

# **An Investigation Report on the Health Insurance System and the Health Care Scheme in Netherlands and Germany**

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According to the arrangement of EU-China Social Security Co-operation Reform Project and at the invitation of the Dutch and German government, lead by the Mr. Xiong Xianjun who is the Secretary-General of Health Insurance Research Association of China, a delegation of 16 members from various departments of MOLSS, General Office of State Council, Ministry of Civil Affairs and provincial MOLSS (the attachment shows the name list), makes a deep and systemic investigation on the Healthcare system in Netherlands and Germany from June 18 to 28 of 2007. During the study tour, the delegation attended the 2nd EU-China High Level Round Table on Social Security in Berlin, Germany. The delegation has learned: ① The recent development of the Health insurance Reform in Netherlands and Germany, the main problems occurs in the procedure of enforcement and the further strategy; ② The integration policy of the European health care and the legislation on patients' cross-border movement in EU ③ The implementation of DRGs in Netherlands and Germany. In Netherlands, the delegation visited several organizations such as Ministry of Health, Welfare and Sport, a health insurance company Achemea which takes a lion's share in Netherlands, DBC Center, Dutch Health Care

Authority (Nza), Service Medical Foundation (CBF). And in Germany, the delegation visited Ministry of Health, AOK foundation and Charite Hospital. The members of the delegation communicated with the related personnel and discussed some issues which two parties were interested in. To expand as follows:

## **Netherlands**

### **I. Profile on Netherlands**

The territory of Netherlands is only 41528 square km. , which equals to 2.5 Beijing areas, with 16.5 million citizens. The Netherlands is a constitutional monarchy with a parliamentary system of government and is a prosperous and open economy depending heavily on foreign trade. The well developed economy makes its GDP reach to 28,400 Euro and Dutch as one of the strongest economic force and was impressed by its combination of tradition and innovation. Structural policy has become one important factor since 1980's, which defined as mature financial budget of government, reduced employment cost of enterprise, reduced social benefit, efficiency of market and legal spirit, and infrastructural investment of government. For mature financial budget of government, government cuts expenses on one hand, and lightens people's tax burden on the other hand. For reduced employment cost of enterprise, labor cost is decreasing because of lower total expenses of enterprise, and it is possible to improve the employment rate. For reduced employment cost of enterprise, the

standard of paying social security is freezing, and the minimum wage of people who join social security system is falling at the same time, both of those are the reason to activate the labor market.

For efficiency of market and legal spirit, along with the implementation of Dutch Economic Competition Act, Commercial Register Act and other new acts, the market efficiency becomes higher and innovative. For infrastructural investment of government, the government continues to invest on the projects including basic infrastructures, science investment and education investment.

As the most European countries, the Dutch social health insurance system is run as financially foundations, which is separate from public medical service and responsible for the fund contribution, management and the benefit payment; accordingly, it covers not only the daily medical expense of individual citizens, but also the national healthcare perspectives, which includes prevention, daily health care, medical treatment, nursing, rehabilitation and so forth.

## **II. The Health Care Reform in Netherlands**

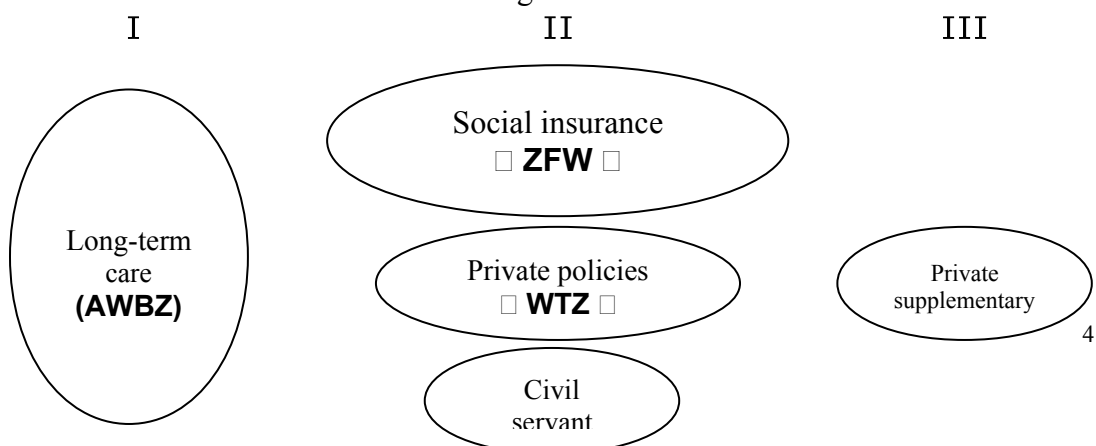
Just like the construction of their great dam, the Dutch have had long tradition of having numerous rounds of debates and discussions in every possible aspect of the related areas before executing a project. After nearly 30 years of debate, the Netherlands finally formed a comprehensive scheme for health care reform and is well stepping into a new era. Today, the Dutch can be proud and confident to look back on their successful path of evolution.

# 1. Background

**For medical service system**, the expected health expenditure in 2040 is 14% of GDP, and in 2025, 22% of labor force will be in health care in health care; but there is insufficient cost and quality awareness; meanwhile the government intervention on prices and quantities led to the lack of innovation, the lack of incentives to perform well and waiting lists.

**For health insurance system**, on one hand looking back, no level playing field, that is to say insurers on a ‘fragmented market’ with different sets of rules (see figure1); insufficient mobility of insurance; risk selection within private insurances led to refusing insure the elderly and the chronically ill; arbitrary and unfair income effects depending on personal situation (see level II of figure1), and three different agency and staff cost much. On the other hand, looking forward, the proportion of the elderly over the age of 65 years old to the Dutch population is 11% now, and the expected figure in 2040 is 22%; it can lead to a health expenditure jumping, therefore Dutch finance will have to face a record-breaking stress. After a 30-year-brewing, Dutch government had improved the medical service system and the medical system simultaneously, regarding these two parts as an integer, to deal

**Figure 1. Dutch health insurance system before the reform(2006): Three-pillar framework**  
with the insufficient of labor force in clinical nursing and medical treatment .



