollars

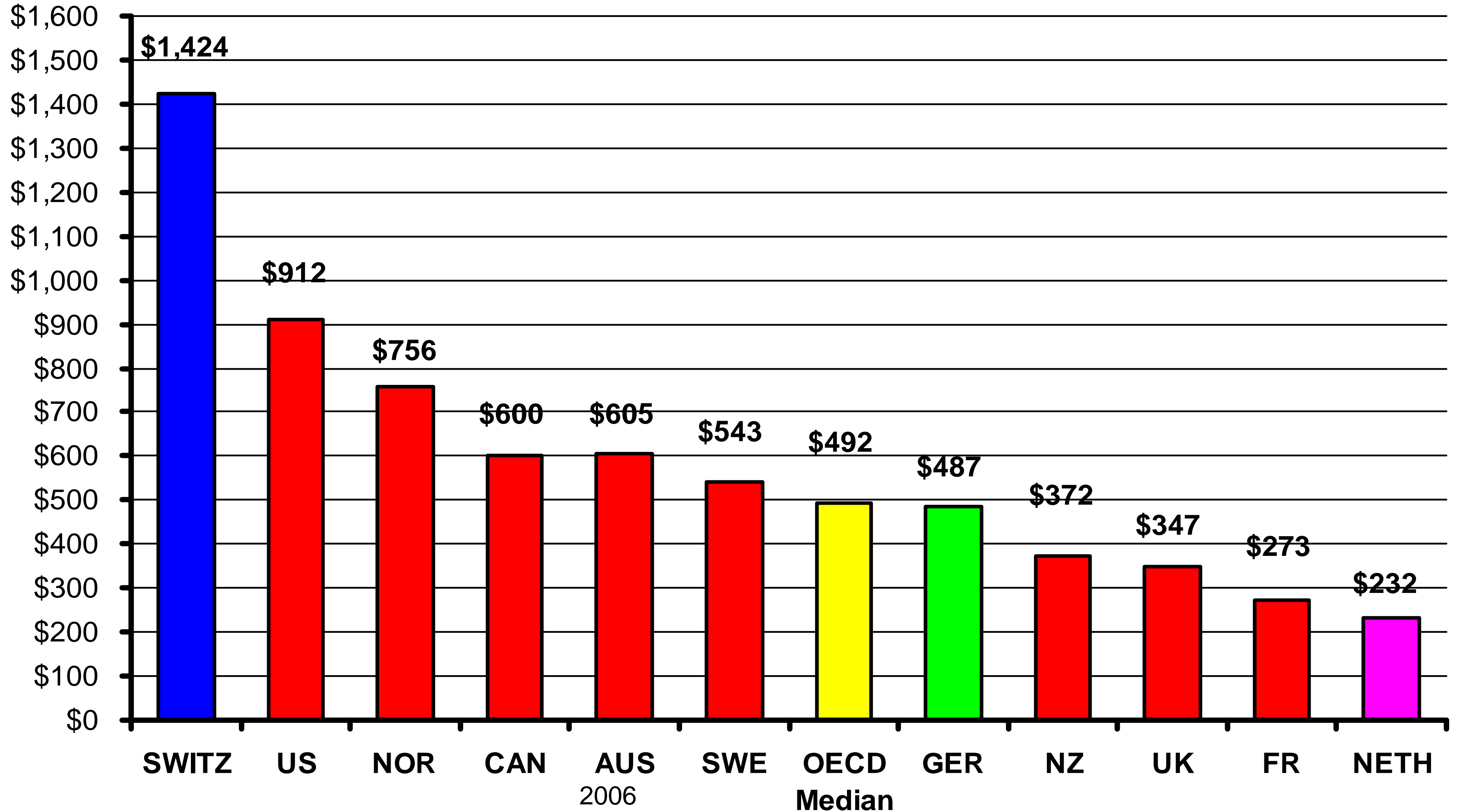


* 2007

SOURCE: OECD DATA BASE 2010, cited in Anderson and Markovich, “Multinational Comparisons of Health Systems Data, 2010, Commonwealth Fund International Symposium, 2010.

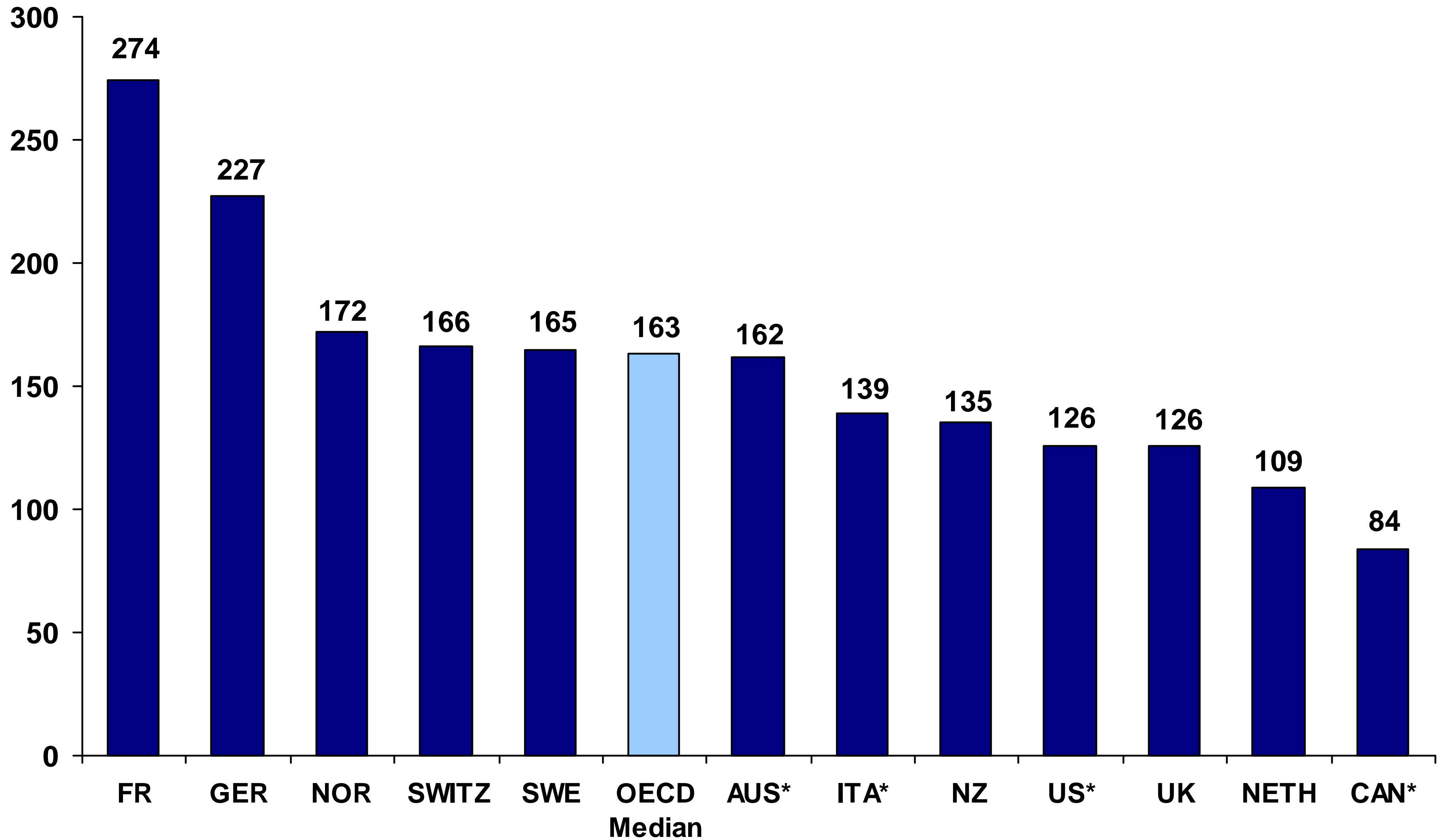
Out-of-Pocket Health Care Spending per Capita, 2008

In Purchasing-Power Parity Dollars (PPP $s)



