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中国 - 欧盟社会保障合作项目

Selected EU Health Insurance Models – An Update on Health Care Policy

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Introduction and Methodology

- The EU today consists of 25 Member States with huge differences regarding the individual systems of health care .
- These will be grouped according to basic features describing basic characteristics, problems and methods of policy-making.

National Services of Health Care



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Countries: Britain, Ireland, Denmark, Sweden, Italy, Spain, Portugal, Greece, Finland, Malta, Cyprus

Idea: Equal access to medical care under State control. Financed largely through taxation. Service providers largely depending on State if not employed. No market influence or just pseudo-markets of internal nature . Public control and direction. Quasi omnipotent role of Government.



National Services of Health Care

Pros and Cons

- Relatively easy to direct
- Degree of generosity and efficiency variable
- May co-exist with official private market
- „Cheap“ by comparison or percentage of GDP spent on health care
- Masterminding a sometimes chaotic conflict of group interests
- Currently all such systems within the EU are under funded due to adverse spending preferences of Governments
- Long waiting lists for most medical specialties.
- Regional disparities
- No or extremely limited choices for patients

National Services of Health Care Access, Reimbursement, Planning and Cost Containment



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- Access by regional provision and disease-related diagnose. Generous investments by the Government have reduced, not solved the problems
- Methods are simple: centralised institutions define and limit patients' choices, options and perspectives. Policy-makers in search of new answers to structural problems. Better linking-up of public-health issues and ways to meet them. Regulating access to costly treatments and drugs. England is moving in a better direction, though with difficulties.

State Controlled National Insurance Schemes



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- ***Countries: Austria, France, Luxembourg***
- ***Idea: Universal access to health care based on compulsory social insurance with public institutions under decentralised Government control.***
- ***Private and public providers of services***
- ***High degree of patients' choice among contract based providers.***
- ***Relatively low market influence on pricing and service provision***

State Controlled National Insurance Schemes



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Pros and Cons

- Private providers and high choice for patients
- No or minimal waiting lists
- Quasi universal coverage
- Patient empowerment and participation
- Relatively expensive
- Consumer and provider driven
- Legally relatively complicated
- Danger of too much State leading to want
- No competition, even where socio-economically feasible

Social Insurance with Competing Insurers



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- **Countries:** Belgium and Germany
- **Idea:** *Even and accessible degree of coverage for all below a certain income. Voluntary insurance for others*
- **High degree of choice with different contribution rates and standard scope of legally defined benefits.**
- **State fixing general conditions. Details arranged between providers and insurers. Health funds under control of the insured and strictly not for profit. Socially acceptable employment of restricted market forces allowing broad degree of participation at market of health care.**

Social Insurance Models with Competing Providers



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Pros and Cons

- Very high degree of accessibility. No or just short waiting lists.
- High degree of choice and innovation for patients
- Socially feasible competition and high degree of regional equity
- A macro-economic job machine
- Very expensive and quite difficult to direct and to control.
- Tricky to change and open to lobbyists' activities.
- Exposed to demographic challenge
- Creating a demand-driven public attitude
- Profit-orientation whilst rendering care sometimes problematic

Privatised Insurers under Government Direction



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- ***Countries:*** Netherlands and Slovakia
- **Idea:** Stimulation of competition while upholding Government influence
(Netherlands) Largely unknown
(Slovakia) Perhaps eschewing responsibility for failures of the past.
Very recent type of system. Limited experiences and much opposition.

Privatised Insurers under Government Direction



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Pros and Cons

- Alleged advantages of stimulated competition
- Equal access to care based on Government legislation
- Policy-making sometimes very confusing and time consuming. Cost containment a mixture of control and market forces
- Effects remain to be seen (Netherlands)
- A downright failure in Slovakia yet replacing a system on paper with high degree of shadow economy
- Risk of two-layer medicine and social cleavages in quality of care



Methods of Cost Containment 1

- Definition: cost waving into private sector or genuine improvements of spending habits within a system of social insurance
- Methods on paper: strengthening planning efforts, avoiding waste of resources, restricting influence of providers working for personal gain. Rationing and rationalisation of diagnostics and therapies. Limiting offer and quantities of providers. Improving quality of care rendered.



Catalogues of Benefits 1

- On paper most essential medical care will be covered.
- Generally speaking, insurance systems with competition may be more generous (Germany) than National Health Services
- Tradition plays a strong role , e.g. spa-treatments in Germany or prenatal screening in Sweden or Denmark.



Catalogue of Benefits 2

- Universal coverage or minimum package?
- The medico-industrial complex and social payers
- Limiting choices and cost containment are discussed everywhere
- How much do we spend on what in health care?
- Planning and policy-analysis: new approaches by experts

Purchase and Procurement of Services



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- Differences between „State“-models and competitive insurance systems
- „Germany“ and contract –based purchase
- Britain and „in-house production“ of services
- Pros and cons of these different ways.



Quality Assurance of Care 1

- Quality is at the centre of policy making
- How to define „quality“ of care?
- The British approach: „NICE“ and guidelines
- The German approach: „IQWiG“ and non-binding suggestions to higher administrative institutions



Quality Assurance of Care 2

- How to define prices and how to direct limited funds in a social health care system?
- Is this service „now“ necessary, nice, superfluous or essential?
- What will be its effect for the cure of the patient?
- Is it done in a professional and serious fashion?