## 2. Seedtime of the Reform(2003~2005)

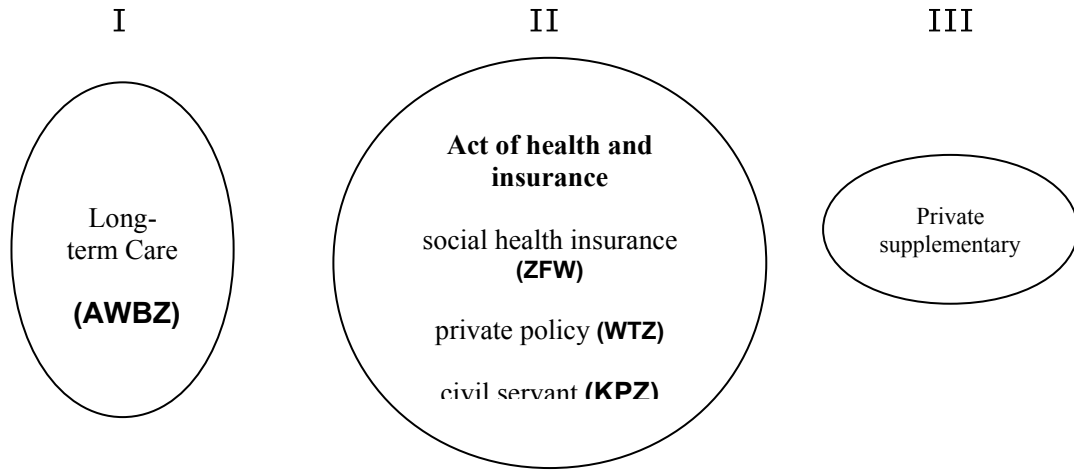
A series of adjustments was conducted to the social health insurance (ZFW). **Primary adjustments:** the methods undertaken by the government pointing to the old insurance system contains: the first is to decrease service scale of the health insurance. The second is to properly increase the percentage of the personal payment. The third is to loosen the constraints to the health insurance system and the medical service system in order to provide more freedom. The fourth is to modify the paying channel of the health insurance, and to create a encouraging mechanism to the medical service provider based on the performance management (imported the DRG system from Germany which pay according to the illness, and localized is into DBC system), which considered people's economical ability when satisfying medical needs. The fifth is to build open and transparent inspecting system (Nza, Dutch Health Care Authority, Administration of Health insurance, and other departments). The sixth is to bring in private insurance company to form a layout in which public and private units manage the health insurance together. **Other methods:** insurance participant can select insurance company freely, and can switch once a year. Health insurance companies decrease

insurance fee and improve service and so forth to increase competitive ability. On the other side, medical service provider promise to provide attracting price and high quality medical service.

### **3. Framework after the Reform (from 2006.1.1)**

Health Insurance Act was adopted. The Dutch health insurance is a social insurance system built under the European juristic framework. The reform combined the health insurance system, which pointed to different group of people, into a single system.

**Figure2. Three pillars of the Dutch health insurance system  
after reform (2006)**



### III. The Health insurance System

#### 1. The new system

The responsibilities of the four parties – government, citizen/insured/patient, provider, insurer - are clear. The aims of health insurance are access, solidarity and quality. Government defines coverage (basic package). Insurance company is obliged to accept all thus no risk selection for the insurance companies. A risk adjustment scheme set by the related department. Government pays for the children younger than 18 years old, same policy and same premium for all the citizens. Tax compensation for low incomes (health care allowance), government guarantee the insurers the provision of care (contracting or reimbursement). Competing private insurance companies (choice:

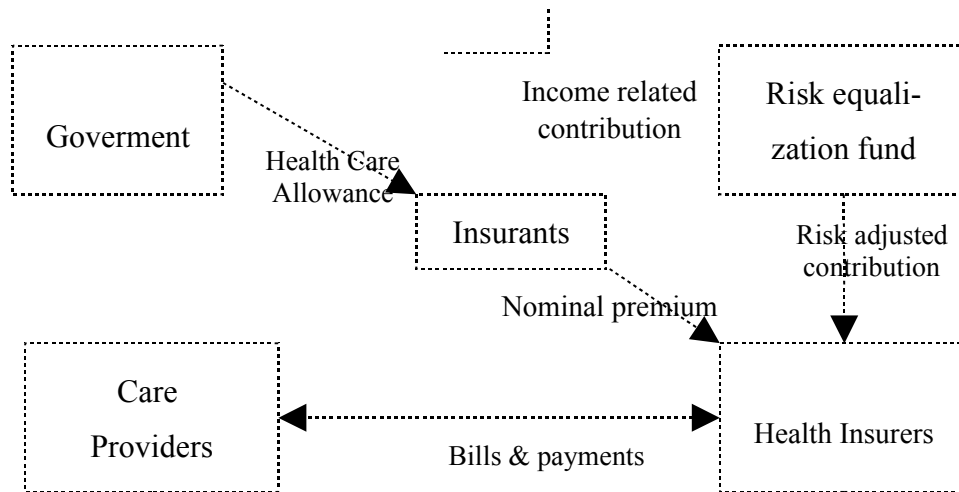
profit or not for profit); the insured can choose an insurance company to sign contract, and make a change freely each year; insurers can set lower nominal premium to attract more insured; insurance company and medical service provider negotiate to sign contract; higher transparency.

## **2. The Mechanism of Fund Contribution**

The health insurance fee paid by the people who participate in the insurance mainly contains two parts □ 50% is for Risk Equalization Fund and 50% is used to pay the Nominal Premium of the insurance company. The health insurance of employed citizens over 18 is paid by both the employers and citizens themselves. The health insurance of unemployed citizens over 18 who have income is paid by citizens themselves. That of citizens under 18 is paid by the government. Besides, government will provide financial aid to those needed. Risk Equalization Fund is a kind of adjustment fund, which is managed by some administrations specifically established by the Ministry of Public Health. The fund is raised as 6.2% of the income based on the level of GDP (capped by 35,000 euros). Government estimates the risk of paying for next year according to the sexuality, age, the economical level of residence, the expenditure for drugs and medical care of the participants. Then it gives the participants the corresponding stipend of risk fund by paying to insurance company directly. The administration for Risk Equalization Fund track the operation and management of insurance company, make public the data of insurance company periodically. It will also notify the

public those companies which are in bad operation and charge financial penalty on them.

Figure 3. **The Dutch Fund Contribution Mechanism**



### 3. Individual responsibility on Health insurance

For those services included in the basic package of health insurance, the participants don't need to pay by themselves if they take the diagnosis by the full-time doctors and transfer to other hospitals according to the regulation of the diagnosis. Those who need long-term care and family bed care need to pay 8% of the total by themselves. Citizens who haven't participated in health insurance are require to pay the insurance fee fro 2~3 years (subject to the policy of individual insurance company) before treatment if they want to have the health insurance.

### 4. The Effect of Reform

After the reform, the insurance fee is lowered than expected. Citizens have more flexibility

in choosing health insurance (18% of participants changed their insurance companies in 2006). There are also more groups participating in insurance (participating in health insurance as group can have 10% discount, this policy is especially for immigrants and the young). Citizens and companies appear to be more alert to the service, the price and the incentive mechanism.

## **5. The Trend of Reform**

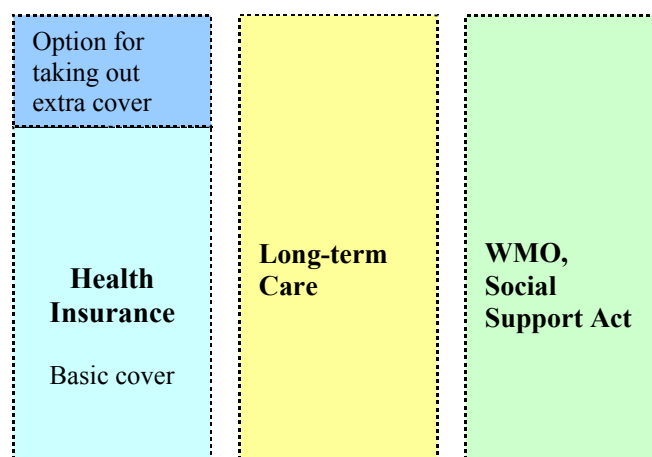
In the future, we expect more flexibility in the price and quantity of medical service. More kinds of services are expected and new medical service provider is expected to be introduced (full-time doctors play important roles in this). The publicity of information on the quality of medical service is also welcome. Regional government is expected to keep on the reform in mutual beneficial way, pay more attention to the public health and prevention (disease management process).