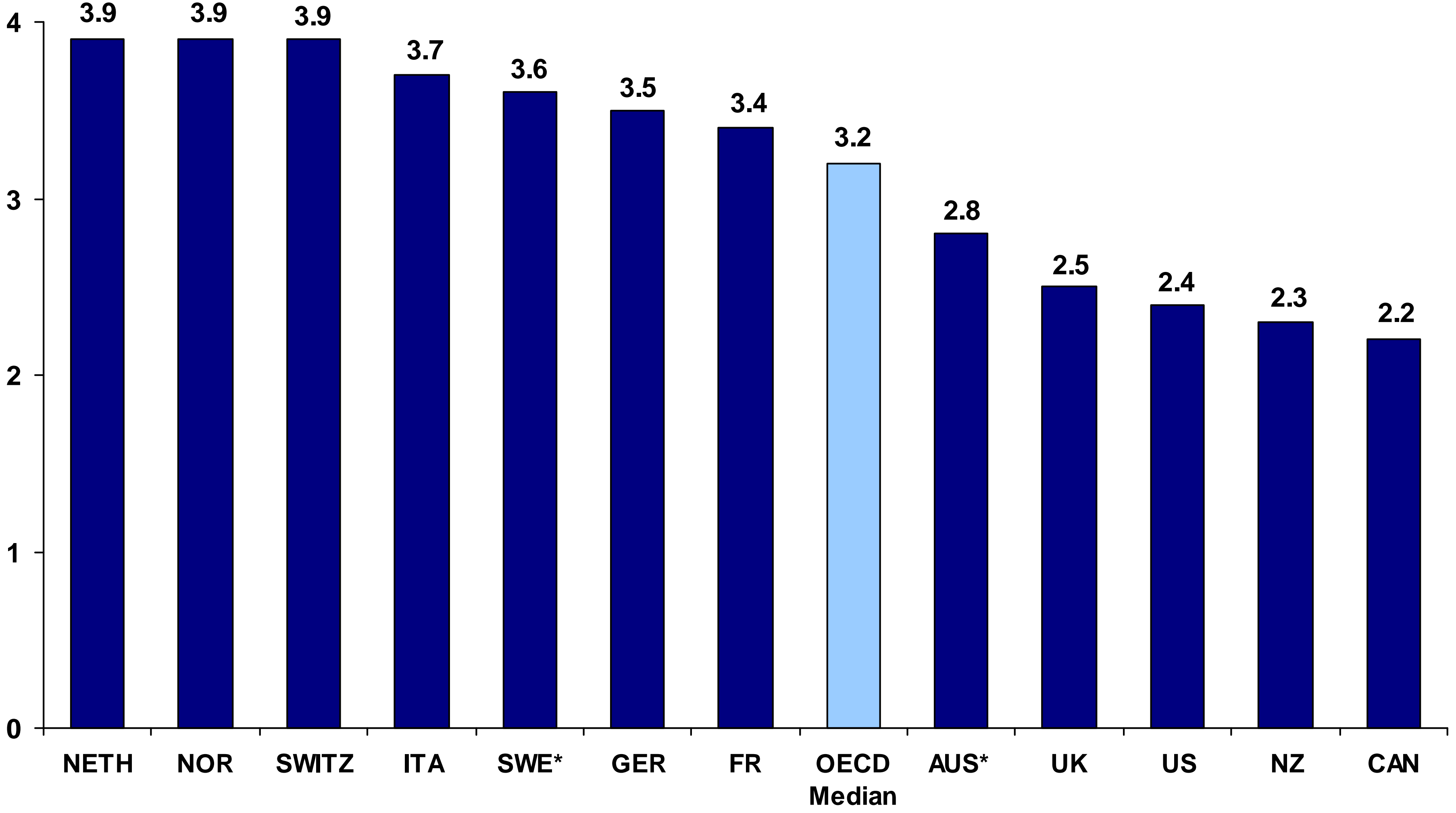
SOURCE: OECD DATA BASE 2010, cited in Anderson and Markovich, "Multinational Comparisons of Health Systems Data, 2010, Commonwealth Fund International Symposium, 2010.

Hospital Discharges per 1,000 Population, 2007



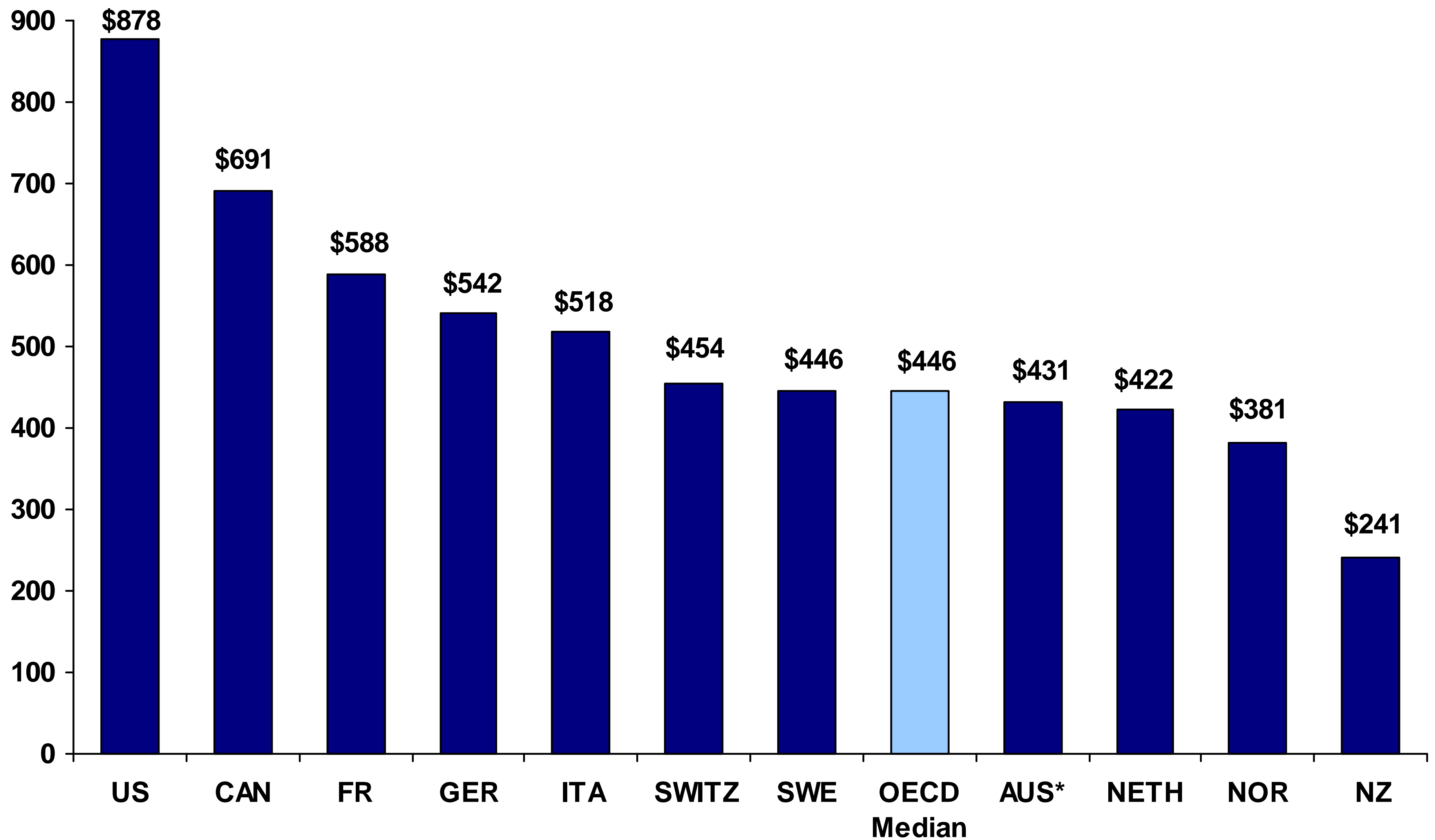
* 2006
Source: OECD Health Data 2009 (June 2009).