Participation at Medical Innovations



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- Questions for policy-makers everywhere:
- What is an innovation and why is this so?
- If we pay for this, do we have to cut expenses elsewhere and is this good or bad?
- Ways how to integrate money, quality of services rendered and outcome-based service provision



Actors of Health Care 1

- Doctors and health professionals
- Hospitals
- Patients
- Industry
- Government



Actors of Health Care 2

- Their role in different EU systems:
- Britain and the NHS(National Health Service)
- Germany and the corporate medical system
- Sweden and the regional State controlled service provision

Financing of Health Care Systems



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- Tax-financed State systems (e.g. Britain)
- Germany: contributions from employers and employees flanked by direct money from the State
- All systems are under funded and exposed to future difficulties

Reimbursement Practices and Incentives 1



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- State systems depend on public money
- Insurance based models are exposed to State pressure in order to remain „cheap“
- Insufficient systems in some East European countries have developed black markets for care

Reimbursement Practices and Incentives 2



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- „Fee for service“ – simple and dangerous
- Lump-sum payment based on budgets and limitations of expenses (Germany)
- Separation of service provision and individual economic interest (Sweden)
- Payer should be purchaser, so as to make a deal

Regional Stratification of Services



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- Few countries do not have differences between regions regarding health care
- Differences are acceptable, cleavages are a problem
- Planning of regional offer of care in Germany, France, Britain and Sweden



Cost Containment in Detail 1— at the Centre of Policy-Making

- Rising costs are a severe problem everywhere, more so in times of economic crisis
- In spite of the structural differences between European systems, many cost containment approaches are almost identical.
- CC is a science but needs political support

Cost Containment in Detail 2



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- ***The scientific approach:*** Government defines rules for cost driving elements of the health care market. Institutes – independent or depending on Government – provide scientific basis. Insurance models with more market try contracting and competition among providers.

Cost Containment in Detail 3



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- ***The brutal approach:*** create or tolerate bottlenecks to care and reduce patients' choices by waiting lists. Deflect public demand into private sphere which is mostly not looked at when talking about health care expenses. The ultimate stage is a black market for health care, common in most East European EU Member States.

Methods of Cost Containment 4

Scientific Institutions in Britain and Germany



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- ***NICE in Great Britain***
- ***Part of a Governmentally directed system. Furnishing guidelines binding to all actors. Instrument to reduce choices for all other actors. Flanked by massive waiting lists and quality problems.***
- ***IQWIG in Germany***
- ***Financed by independent social insurers. No direct control of system. Giving recommendations. Conflicting alternating Government preferences and interest of powerful lobbyists.***

Cost Containment Methods 6



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Main Results

- Health care available to all will be more expensive tomorrow than it is today. Innovation, scientific progress, improved demands and the demographic scenario of more people living longer are the main factors. The question is not how to pay less in the future but how to achieve much more with limited financial means. Market forces can be useful, if reigned in properly. The market for health care is provider-driven and the patient open to manipulation. Co-payments are used frequently, but have a chance only where non-life-threatening diseases.

Cost Containment in EU Systems



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Britain	Germany	France	Sweden
Regional Funds and control	Budgets and max. sector expenses	Central control by State	Regional financial responsibility
Central scientific support	contracting and competition	Restrictions of choice	In-house production of services
Better pay – more productivity	Co-payments	Co payments	co payments
Waiting lists	No waiting lists though some difficulties	Few waiting lists	Waiting lists
Active drug policies	Lenient drug policies	Lenient drug policies	Strict drug policies

Cost Containment Methods 7



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East European Member States

- Most East European Member States have a very weak social health care system. The changes from the old State system stopped somewhere under way. Sluggish, bureaucracies, underpaid staff, and helpless control by the State have stimulated huge shadow economies, private facilities for the wealthy and cross-border access in other EU countries. Backhanders are frequent and undermining legality.
- The issue is low on the political agenda. The public sector underpaid and thus of poor quality.

EU Policy Development and Influence on National Policy Making



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- The EU has no political mandate to interfere with the shaping of national system of social insurance.
- There is no real “EU-Social Model“ since the differences among Member States are extreme
- There is EU influence on national spending habits through the backdoor of budgets and stimulation of growth, as laid down in the Lisbon Strategy.
- There is huge indirect influence through the deregulation of national markets. Patients of the future will become consumers
- There is occasional, yet effective influence from the European Court of Justice

EU Systems of Health Care: Common Challenges and Problems



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- Rule of law in society and importance of social participation
- Welfare State important for social cohesion and collective prosperity
- Welfare State essentially important in times of economic constraints and problems
- Demographic challenge, the scientific progress and sustainability
- Limitations of the social system and protection against over-abuse
- How to find a balanced solution between market and social protection?



Summing Up 1

- Policy making is the art of letting a system work sufficiently well, even under economic strain
- Policy making is strategic and operational
- Policy making should have the full backing of those entrusted with legislation
- Policy making combines economics, medical demand, the necessities of the actors and lawmakers



Summing Up 2

- Policy making depends on the individual structure of the system. Thus copying experience may not work well.
- Harmonious exchange of reliable information is important.
- There is no „patent solution“ which will last for all times
- Limitations are nothing to be ashamed of.