## **IV. The medical services system and the payment of the health insurance system**

### **1. General View of the Dutch Health Care System**

The establishment of the system is based on three main areas, Health insurance, Long-term Care, and Social Support Act, to guarantee every citizen's right to health care □ see figure 4 □ .

**Figure 4. The Dutch Health Care System**

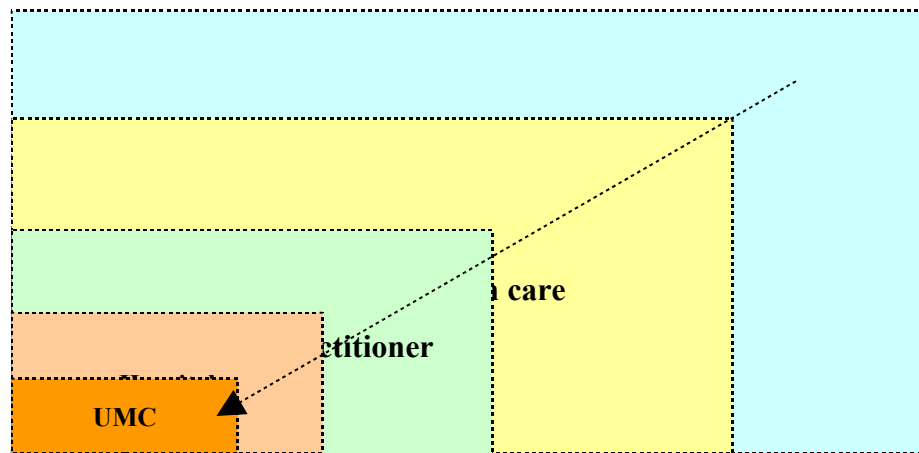


Based on the levels of care, the health care system can be divided into Public Health which is the basic health care, Primary Health Care which includes general practitioner and live-in care, and Tertiary Care which includes rehabilitation and long-term care. At early stage of an illness, the patient first performs self treatment when possible. If not healed, the patient can go to the community's primary health care system to consult with a general practitioner or undertake treatment and medication from a general practitioner. The general practitioner can authorize the patient to be treated in a general hospital or a medical school hospital for further treatment based on the patient's state of illness. Figure 5 shows the general path of patient undertaking medical treatment. It's not difficult to observe that transferring patients based on different classes of medical treatments will be significant in fully utilizing basic level medical treatment resources and maintaining reasonable expenditures on medical treatments.

## **2. A Strong Primary Health Care System**

The key difference between the Dutch and Chinese health care systems is having a complete Primary Health Care (PHC) System which provides the patient with basic medical treatment services before the patient gets treated by a hospital. PHC indicates the first hand professional medical treatment service the patient receives. They are embedded in the communities for conveniently performing first hand general medical treatment and care, and providing broad areas of services such as health care education and basic medical treatments. This is similar to the community medical treatment services currently being provided in China. PHC is important in the health care system because it encourages patients to first perform self treatment when possible, provides general medical care, and provides medication when necessary. A complete PHC helps to achieve three objectives, reachability, quality treatment, and Restriction on the flow of medical treatment expenses. The PHC provides 24-7 close distance medical treatments. To ensure the patient's safety and satisfaction, it provides continuous care. It also acts as the gatekeeper on restricting medical expenses which ensures the efficient usage of such expenses.

**Figure 5. The Clinical Path under the Dutch Health Care System**



Up to the end of 2005, the Netherlands has 8495 general practitioners, 89% out of which are independent. The percentage of female doctors has increased from 17.5% in 1993 to 34%. Out of them, 21% are below the age of 40; 23% are above the age of 55. Out of the 8495 general practitioners, 47% are part-time, 8% qualify to provide supplementary medication treatment. In 2005, the annual budget for the general practitioners in the Netherlands was €1,600,000. Though most of these general practitioners are independent doctors, they are mostly members of doctors' associations and foundations. There are 57 doctors' associations and foundations nationwide in the Netherlands, having branches in 131 different areas, serving 15.9 million citizens (96% of the entire national population).

According to the 2002 data, patients have high confidence in the general practitioners (the survey has choices of very high, high, low, very low). 15% of the patients think the general

practitioners are very reliable; 70% of them think the general practitioners are relatively reliable.

These results are closely related to the Dutch government's close attention to the basic education, training procedures, and continuous education for the general practitioners.

### **3. Independent Medical Treatment Service Provider 私人医疗服务提供方**

Hospitals, general practitioners, and pharmacies each take on their own responsibilities. In the mean time, the health care system maintains the framework that ensures disease prevention through the life time of each citizen. It includes the primary prevention, pregnancy sanitation; secondary prevention, the family doctor; tertiary prevention, the hospitals; and rehabilitation, the medical cares.

In 2003, the Netherlands spent €12.5 billion on disease prevention, 80% of which were used on health precaution such as the improvements of the sewer system, road safety establishments, and quality of drinking water and air; 17% were used on disease prevention such as vaccination; 3% were used on enhancing healthier life such as inducing people to develop health lifestyle.

### **4. Medical Expense Payment System**

**Primary health care payment:** Health insurance companies make payments to primary health care providers. The pricing standard is €52 per insured per visit. The insurance companies also pay the general practitioners for medical consulting fees (€4.50, €9 and €13.50) and extra charges for unusual diseases, locations, supplementary treatments, and technical updates.