Number of Practicing Physicians per 1,000 Population, 2007



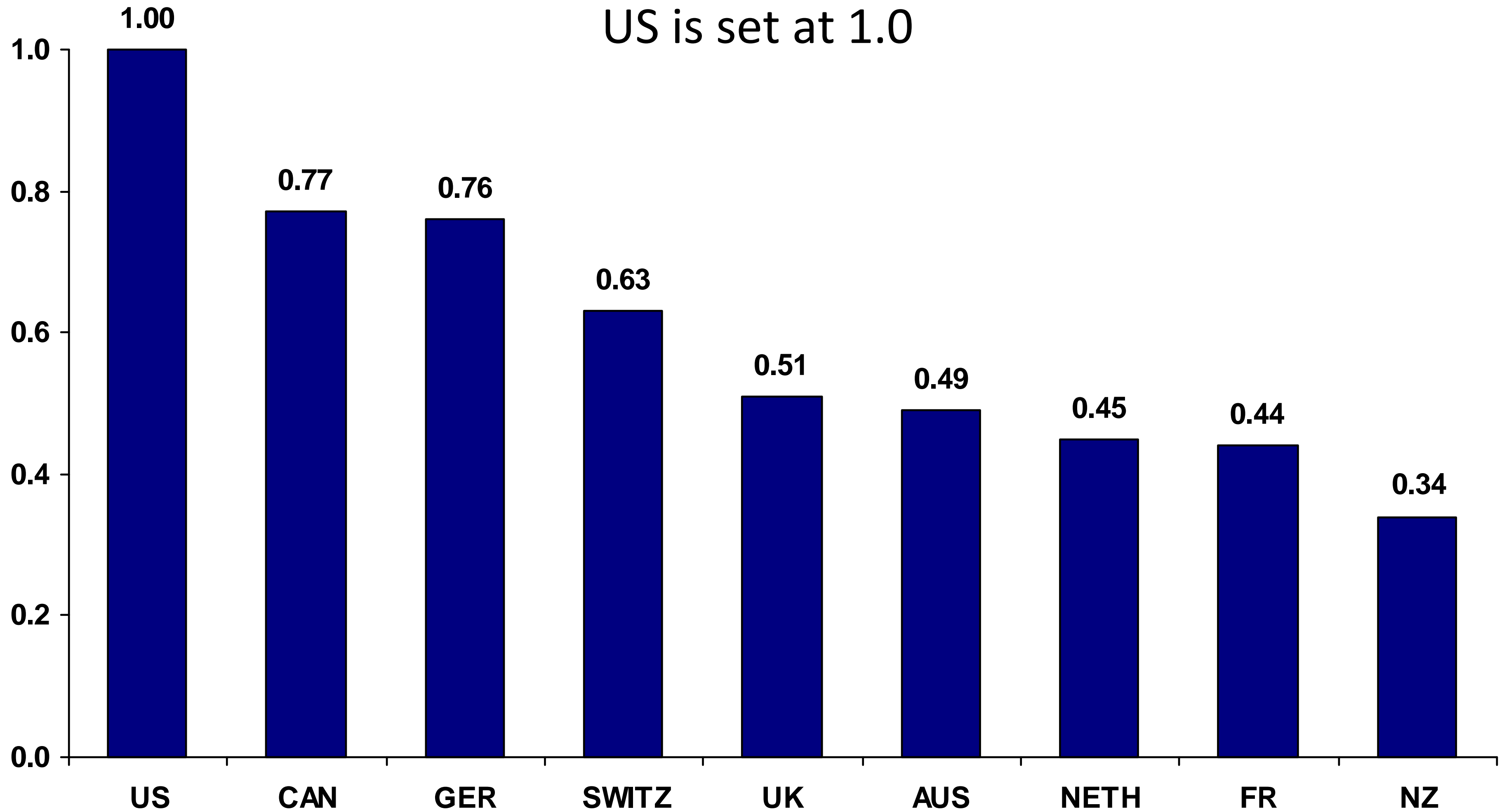
* 2006
Source: OECD Health Data 2009 (June 2009).

Pharmaceutical Spending per Capita, 2007



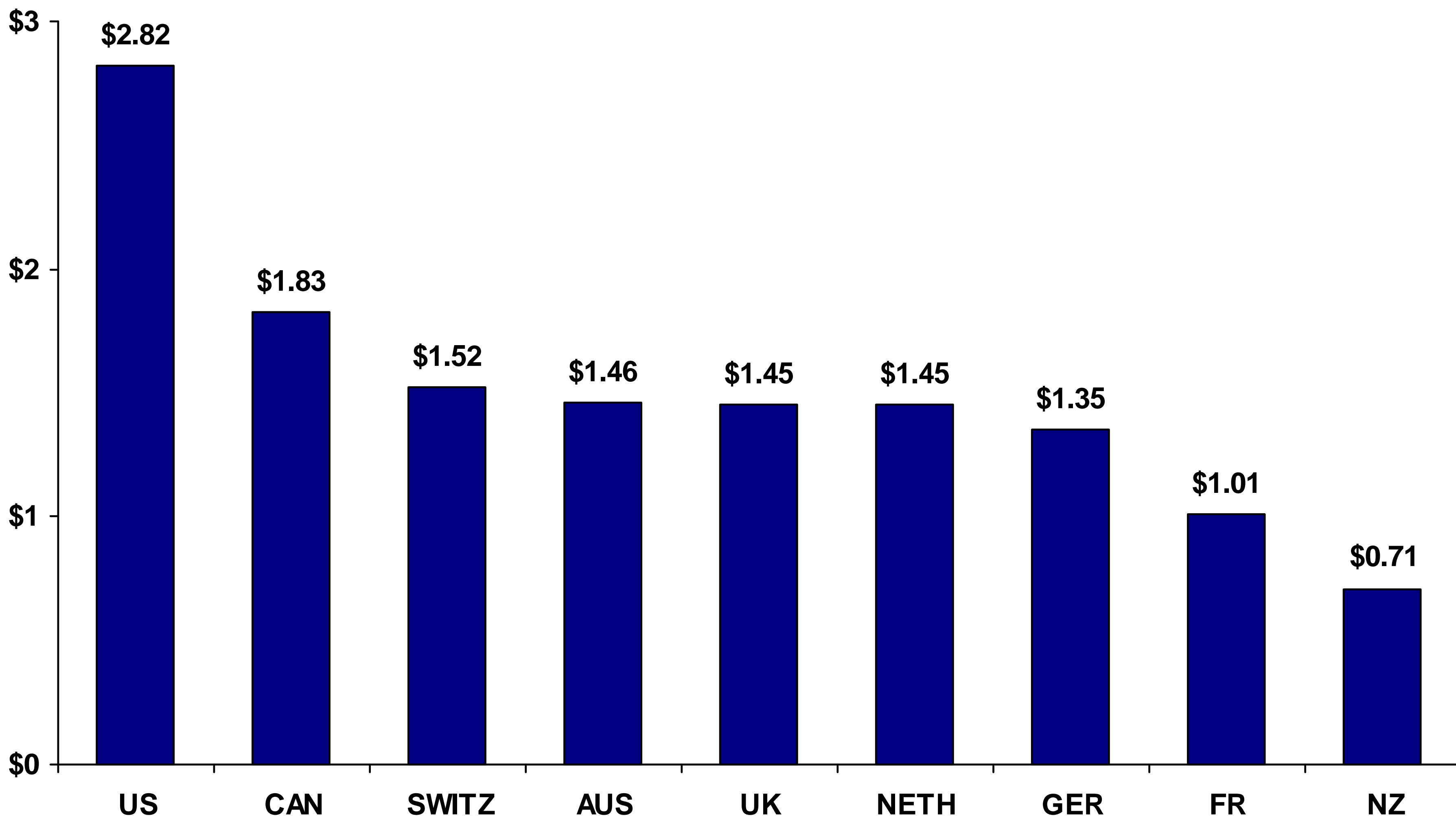
* 2006
Source: OECD Health Data 2009 (June 2009).

Drug Prices for 30 Most Commonly Prescribed Drugs, 2006–07



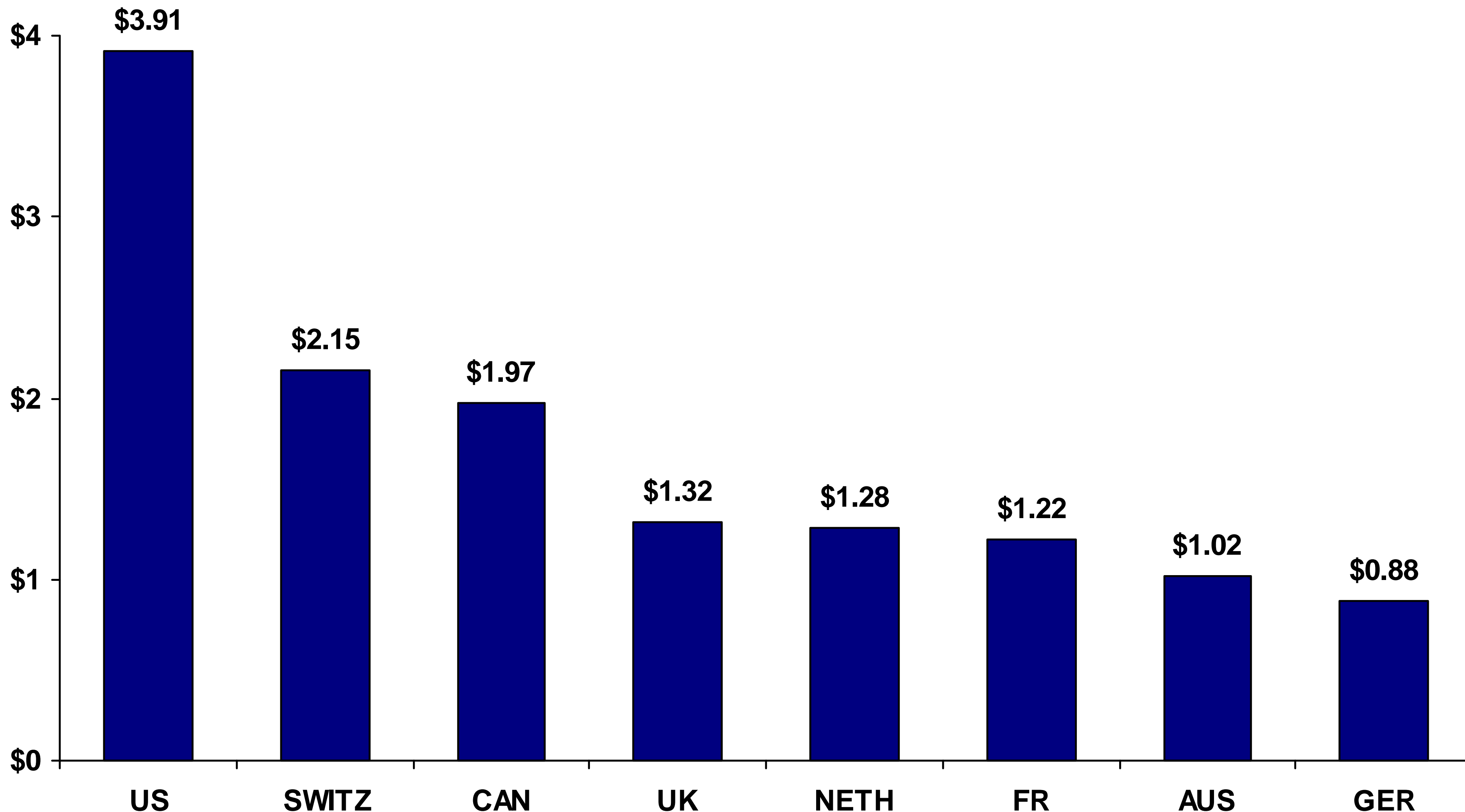
Source: IMS Health.