**Hospitalization payment:** The Netherlands used to settle payments on daily basis before

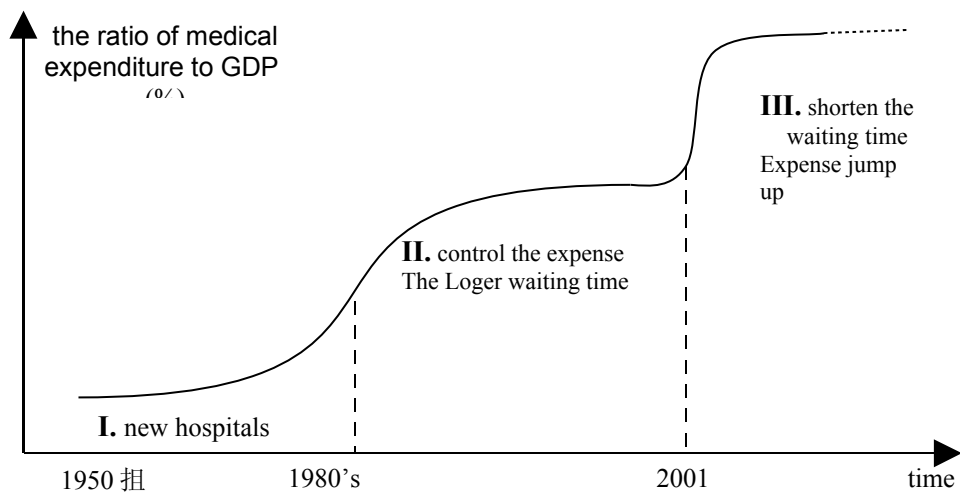
implementing DBC ( Diagnose Behandel Combinatie, Dutch for diagnosis-related groups) . DBC is a health insurance expense payment system inspired by the German DRGs. The system which has a more complex classification on diseases was first established in 2003 then put in practice in 2005. The services included in the DBC payment system constantly gets feedback from the patients from diagnosis stage to the completion of the treatment. The DBC set a new standard for standardization and information system, including 25 medical departments and 110,000 diseases that qualify for medical reimbursements; 3500 diseases that can be reimbursed by private insurance companies after meeting specified criterion; 1500 diseases that are not reimbursable by health insurance but can be reimbursed by complementary health insurance. 90% of the current pricing of medical services are fixed (A); 10% are negotiable (B) and determined by hospitals and insurance companies. In 2006, the total medical expense of the Dutch population of 16 million people was €60 billion; hospitalization cost per capita was €2,000 (not including long-term care and mental diseases). 50% of the total hospitalization expenses were paid by DBC.

As the reform progresses, the percentage shall increase in the upcoming years. Before the reform, after the patients paid their medical treatments in the hospital, the hospital mailed the receipt directly to the patients and then the patients had to personally take the receipts to the health insurance companies to claim for reimbursements. Now after the reform, the hospitals can directly settle the

payments with the insurances companies. This has greatly simplified the procedures and reduced the economic pressure on the policy holders.

|  | Fixe price<br>(A)90% | Negotiated<br>price<br>(B)10% |
|--|----------------------|-------------------------------|
| 110000 diseases<br>(coverd by Health<br>Insurance) |                      |                               |
| 3500 diseases<br>(conditional)                     |                      |                               |
| 1500 diseases<br>(not reimbursed)                  |                      |                               |

**Figure 6. The Dutch Medical Expenditure Controlling**



## □ . **Organizations and Supervision System**

### **1. The government defines the basic rules**

The department is in charge of the building of the relevant regulations, which defined the responsibility of the government in depth. Private insurance companies play a more and more important role in social medical care, so do the patients association, hospital association and doctor association. Since the specific features of the medical care, which made it to be unique from the common commercials, the government has to regulate and monitor all the aspects of the health insurance system. The public insurance is also funded by the government.

### **2. Developed private insurance market dealing with medical care**

Before the reform in 2006, the medical care for the citizens with annual income less than 30,000.00 euro is handled by the public insurance services ;and the citizens with annual income more than 30,000.00 euro chose the private insurance. Since 2006 the medical care operation is transferred to developed private commercial insurance company.

According to the government regulations, when private insurance companies insure medical care, it can choose profit and non-profit model. During this process, the public health insurance agencies have been either merged by private insurance companies or privatizing and continued to bear the corresponding operations in the new action services system.

The insurance applicants are allowed to change the insurance company by the government who

introduced the medical care action service system, so as to reduce handling costs and improve efficiency. On the one hand, the private insurance companies are permitted to charge management fees in case of medical care operations, and they decide the annual rates: the rate now is 18-19 euro per person per year. At the same time, in order to reduce the workload and handling costs, the insurance companies are allowed to grant the insured persons in group the highest 10% of the premium concessions. In order to attract people insured, insurance companies formulate the preferential policies, for example: the insured person can access to the return of a certain amount of premiums when no medical care pay occurred (ex: insurance companies return 300 euro to insured persons within 100 euro charged early this year). In 2006, 20% insured persons changed insurance companies, 44% insured in group; In 2007, 3% changed companies, 57% insured in group, the medical care service system is to be more stable with sustainable development.

The government established the risk balance mechanism, in the purpose of prevent converse selection of applicant by the insurance companies. On calculating the compensation criterion of risk balance for every insured person in a population of 1,6 millions in Netherland, the cost is controllable. But the operation formerly handled by public services are gradually transfered to private insurance companies in 2008. In the fierce competition in the market, the insurance companies improve further efficiency and reduce handling cost to gain more profit.

The insurance companies sign the service contract with medical care organization. To estimate the level of cost, the insurance companies established a Ex-ante budget model for the supplier of medical services: The fixed expenses for hospital treatment, the flexible expenses of treatments from hospitals and doctors, treating cost for mental diseases, other costs. The parameters in the budget system of medical treatment expenditure: patient's age, gender, income level, region, etc, different disease different estimate. This budget model on base of a clear cost accounting system plays an important role in operation of private insurance companies. When final account is discrepant from budget, we will take a measure called Temporary ex-post compensations, that means in early year prepay the insurance companies the shortage and regulate at end of year.

Achmea insurance company bears the social medical care operations in Netherland by the financial group Eureko who has mainly insurance business. During the reform, Achemea merged with another insurance company, who possess 26.2% market share in Netherland and has 25,000 staffs serving 470,000 insured persons, on the average 1300 insured by a staff.

### **3. Consolidate the powerful supervisor administrations**

Establish a public and transparent architecture for supervisor administrations which is made up of two parts: one part is driven by the patients (choose medical facilities based on the information); the other part is supervisor administrations (supervise the market and bolster the

development of this industry). It is primarily responsible for the medicine market, the privilege of participants, providing service, the enforcement of health and insurance bill, the efficiency of related administrations.

In Oct 2006, NZa, Dutch Health Care Authority was established. This administration belongs to the Department of Health, Benefit and Sports, and is responsible for make related laws which are used for supervise the medical service providers and the operation of health insurance companies. It evaluates the medical service providers and health insurance companies and makes the grade and credit level public on Web periodically. Besides, it also has hot lines and dedicated reception room for incoming visits. The primary penalties include: Administrative warning and adjustment in a fixed time, financial charge on those who failed to accomplish adjustment before deadline (based on severity, at most 10M euro fine can be enforced), notify those companies which failed to finish adjustment before deadline to the newspaper, websites and other media.

Coordinate with other administrations, establish effective supervision system. Dutch CenTral Bank, DNB is responsible for the financial operation of the insurance companies, Inspective Voor De Gezondheidszorg, IGZ is responsible for supervise the quality of medical service.

[Dutch Data Protection Authority](#), CBP is responsible for securing the personal information of patients,

National Medical Association, NMa is responsible for regulate the competition of medicine market

and avoid malicious occupation among medical facilities.

## Germany

Since 1883, statutory health insurance has been one of the most important parts in Germany, and has closely related with the other social insurances such as the retirement insurance.

### 1. General situation of social security

Germany is the 1st country which implemented social insurance by legislation. In 1883, Disease Insurance Law was promulgated, and statutory health insurance was carried out. In 1884, Accident Insurance Law was promulgated, and statutory accident insurance was carried out. In 1889, the elder and handicapped social insurance Law was promulgated, the retirement insurance was carried out. Unemployment insurance and long-care insurance were implemented in 1927 and 1994, respectively. During the development of many years, more perfect system on social insurance has been formed, including all kinds of risks in the lifetime.

Nowadays, the contribution rates of social insurances in Germany are as followed: 20.3% of retirement insurance, 13.4% of health insurance, 6.5% of unemployment insurance, 1.7% of care insurance and 1.47% of accident insurance. The total contribution rate of social insurance is 43.37%. The premium of accident insurance is paid totally by employer, and those of other social insurances are co-paid by the employer and employee in proportion. According to the contribution rates of every

insurance and the proportion set by the government, employers work out the premium of medical, retirement and unemployment insurance which should be paid in last month before the 15th of every month. Then, the employers will remit the premium and list to the administration institutes of health insurance which employees belong to, and which will remit the contribution to institutes of retirement and unemployment insurance within the next day at latest.

In Germany, statutory social health insurance is the major source of health financing.

Statutory accident, retirement and long-term care insurance have a certain proportion of health financing (see Table 1). The fare on in-patient recovery therapy (provided by health institutes of pension) of the insured should be come from pension. Dr Robers introduced, who work in the Recovery Hospital of Bartgingchen, the purpose that the pension insurance provided in-patient recovery therapy to the insured is to avoid some people end their careers early and just depend on the pension because of the diseases and handicaps. That is to say, we should maintain the working capability of the insured and prolong the time length of contribution as long as possible. Because retirement fund not only pay the pension, but also pay the fare on in-patient healing therapy of the insured and statutory contribution of the retirees (the premium of retiree and unemployed men belong to employer portion is now paid by the retirement fund and federal employment institutes). The number of expenditure was high. The federal government provided huge subsidy to the old age

pension insurance yearly (77.9 billion EU-dollars), in order to maintain the current pension system.

Nowadays, 1/3 of pension is from federal subsidy in Germany. In 2005, Ecology Tax, as a new tax,

was designed specially in order to recuperate the gap. The officer who is responsible for social

insurance in Bartgingchen said, social insurance in German are faced in many problems, such as the

more difficult collection of financing and the higher pressure of the aging. The need of the population

on the social insurance is more and higher. Therefore, it can be said that the golden time of social

insurance in Germany has gone, and for the future it is very hard to keep the high welfare.

**Table 1. Main sources of health finance in Germany, 1992-2002**

|                                    | 1992        | 1994        | 1996        | 1998        | 1999        | 2000        | 2001        | 2002        |
|------------------------------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|-------------|
| <b>Public sources</b>              | <b>77.7</b> | <b>77.0</b> | <b>77.2</b> | <b>75.3</b> | <b>74.8</b> | <b>75.5</b> | <b>74.9</b> | <b>75.2</b> |
| taxes                              | 13.0        | 59.7        | 10.8        | 8.1         | 8.0         | 7.9         | 7.8         | 7.8         |
| Statutory health insurance         | 60.7        | 2.4         | 57.4        | 56.7        | 56.8        | 56.9        | 57.0        | 56.9        |
| Statutory retirement insurance     | 2.3         | 1.7         | 2.4         | 1.7         | 1.7         | 1.8         | 1.8         | 1.7         |
| Statutory accident insurance       | 1.8         | 1.9         | 1.7         | 1.7         | 1.8         | 1.7         | 1.7         | 1.7         |
| Statutory long-term care insurance | n.a.        | n.a.        | 4.9         | 7.0         | 7.1         | 7.2         | 7.0         | 7.0         |
| <b>Private sources</b>             | <b>22.3</b> | <b>23.0</b> | <b>22.8</b> | <b>24.7</b> | <b>25.2</b> | <b>24.5</b> | <b>25.1</b> | <b>24.7</b> |
| Out-of-pocket payments             | 20.7        | 11.1        | 11.3        | 12.6        | 12.3        | 12.2        | 12.3        | 12.2        |
| Private insurance                  | 7.3         | 7.6         | 7.3         | 7.8         | 8.3         | 8.2         | 8.2         | 8.4         |
| Employer                           | 4.3         | 4.3         | 4.2         | 4.2         | 4.1         | 4.1         | 4.1         | 4.1         |

Source: Federal Statistical Office 2004

## 2. Statutory Medial Insurance

since 1883, German has been carried out statutory health insurance. The main framework hasn't

changed and kept the policy continuity well in despite of several adjustments.

## 1) Coverage Population

Through the development of 120 years, the coverage of statutory health insurance was gradually extended from some specific occupational workers to almost of the whole population. The proportion of premium paid by employee is from  $\frac{2}{3}$  down to  $\frac{1}{2}$ , and which paid by employer is from  $\frac{1}{3}$  up to  $\frac{1}{2}$ . In 2003, the number of statutory health insurance was 88% of the population (about 78% was insured compulsorily, and 10% was insured voluntarily). Among the people without statutory health insurance, 10% is involved in private health insurance, 2% is involved in special health insurances about the army men or policemen. About 0.2% (about 170 thousands) didn't been covered by any insurance system.

Currently, the statutory health insured in Germany are divided into three categories:

- Compulsory insured. It is a mandatory obligation to participate in statutory health insurance for them, and each part can't be free from this obligation through oral or written promise. It includes: the employees whose premium is below a certain amount (75% of the statutory health pension base ceiling) before they pay all fees, and the number is about 45,900 mark in 2003; students in the state university; Persons receiving skill training; pensioners; artists and freelancers; the handicappeds who work in the permission place or receive occupational training; unemployed people with the benefits from Federal Employment Services;

Agriculture-forest owners and the family members (over 15-year-old).

- Voluntary insured. Law allow some persons who has income may free from statutory health insurance, whose premium is higher than statutory health pension base ceiling in the last year and who participated in special health system, such as the army men, civil servants, judges and clergies. They may take part in statutory health insurance voluntarily in some condition.

For example, the employees whose statutory insurance were terminated because their income were more than the premium base ceiling but over some time length of taking part in statutory health insurance; The employees whose first income exceed statutory health premium base ceiling but apply for statutory health insurance in three monthes; Handicapped severely.

- Related insured. They are the spouses and children of the compulsory insured. Law allow they are free from the health premium and enjoy the same privilege as the compulsory insured. The qualifications of the related insured are the family income less than 630 marks, and children under certain level and spouse don't participate in own medical insurance.

## **2) Benefits**

Although statutory health insurance provide many kinds of benefits, but it is not contain anything. Otherwise, it would not operate well. The benefits of statutory health insurance include:

- health promotion and early detection of certain diseases. Woman from 20-year-old and man from 45-year-old have a cancer screening annually. Adults from 35-year-old have a physical examination once a year;
  - dental care;
  - vaccination: The vaccination must be allowed by the Committee and health insurance fund, except of the vaccination because of go abroad;
  - rectification dental care only for under the age of 18;
  - ambulatory and dental treatment, the insured have free choice of physicians, only who qualify in health insurance.
  - Drugs, dressings and complementary treatment equipment, such as hearing aids and wheelchairs;
  - necessary dentures and crowns;
  - inpatient treatment;
  - necessary prevention and rehabilitation costs;
  - sickness benefit: when the insured are in sick leave, the employer will continue to pay for six weeks and health insurance fund pay after six weeks. The number is 70% of the salary before-premium, but under 90% after-premium. The time length is at most 78 weeks.
- Agriculture health insurance pay the sickness salary for seasonal insured farmers and pay

subsistence to insured farmers.