Drug Prices: Lipitor (atorvastatin), 2006–07



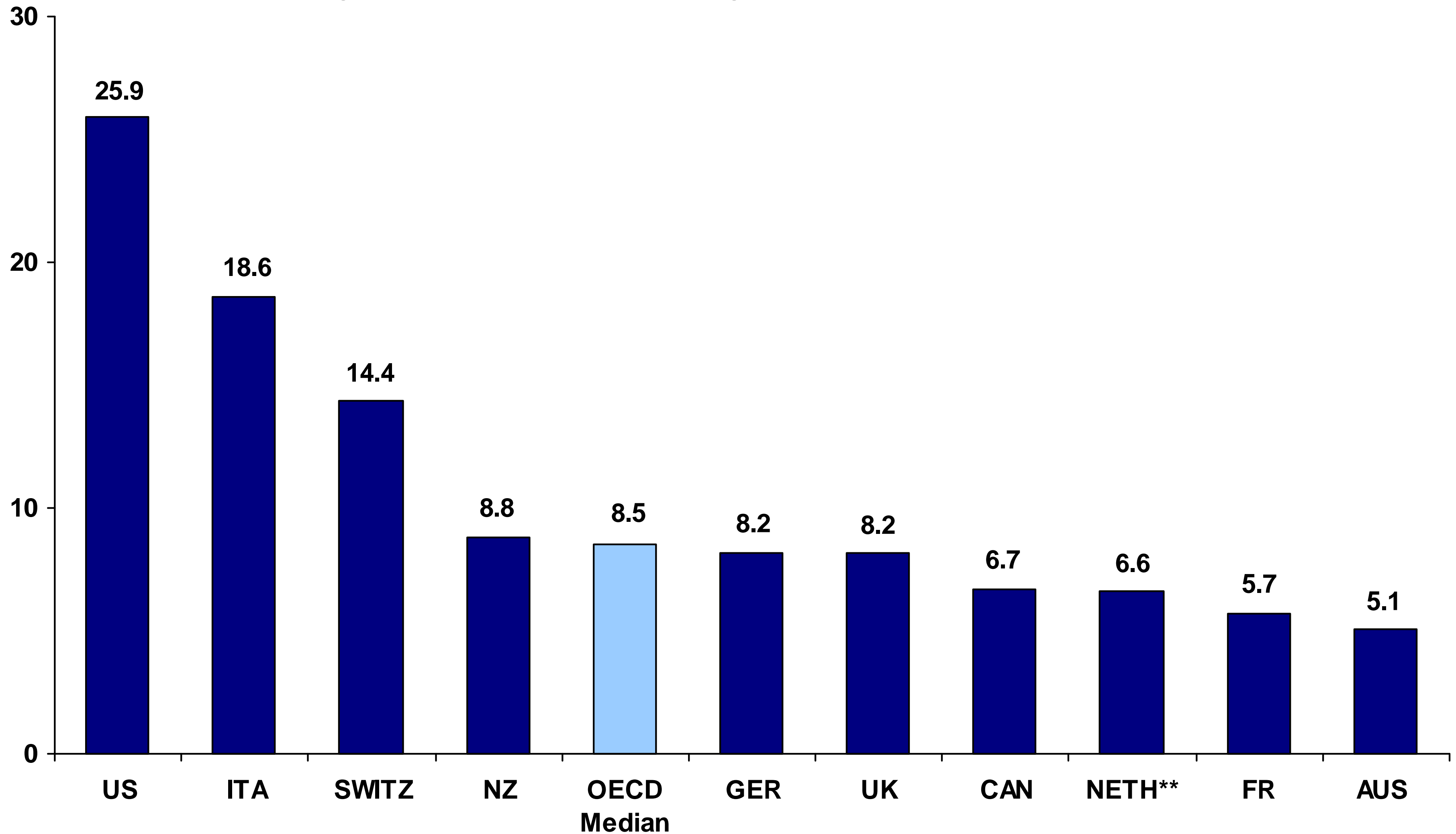
Source: IMS Health.

Drug Prices: Nexium (esomeprazole), 2006–07



Source: IMS Health.

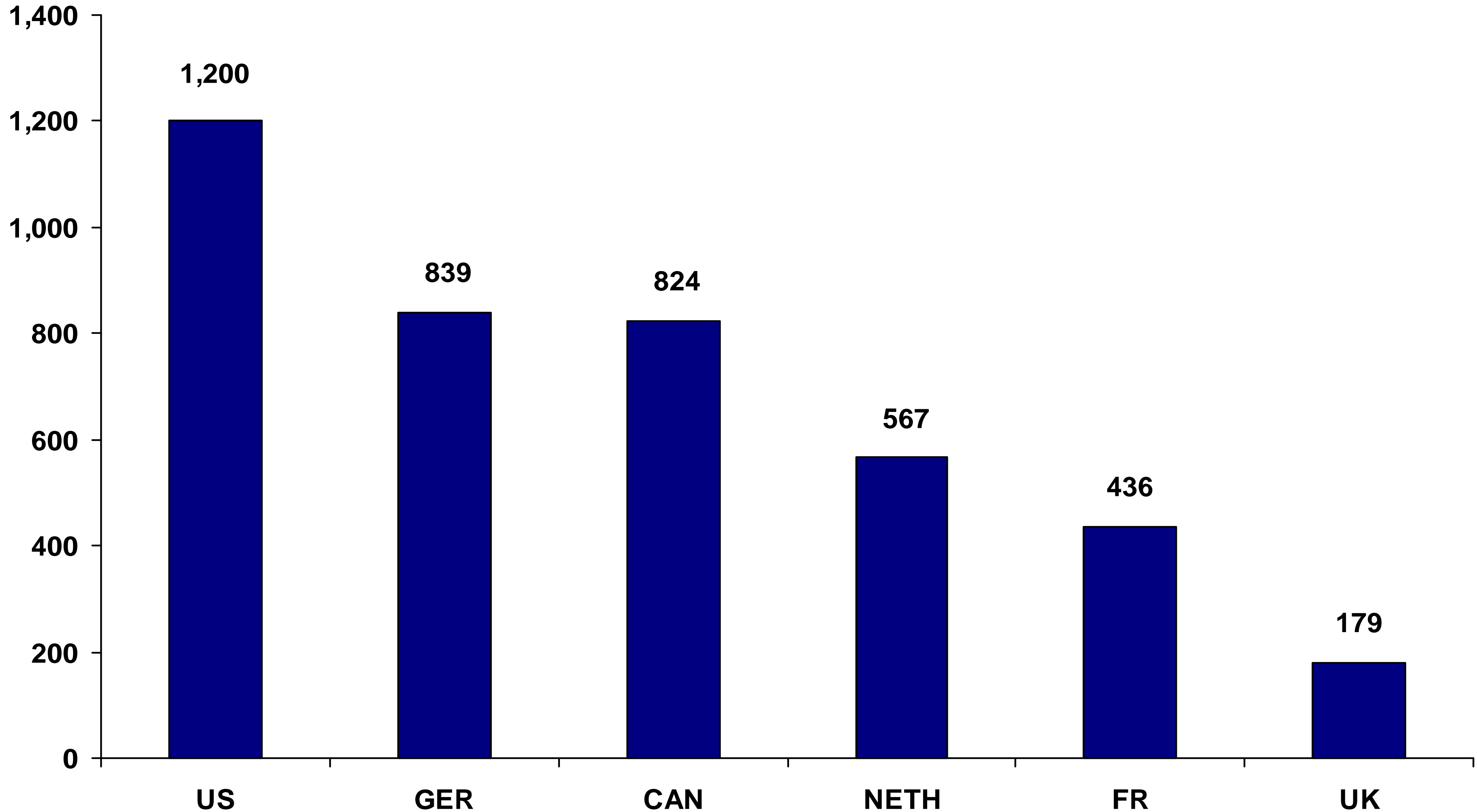
Magnetic Resonance Imaging (MRI) Machines per Million Population, 2007



** 2005

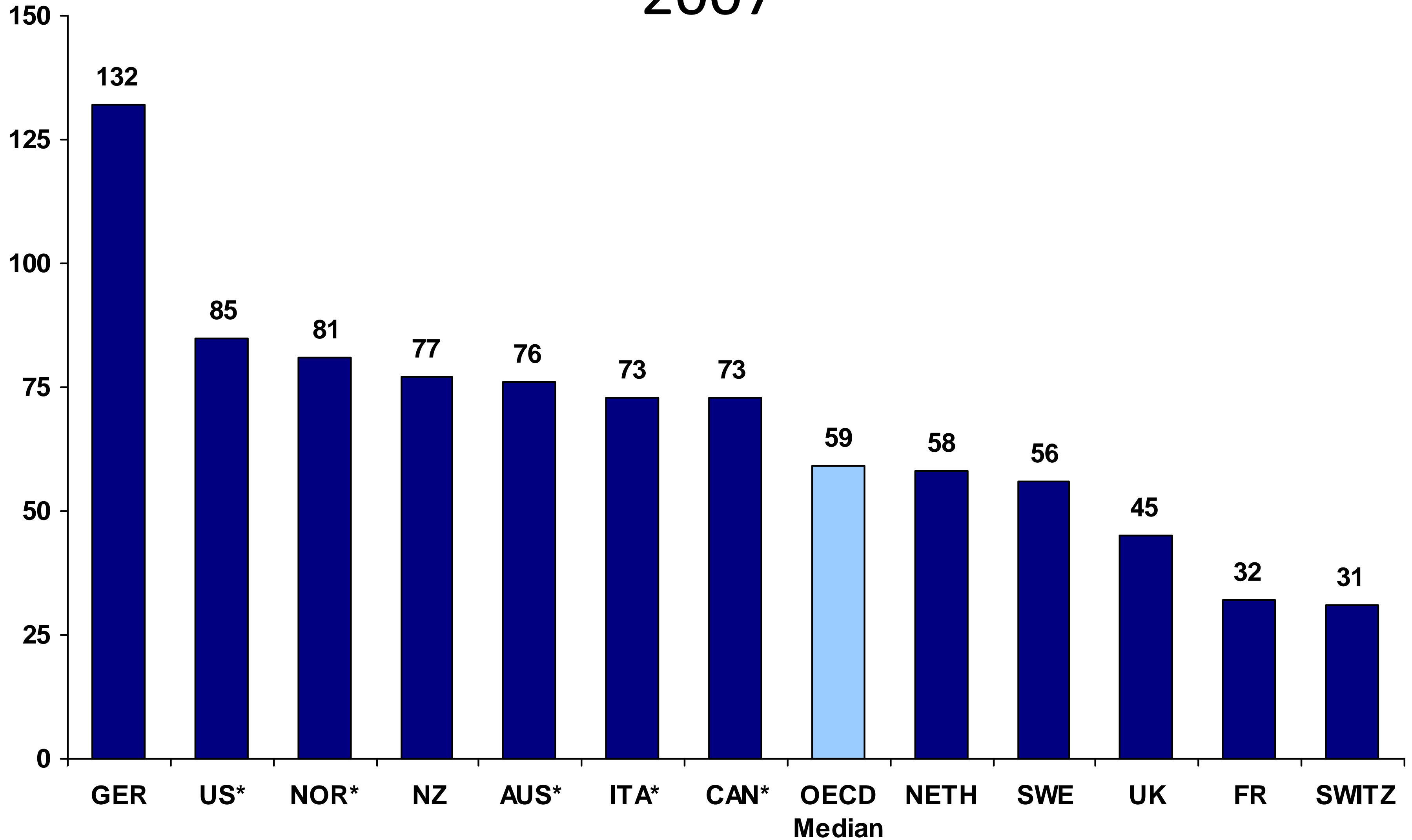
Source: OECD Health Data 2009 (June 2009).

MRI Scan and Imaging Fees, 2009



Source: International Federation of Health Plans, 2009 Comparative Price Report.

Coronary Bypass Procedures per 100,000 Population, 2007



* 2006
Source: OECD Health Data 2009 (June 2009).

A closer look at German health care

THE HEALTH INSURANCE SYSTEM OF GERMANY

A health-are system with the following features

1. Mandated, universal health insurance (about 90% in the non-profit, private, Statutory Health Insurance (SHI) system (initiated by Chancellor Otto von Bismarck in the late 1880s), and about 10% with highly regulated for-profit private insurers.

2. A mixed public-private delivery system with a heavy for-profit component, even among hospitals.

3. Overall pervasive and tight government regulation at both the state and federal levels.

4. By American standards, relatively low cost.

THE STATUTORY HEALTH INSURANCE SYSTEM OF GERMANY

The system grew out of the self-help “friendly societies” established by workers during the industrialized revolution of the 1880s.

Became a federal system in 1998 with *Bismarck’s RVO – the Reichs-versicherungsverordnung* (Imperial Insurance Decree) which survives, after a myriad amendments over time to this day.

Originally composed of over 1,000 quasi-private, non-profit sickness funds with what is called “self-regulation”, but only within the very narrow limits allowed by the RVO.

THE STATUTORY HEALTH INSURANCE SYSTEM OF GERMANY

Up to an income threshold that has changed over time (currently $62,500), all employed Germans were mandated to be insured under the SHI. Above the threshold people were free to choose private insurance or remain in the SHI or go without insurance.

Until very recently (starting in 1992 and fully since 2004) people in the SHI did not have a choice of sickness plans, but instead were assigned to it on the basis of either craft, employer or location.

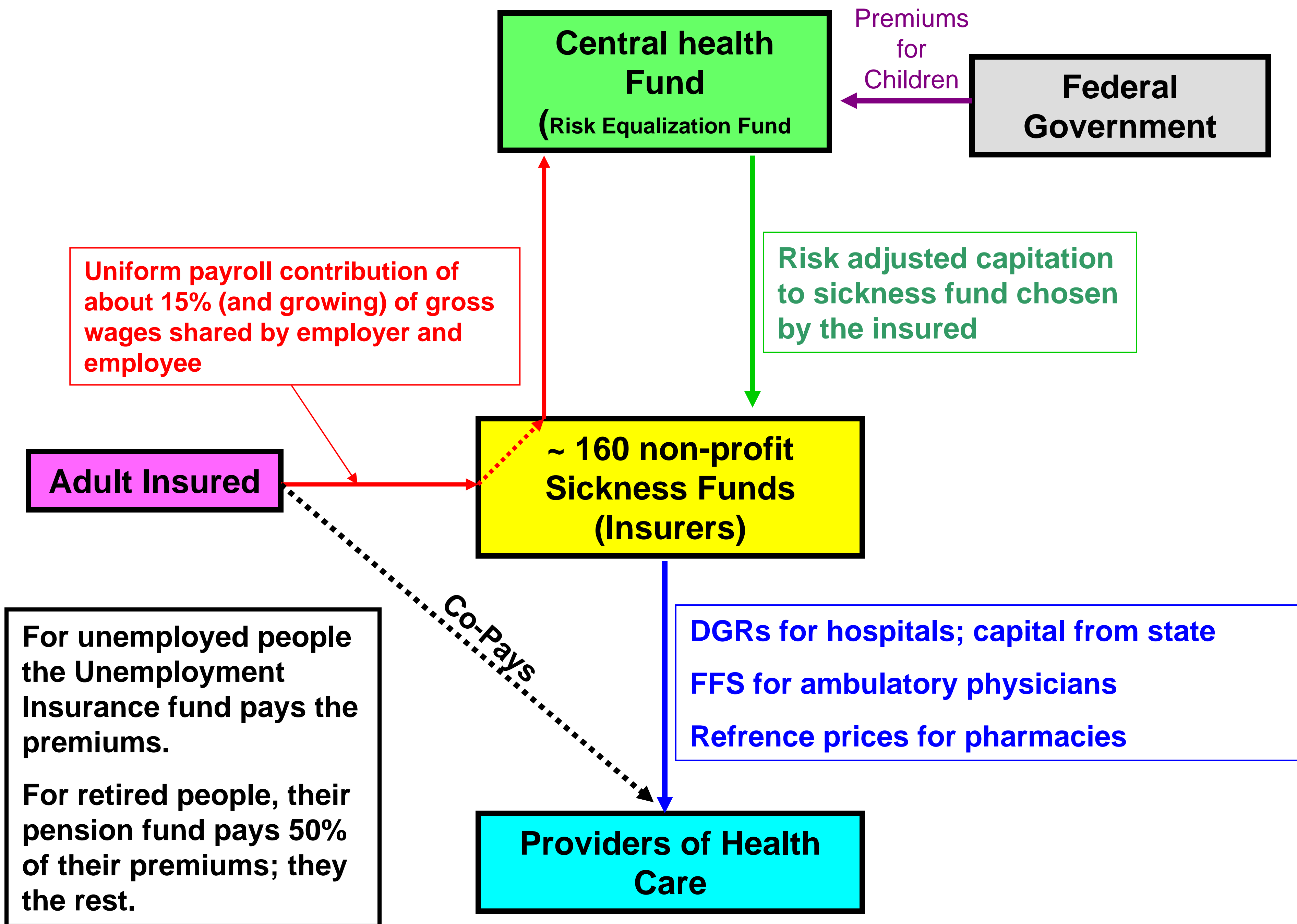
Until 2004, the payroll contributions to the SHI (shared 50:40 by employers and employees) varied enormously among funds, which brought on the reforms of 2004.