- The subsidies to the insured neglect works because of taking care of sick children under 12-year-old. There are two premise: the medical certificate and the proof of nobody take care of children. The time length is one year and ten days at most. If the insured is a single father (mother), it is one year and twenty days at most. If the insured has several children, it is 1 year and 25 days, and 1 year and 50 days for a single father (mother).
- domestic helpers. If the insured can't do homeworks and take care of children under 12-year-old or the disabled children over 12, health insurance fund will provide domestic services for them.
- home care;
- provide perinatal care for post partum women;
- sociality therapy. Organized the depression insured to participate in various social activities to prevent them from illness.
- Provide medical services and maternity benefits for women during pregnancy and post partum. Insured women can enjoy 12 weeks of maternity benefits (both prenatal and post-natal have six weeks, which is the statutory maternity leave); Multiple-baby or premature birth delivery can enjoy 12 weeks longer post partum time. The amount of the allowance to

the insured depends on the average salary of last three months or 13 weeks before the treatment. The maximum payment of medical insurance fund is about 25 marks per day, and the difference between after-tax salaries and 25 marks was paid by employers.

- funeral subsidies. Limited to the insured who participated before January 1, 1989.

### **3) Co-payment and corresponding exemption mechanisms**

To encourage the insured build up cost awareness and reduce the medical waste,

*Health Insurance Law* stipulates that the insured should pay the part of health cost, including:

- expenses of prescription drugs. The costs changes with the total expenditure, 8, 9 or 10 marks, respectively. The expense was paid by themselves if the drug cost is less than 8 marks.
- expenses of wound dressing materials. Each prescription is about eight marks. If the materials cost less than 8 marks. The expense was paid by themselves if the costs is less than 8 marks.
- 15% of other treatment expenses;
- 20% of other supplementary medical material expenses;
- expenses of inpatient rehabilitation therapy, outpatient rehabilitation therapy and hospital care. It cost about 17 marks a day in the former West Germany, and about 14 marks a day in the former East German, all above were limited to the first 14 therapy days every year.
- dental expenses. the percentage of co-payment in routine preventive treatment is about 35 ~ 40%, and in other treatment is about 50%.

- transport fares. About 25 marks each time.

The law provides personal responsibility for the co-payment, and gives full consideration to the economic capacity of individual at the same time . It allows corresponding exemption situations. The following three categories of people may apply for exemption to co-payment, except of adult inpatient care:

- The following benefits recipients:

--social assistance rated by the Federal Social Assistance Act;

--the benefits rated by the Federal Relief Act of war victims;

--unemployment allowance rated by the Social Act III;

--educational assistance rated by the Federal Education Aid Bill;

-- welfare provided by Federal employment service agencies to promote the personal

professional skills and enhance employment opportunities and career development of handicapped;

- people who pay the rent from the help of social assistance agencies or war victims salvation agencies;

the insurant whose month income is below certain standard before family payment . In the former West Germany, the standard of the single person is 1,792 marks, married person is about 2,464 marks and if the family adding one person, such as children, the standards will rise 448 marks in

2000. In the former East Germany, the standard is 1456, 2002 and 364 marks, respectively. It changes with the wages level. The household income means the total income of couples and their children. It will exclude the income of children over 18-year-old. The income of other people living together didn't been included.

If the insurant don't meet the exemption criteria of the co-payment, but can't afford for medical expense, they may apply for part-exemption. The regulation require the applicants' family month income before paying for the premium is under a certain standard. In 2000, the standard of the single person is 1,792 marks in the former West Germany, and for married persons, the first family member (husband or wife) will increased 672 marks, and other family members (such as children) ,each one will increased 448 marks. In former East Germany, the standard of the single person is 1,456 marks in the former West Germany, for married persons, the first family member (husband or wife) will increased 546 marks, and other family members (such as children), each one will increased 364 marks.

The item of part-exemptions include: the co-payment part of prescription drug, wound dressing materials and other treatment costs; the co-payment part of transport fares .

#### **4) Managment**

The managment system of Germany's statutory health insurance is based on separation of the

government from management authorities. The government is responsible for administration, major work is the formulation of policies and supervision. The Federal Ministry of Health is responsible for the health insurance legislation, legal consultation and reform measures. They also supervise the operation of health insurance. Federal Social Insurance Bureau is responsible for about 180 federal attached disease funds and private health insurance companies. The mainly supervisions are: verify and ratify the establishment of disease funds and private health insurance companies; audit the organizational charter and service contracts of disease funds; audit the adjustments of premium and annual financial Budget accounts of the disease funds; check the reserves, real estate investments of disease fund. In addition to the administrative supervision, Germany also set up an independent judicial supervision system, there is a special court in charge of hearing the statutory health insurance related-cases.

Statutory health insurance is handled by the Disease Funds. There are 17 regional health insurance funds (AOK), 42 sectors health insurance funds (IKK), 359 enterprises health insurance funds (BKK), a seafarers health insurance fund, 20 agricultural health insurance funds, a federal mining industry health insurance fund and 13 mutual-insurance funds. All of these funds are organized in the form of laws. These institutions practice with self-management, self-support and self-financing. They have a national management system from up to down. The expense of the operational

institution was extracted from the Fund, generally less than 15% of the total funding.

## 5) Reform and trend since the 1990s

### (1) Increasing the government's input

The federal government: The federal government pays the part of the statutory health insurance which is paid by the employer for arts and students. Since 2004, the federal budget has earmarked a sum special fund for the disease fund and family policy-related benefits, including fertility treatment, parents' sick leave wages to care for sick children, in vitro fertilization, sterilization and contraception (20-year-old former) expenses. In 2005, Germany has raised tobacco tax to one euro per pack for the statutory health insurance.

Local government: Since 2004, social welfare recipients who have no insurance and immigrants who seek political refuge were asked to participate in the statutory health insurance. They are free to choose sickness fund. Those people are free of charge and enjoy the same treatment with other insurant; the actual cost of their medical expense is paid to the corresponding sickness fund by the local government.

### (2) Increasing employees' payment responsibility

At the beginning of implementation of the statutory health insurance, the German fee-sharing ratio is 1/3 for employers and 2/3 for employees. In 1949, this proportion changed into 50% for

employers and employees respectively, and continued until 2004. From June 2005, dental cost in the statutory health insurance carry out an overall planning, the co-rate is 0.9% which is paid entirely by the employees, at the same time, the current rate reduced by 0.9%. This means that employees will assume more responsibility for the toll, that is to say employees will assume 54% responsibility for the payment, and the employers' responsibility fell to 46%.