THE STATUTORY HEALTH INSURANCE SYSTEM OF GERMANY

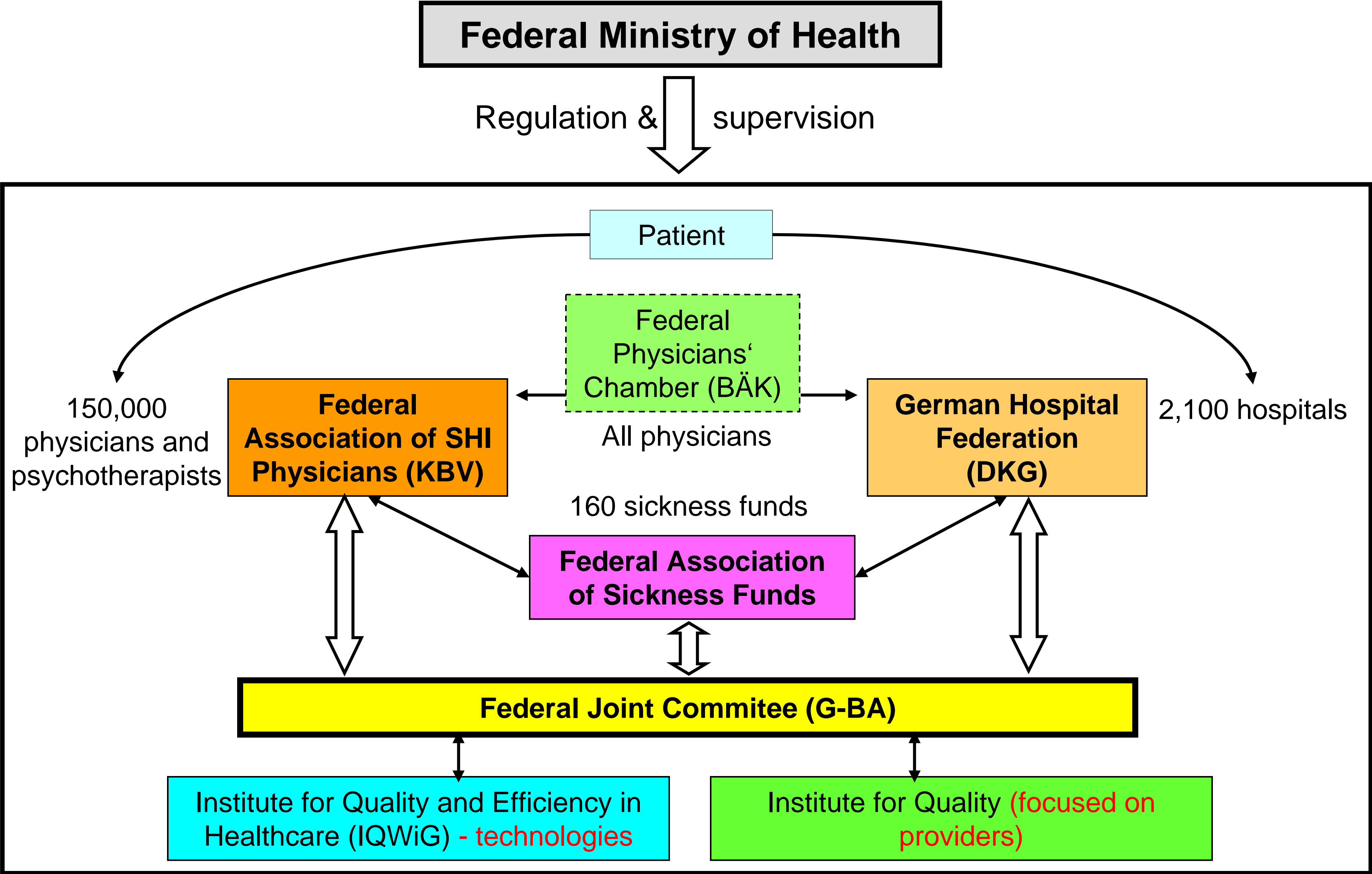
Since 2004, Germans can choose among any of the 200 or so surviving sickness funds, at a uniform payroll tax, which covers the employee and dependent non-working spouse, but not children, whose premiums are paid by the federal government.

Unlike in the US, where patients often are confined to networks of providers, Germans have long enjiyed completely free choice of providers.

Premiums paid by the insured now flow through the system as follows:


Central health Fund
(Risk Equalization Fund
Premiums for Children
Federal Government
Uniform payroll contribution of about 15% (and growing) of gross wages shared by employer and employee
Risk adjusted capitation to sickness fund chosen by the insured
Adult Insured
~ 160 non-profit Sickness Funds (Insurers)
Co-Pays
For unemployed people the Unemployment Insurance fund pays the premiums.
For retired people, their pension fund pays 50% of their premiums; they the rest.
DGRs for hospitals; capital from state
FFS for ambulatory physicians
Refrence prices for pharmacies
Providers of Health Care

Self-Governance under Germany‘s Statutory Health Insurance



Source: Reinhard Busse.

For a more detailed chart on governance, see a separate handout.

THE PRIVATE HEALTH INSURANCE SYSTEM OF GERMANY

Provides full covers less than 10% of the German insurance, but supplemental coverage to millions of SHI insured (mainly for better amenities).

Premiums at time of enrollment are actuarially fair, but thereafter can change by age, regardless of health status.

Premiums are per individual, not per family.

Pay higher fees to physicians, but also registers higher health spending per capita.

People who opt for private insurance cannot ever return to SHI unless they are poor.

The industry is heavily regulated by the federal government, which sets the fee schedule (e.g., age reserves).

HEALTH-CARE DELIVERY SYSTEM OF GERMANY

Until very recently, there had been a strict division between ambulatory and inpatient care. Hospitals give only limited outpatient care.

Hospital-based physicians are (rather poorly paid) salaried employees of the hospital whose salary is included in the DRGs.

Ambulatory physicians are self-employed business people who practice in solo (75%) or group (25%) practices.

The insured may voluntarily enroll in GP gatekeeper models at favorable premiums.

PAYMENT OF HOSPITALS IN GERMANY

Germany has what is called a "dual hospital financing system."

The states (Länder) pay for the structures and equipment of hospitals, within regional health planning), as role the states have jealously preserved for themselves.

The hospital's operating costs are covered by some 12,00 DRGs paid by the sickness fund, traditionally within a global budget per hospital, but not any more since 2009.

There exists in Germany a new *Hospital Payment Institute* that updates the DRGs constantly in light of new medical technology.

PAYMENT OF AMBULATORY PHYSICIANS IN GERMANY

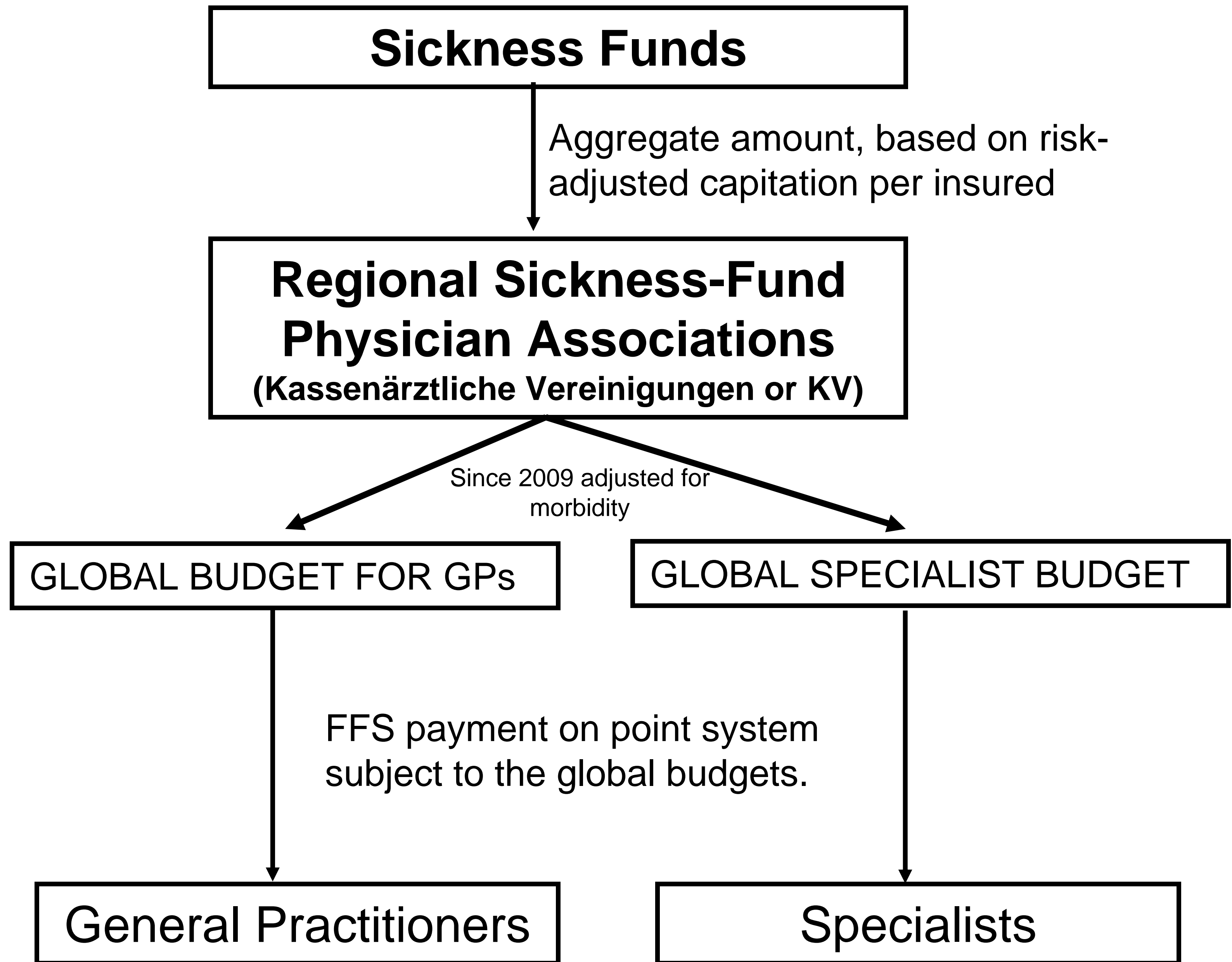
Ambulatory-care physicians are paid on a FFS basis, on a schedule of points per service which is then converted to monetary units through a conversion factor (€/point).

Until recently, this system operated within global budgets so that the €/point automatically fell if the budget was exceeded.

The fee schedules now have fixed Euro prices instead of points, but physicians are still subjects to budget caps on an individual basis. Services rendered beyond the cap are reimbursed at a much lower rate.

State-based associations of sickness funds physicians negotiate annually with state-based associations of sickness funds over the overall aggregate payments to the physician sickness fund association (the *Kassenärztliche Vereinigungen* or KV).

FFS WITHIN GLOBAL BUDGETS



PAYMENT FOR PRESCRIPTION DRUGS

Drug manufacturers in Germany can set their own wholesale prices.

The federal government regulates wholesale and retail mark-ups.

Sickness funds pay for prescription drugs on a reference-price system, coupled with rebates for on-patent drugs, which replaced earlier budget caps per prescribing physicians.

From 2011 on, the system is subject to comparative effectiveness analysis.

A closer look at Swiss Health Care

OVERVIEW

Switzerland 7.5 million people live in 26 cantons, some of which are large cities, other small rural enclaves.

Health insurance is mandated in Switzerland, on a cantonal basis, but within an overarching federal health insurance law passed in 1996. There are few uninsured (about 1.5% of the population).

As in Germany, there are no government-run health insurance programs in Switzerland. All insured purchase coverage from private insurers that cannot earn profits on the mandated benefit package but may earn profits on supplemental insurance.

The health-care delivery system is a mixed system, as in Germany.

Governance of the system is highly decentralized, involving federal, cantonal and communal governments.

SWITZERLAND'S HEALTH INSURANCE SYSTEM

Mandatory basic health insurance in Switzerland is regulated and supervised by the Federal Office of Public Health under the Federal Health Insurance Act of 1996. It covers about 43% of total national health spending. Long term care is not part of social insurance and is still paid largely privately out of pocket.

Nationwide there are over 80 private insurers, although not all of them sell insurance in every canton, and the 10 largest carriers cover 80 percent of the population.

For the mandated basic package – which excludes dental care -- insurers can vary the deductible from a minimum of CH300 to a maximum of CH2,500. In addition, a coinsurance rate of 10% applies to all but a few exempt services. Out of pocket spending therefore is very high in Switzerland (30% of total national health spending), although very low-income people receive subsidies from the cantons.

SWITZERLAND’S HEALTH INSURANCE SYSTEM

Every insurer is free to set the premium for the mandated basic benefit package, but an insurer’s premium applies to all customers regardless of age or health status.

Because of guaranteed issue and community rated premiums, there is cantonal a risk equalization fund, but it relies on few variables (only age and gender, while Germany’s as well as the Dutch risk adjusters have over 80 morbidity variables) for risk adjustment and is judged far from satisfactory.

As a result, individual insurers in Switzerland have an incentive to cherry pick – not to earn profits (which is prohibited on the mandated package), but to be able to compete with lower premiums.

Low-income people in Switzerland receive public subsidies toward the purchase of health insurance.

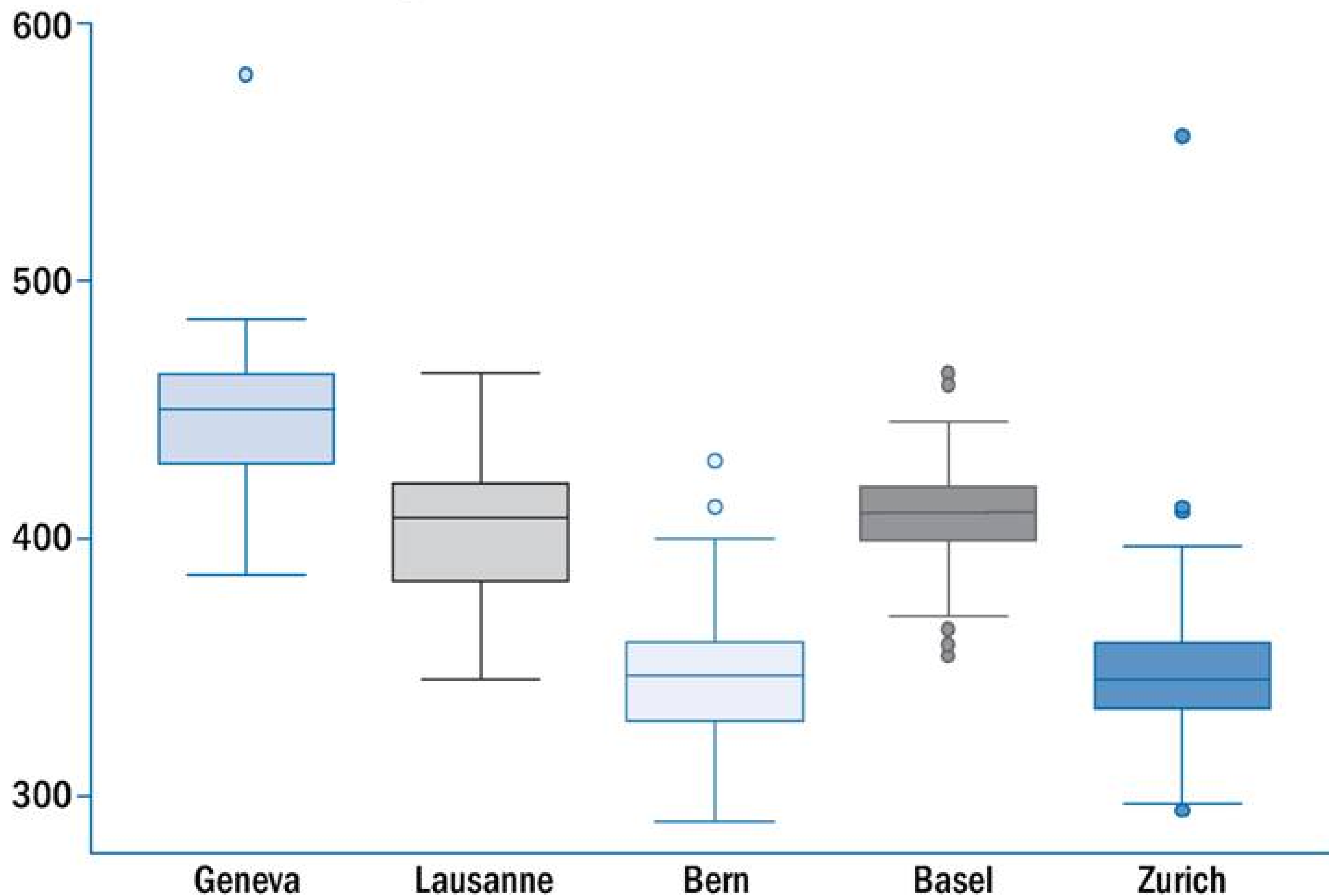
SWITZERLAND’S HEALTH INSURANCE SYSTEM

Because health insurance is decentralized on a cantonal basis, there are significant differences in health insurance premiums for identical benefit packages.