### (3) The establishment of Risk Structure Compensation Mechanism

Because the differences of insurant's age, sex, health status, income and the number of related participants, the different sickness funds have different revenue and expend. In order to balance the burden and ensure fair competition, Germany introduced a risk structure compensation scheme in 2004, the scheme regulate that every sickness fund should turn in a certain percentage of revenue(13.5% in 2004) to the Federal Social Insurance Board, and this part of revenue was regulated by the Federal Social Insurance Board. High-risk sickness funds were compensated mainly through comparing the number of insured, insured status, fund's revenue and medical expenses, and so on. What should stress is that no all expenditure of sickness funds is in the regulative scope of RSC, RSC only considers the expenses of nationwide statutory health insurance benefits, but take no account of the management expenses and additional treatment expenses of each sickness fund. To avoid crowding-out effect, sickness fund was encouraged to provide the necessary treatment for patients

with chronic diseases. In 2001, Germany amended the RSC which point out clearly that the RSC will be 'morbidity orientation' since 2007.

(4) Expand the insured's free choice right of sickness funds

Before the publication of *Medical Care Organizations Law* in 1993, the majority insured of statutory health insurance have no right to choose sickness fund, their participations in sickness fund were decided by their work locations and their work attributes. Because there were difference income and disease risk between people with different work, such mandatory distribution of insured led to big discrepancy between the difference sickness funds. At the beginning, only the white-collar who are voluntary insured have the right to make choice among a limited number of sickness funds. In 1989, this crowd extended to voluntary insured blue-collar, then the mandatory insured white-collar and some mandatory insured blue-collar also have the right to choose sickness funds when they first participant in the insurance and replace their work. By the early 1990s, about 50% of the insured persons have at least part of right to choose sickness fund. The

*Medical Care Organizations Law* which was promulgated in 1993 almost endows every insured the right to choose sickness fund freely and the right to replace the sickness fund (once a year, notice ahead three months). From 1996, all regional disease health benefits funds (AOK) and all alternative funds are fully open to the insured. Enterprises health benefits funds (BKK) and industry

health benefits funds (IKK) can maintain the closed state, but if they become opened funds, they should open to all insured. Only farmers and seafarer sickness funds remain the approach of assigning insured person. Since 2002, the insured can replace funds at any time, but the selected sickness fund should be covered at least 18 months (except the voluntary insured whose income exceeds the base ceiling of the statutory medical insurance).

## **(6) Problem and Argument**

In the past quite a long time, statutory health insurance expenditure proportion of GDP has been the focus of public attention in Germany. Since 1977, a series of cost-control measures have been taken. Now the growth of German statutory health insurance is roughly equal with the growth of GDP, but the sickness fund's revenue still can't balance with expenditure (table 2). From 2001 to 2003, the annual deficit of sickness funds is about 3 billion Euros. According to the law, sickness fund can't operate with deficit for a long time, therefore, for the past 25 years, statutory medical insurance's payment rate has been increasing, but the growth rate of statutory medical insurance still has been less than the growth rate of GDP and health expenditure. The reasons are as following: First, the German statutory health insurance is a type of occupational association, the fee revenue are closely related with employment rates, in recent years, the German unemployment rate remains high, and the payment rate of unemployed population is reduced to the half rate of employ population, which result in the

reduced fee revenue; Second, the statutory health insurance is based on the wage, but the proportion of salary income in the national income and the proportion of capital income increased year by year; Third, the salaried men, such as civil servants and self-employed persons, were not compulsorily brought into the category of statutory health insurance.

Table 2. Trends in financing statutory health insurance, 1992-2003 (unit: billion€)

|                          | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 |
|--------------------------|------|------|------|------|------|------|------|------|------|------|------|------|
| <b>Revenues</b>          | 103  | 114  | 119  | 120  | 124  | 126  | 128  | 131  | 134  | 136  | 140  | 141  |
| <b>Expenditures</b>      | 108  | 10   | 124  | 124  | 126  | 125  | 12   | 131  | 13   | 139  | 14   | 145  |
| <b>SALDO</b>             | -4.8 | 8    | -3.7 | -3.7 | -3.6 | 0.9  | 8    | 0.3  | 4    | -3.0 | 4    | -2.9 |
|                          |      | 5.3  |      |      |      |      | 0.3  |      | 0.0  |      | -    |      |
|                          |      |      |      |      |      |      |      |      | 2    |      | 3.   |      |
|                          |      |      |      |      |      |      |      |      |      |      | 1    |      |
| <b>expenditures</b>      |      |      |      |      |      |      |      |      |      |      |      |      |
| <b>-cash benefits</b>    | 9.6  | 9.3  | 8.7  | 11.1 | 9.4  | 9.7  | 9.3  | 9.3  | 9.4  | 9.9  | 10   | 8.5  |
| <b>-in-kind benefits</b> | 99.0 | 99.  | 109  | 113  | 117  | 116  | 11   | 122  | 12   | 129  | .3   | 136  |
| <b>As % of GDP</b>       | 6.1  | 2    | 6.2  | 6.3  | 6.4  | 6.2  | 8    | 6.2  | 4    | 6.2  | 13   | 6.4  |
|                          |      | 6.0  |      |      |      |      | 6.1  |      | 6.1  |      | 3    |      |
|                          |      |      |      |      |      |      |      |      |      |      | 6.   |      |
|                          |      |      |      |      |      |      |      |      |      |      | 3    |      |
| <b>Average</b>           | 12.7 | 13.2 | 13.2 | 13.2 | 13.5 | 13.6 | 13.6 | 13.6 | 13.6 | 13.5 | 14.0 | 14.3 |
| <b>contribute rate%</b>  |      |      |      |      |      |      |      |      |      |      |      |      |

Source: Federal Ministry of Health 2004.

Since 2003, the emphasis of German's statutory health insurance was transferred from expenditure to revenue, how to establish a stable, sustainable financing mechanism has become the focus of social discussion. The basic consensus now is that the high toll rate will add the burden on enterprises, impact Germany's international competitiveness, and proceed to affect Germany's long-

term development, so it should not through increasing the toll rate to solve the financing problem. As for how to do there are mainly three view now. The ruling party believed that it should expend the coverage to universal on the basis of the existing payment mode, raise the payment base ceiling of the statutory health insurance to the level of base ceiling of the statutory retirement insurance, expand payment base's calculation caliber, and bring added income into payment base, such as rent and interest. Democratic Christian Union considered that it is necessary to introduce a financing mode similar to Switzerland and change employers' payment to tax. All adults should pay health insurance on per capita, everyone pay 200 euros per month regardless of how much the income. The payment of low-income groups was subsidized by the government; The Liberal Democrats are even more radical, they believe that medical insurance should be completely privatized. They also required that the statutory health insurance should be cancelled, and transfer the all existing statutory health insurance to private health insurance for management. Several parties stuck to their own argument and has not reached consensus until now, but the ruling party's scheme get the run upon.

## **The Health Insurance Policy and the Implement of the patients across countries in EU**

The EHIC program formally started from 2004.1.1. By means of legalization and accountancy,

the patients under the health insurance can take medical treatment across various countries in EU economic region and Switzerland. There are four basic rules based on the act: equality of treatment, applicable legislation, aggregation of initial waiting periods, export of insurance payments.

The EHIC has a standard design, just like the EU dollars and the European car license, and at the same time allow each country to personalize their EHIC. The front of the cards are exactly the same, with the patient's name, sex, birth date, card number and the EU sign, etc.. Different countries make their own design on the back of the card. Till now, the EHIC are not intelligent cards, but the standard cards. However, the intelligent EHIC cards will be developed, where the patient's information are stored in the chip.

Meditation across different countries cannot be eventually solved by apply the standardized health insurance cards. It must rely on different factors, such as the development of region economic, the development and planning of medicine market, and the medicine economics, ect. While we are considering applying the unified HIC, we must admit that there is a solid base for EU to apply the HIC. First of all, the members of EU have a balanced development in economics. Secondly, they have a high-standard unified E European Health Care Policy, including the publish of new medicine, the application of new medical technology and the regulation of clinical treatment are more standardized.

Besides the hygiene policy, the health insurance fee, and the standard salary, the other important aspect is to reasonably regulate the cross country flow of the patients. EHIC has a strict auditing policy to regulate the flow of patients. The cross country treatment is classified into planned treatment and unforeseen treatment. When a patient is going to another country for planned treatment, he has to apply to EHIC department in his own country and apply the information such as the destination country, and the stay duration. Based on the submission materials, the local EHIC department will in turn decide whether the application can be approved or not. Specifically, for the planned hospitalization treatment, it is stricter and will not be approved in most cases. But for planned clinical treatment, it is usually more relaxed. For the patients who are in the other country and have to undergo an unforeseen treatment, they can provide their EHIC and can enjoy the same health insurance as the local residents. The deal will be settled between the patients' country and the country where he undergoes the treatment.

During the application of EHIC project in China, we shall gradually complete the policy and related management. In future, we may apply similar adjustment mechanism of insurance fund in Netherland in order to remedy the unexpected risk due to the cross country health insurance policy. The EU is an international organization that combines regional economics and unified politics; it possesses and surpasses the characteristic of country. Its groundbreaking multinational policy of

seeking medical treatment in foreign countries could be a good examples for us to follow.

## **Revelation and Consideration**

### **1. Hold the orientation of reform**

The reform of the health care system is of great complicated. Although there are differences in social, economic, historic and populational factors, the reform in different counties has experienced a similar way in order to improve the quality and accessibility of the medical service, and develop in a durative way. The Netherland government once paid much attention to the details and technical tache, while ignored the orientation of the reform, leading to an unsuccessful result. It is a long way, and need the definite aim, including short-term, mid-term and long-term.

### **(2) Build the system of risk adjustment fund**

After the reform of Holand, half of the insured amount is used to pay for the risk-balanced fund, the other half for the insured expend in name, which could reduce the finance risk carried by the difference of the gender, age, health status of the insurance applicant. The risk reduce program has not only narrowed the gap among the premium rate of different insurance funds. In the year of 1994, the premium rate of about 27% insurant was higher or lower than the average, and the fluctuated range was more than 1%; in the year of 1999, the rate was reduced to 7%. It reduce the differences between

the former east Germany and the former west Germany, unifying the obligatory insured and the ceiling rate and the co-payment by increasing funds to the former east Germany. In China, the situation is similar to Germany to some extent, such as the differences in premium rate, the rate of retirement and the funds risk of insurants, especially the big difference between the east and west. It is suggested that our country can introduce Netherlands risk-balance funds and Germany risk adjustment scheme, and establish health insurance risk adjustment mechanism which is suited to the situation of China. Every overall region turns in the funds according a fixed proportion of the overall funds, establishes central or provincial risk adjust fund and regulates on the basis of the needs.

### **(3) Consider all aspects during extending DRGs**

The government, health insurance institution and medical institutions have different attitudes to DRGs. The government and health insurance institution appraise DRGs highly, and think DRGs control the rise of the health care expense, rule the behavior of the health care institutions and doctors who have higher position in the field of health insurance and hold the power of setting the price in their own hands. By contrast, the doctor think that DRGs go adrift to the clinical treat. Doctors have to study the fussy system of DRGs, which become the barrier in their work. Meanwhile, the doctor seems to emphasize that the price standard of DRGs wouldn't offset the cost of the medical service. A surgeon in Charite, who come from the hospital of a medical college in Germany, bitterly attack the

DRGs in Germany, and suggested that China should take details and consider more perfect DRGs.

Now, the appeal to carry out DRGs is strong. Beijing and other region are trying. The visiting result showed that we should summarize experience and take the interest of all the related aspects into consideration when DRGs will be carried out in the countrywide.

#### **(4) Building gatekeeper system for medical service**

Holland introduces a gatekeeper system for medical service, which demands patients have to see general doctor first, and then go to hospital under approve of general doctor. The system was not carried out in Germany. However, a survey in 2004 showed that 80% of the statutory insurant would like to accept gatekeeper system and 17% would like to limit the scope of doctors in order to hold back the rising trend on payment. This change arose Germany's attention. The gatekeeper system is propitious to rationalize hospitalize behavior and reduce the waste of health resource. We should pay more attention to international trend in time during the course of developing health insurance policy, and reform measures according the situation of China. Considering the low level of community health service in our country, in addition, the basic medical insurance system for urban workers allows insurer to select many kinds of fixed medical institutions and it is hard to change in a short time, it is impossible to practice the gatekeeper system in a full-scale nowadays. It is suggest that we can attempt to establish first examination system in community start from some special programs and

special population in social medical almsgiving and basic health insurance for urban resident.

### **(5) Introducing competition mechanism Operating management**

Before the reform in 2006, in Netherlands, the health insurance of population income below 30,000€ was transacted by public health insurance institutions, and the rest over 30,000€ was handled by commercial insurance companies. After the reform, since January 1, 2006, all of the social health insurance in Netherlands was operated by commercial insurance companies; the original public health insurance agencies were either purchased by commercial insurance companies or become privatization. The government determined the framework and policy of social insurance, and the commercial insurance companies were responsible for administration. The introduction of competition mechanism in medical market reduced the handling cost, and improved operating efficiency. In Germany, the government was responsible for the administration of social health insurance all the time, mainly including policy-making and implementation of the supervision. The disease fund organized by numerous forms of public law, of self-support and self-financing was in charged of the special management. In recent years, whether in theory or practice, the social insurance market operation management has gradually come into fashion; China should pay more attention to this trend.

### **(6) Accelerating legislation and management by law**

The statutory health insurance development history in Netherlands and Germany told us that we should establish a benign operation mechanism, and accelerate the process of social insurance legislation. Health insurance involves many parties, and different parties have different interest. Only through legal measures, the parties can be standardized and unified acts. Among the insurance in Germany, the legislations about statutory insurance was the most. From financing to the management, from medical expenses to supervision, the operation of all aspects has a related legislation and certain responsibilities. It may reduce the dissensions. For the situations that were not mentioned to in the statutory provisions or having different understanding to the provisions, Germany has an independent Special Court in charge of inquisition. In China, the social insurance legislation lags behind. The premium collection relies on provisions, management of medical institutions depends on contracts, and there is not enough legal protection. With the expanding of health insurance coverage, the increasing of number of the insured and the improving of the management difficulties, it is necessary to accelerate the legislative process and ascertain responsibilities by law to ensure the smooth operation of the system.

## **Attachment**

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