Remarkably, there remain large premium differences even within cantons – see the following slides from Rutten *et al*.. These variances are thought to reflect risk selection, rather than relative efficiency in purchasing health care and administering claims.

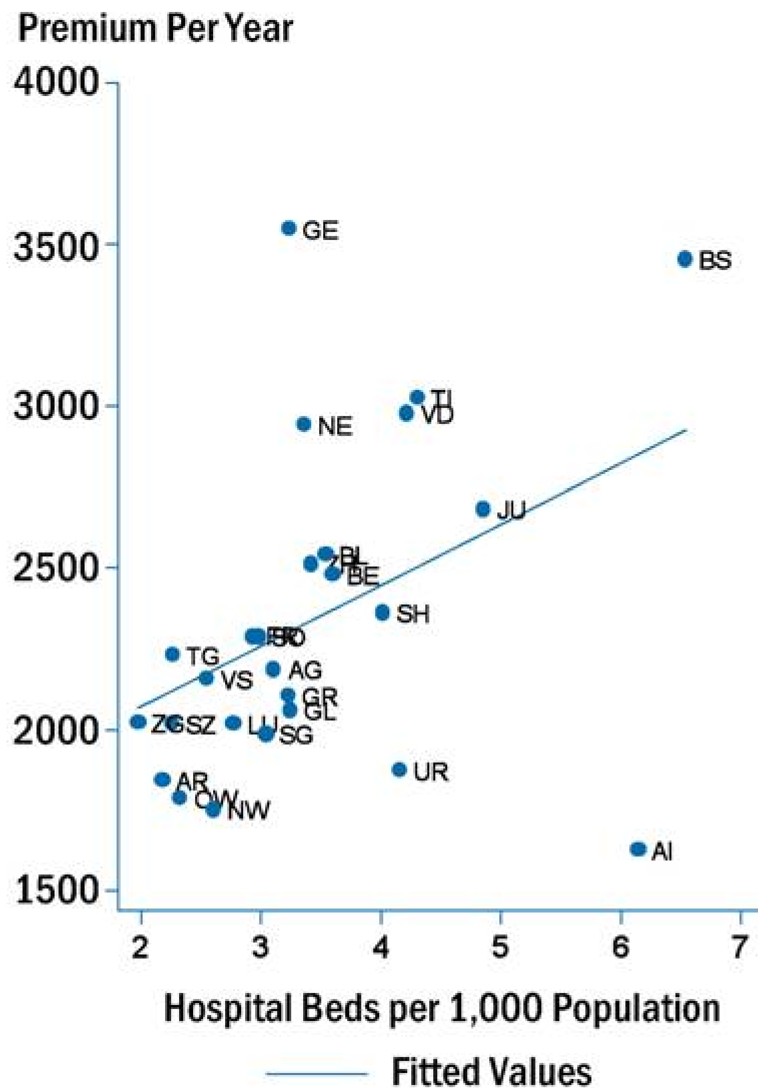
These intra-cantonal variances in premiums suggest that many Swiss citizens do not switch insurers in spite of these large differences. It reflects a bias for the status quo.

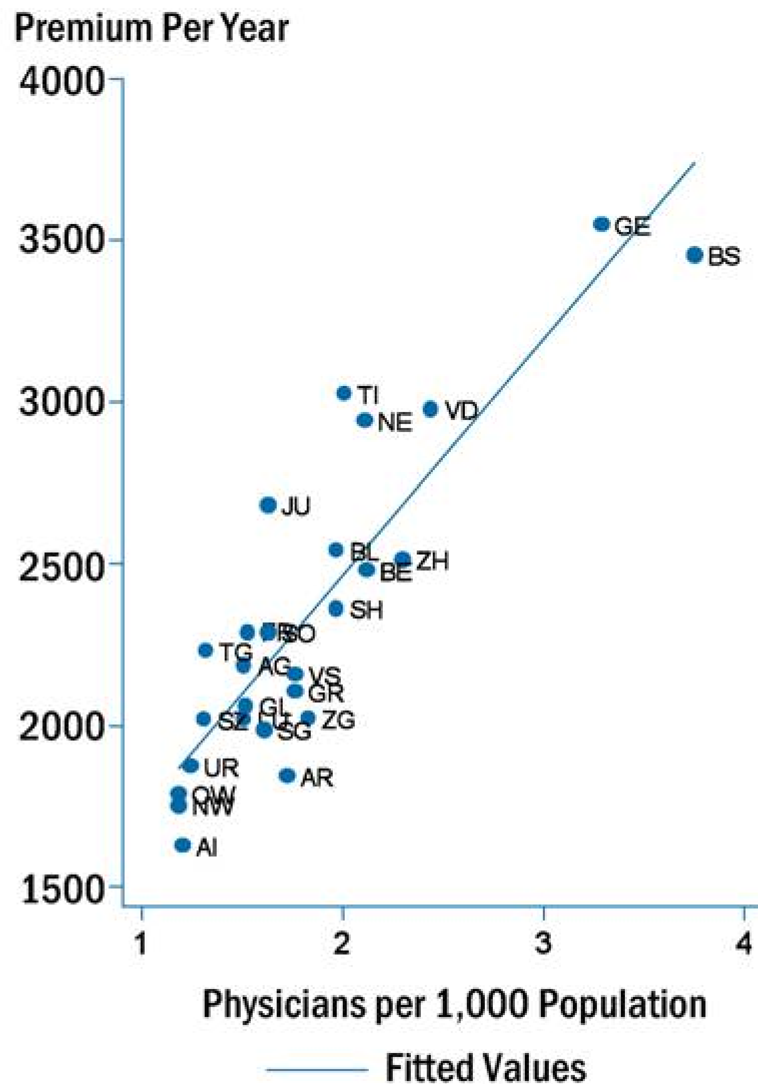
Figure 1. Range of Monthly Premiums of Basic Health Insurance in Major Swiss Cities, 2007 (300 CHF; $255 Deductible)



Note: The box contains the middle 50 percent of all premiums offered, with the median shown by the horizontal line within the box. Lines above and below the box indicate the lower and upper quartile of premiums; points outside these lines are considered to be outliers.
Source: BAG (2006) Gesamtverzeichnis aller Prämien in der Schweiz.

Figure 2. Correlation Between Premium Level and Physician Density/Hospital Bed Density





Source: BfS Krankenhausstatistik 2005, Table D1.

PAYMENT OF HOSPITALS IN SWITZERLAND

Hospitals, which can be public, private non-profit or private for profit receive about a third of their financing from the cantons, within a cantonal planning system.

Hospitals are paid by insurers either on a per diem or a DRG basis negotiated at the cantonal level.

As of 2012, hospitals are to be reimbursed on a nationwide DRG basis.

The cantonal governments absorb hospital deficits.

PAYMENT OF PHYSICIANS IN SWITZERLAND

Switzerland has one of the highest physician-population ratios in the OECD (380 per 100,000 population)

As in Germany, hospital-based physicians are usually salaried.

Ambulatory-care physicians are paid on a FFS basis at fees that are negotiated on the cantonal level between associations of insurers and of physicians.

PAYMENT FOR PRESCRIPTION DRUGS

Drug prices are regulated by the federal government in Switzerland. Comparative effectiveness is a factor in setting prices for drugs.

Generics must be sold at 50% of the corresponding brand-name drug; but only about 9% of drugs sold are generics (compared with close to 70% in the US)

Sickness funds pay for prescription drugs on a reference-price system, coupled with rebates for on-patent drugs, which replaced earlier budget caps per prescribing physicians.

From 2011 on, the system is subject to comparative effectiveness analysis.

CONSLUSION ON THE GERMAN AND SWISS HEALTH-CARE SYSTEMS

Both systems slouch in the direction of what we think of as “regulated or ‘managed’ competition” in the U.S.

Allowing citizens a choice among tightly regulated health insurers provides the illusion of competition, but it is just that, an illusion.

It is an illusion because the prices at which insurers buy health care for the insured are typically out of the insurer’s control.

Furthermore, there is virtually no ability to exclude providers with relatively low quality of services.

But perhaps there is value in the eyes of citizens in a system that provides the illusion that it is not a government-run health insurance system.

Of the two systems, Germany's is by far the more egalitarian system.

Germany's health system also registers significantly lower costs on a PPP per capita basis.

Overall, though, the Swiss health system is generally viewed as one of the highest-quality health systems in the world – certainly outranking the United States on many dimensions.

THE END