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UNIVERSAL HEALTH COVERAGE II – Mandated Insurance: Austria and Germany

The first brief in this series introduced the concept of Universal Health Coverage, as defined by the World Health Organisation. It looked at how the NHI White Paper released late last year conceives of UHC, and posited that this ambitious single payer system should not be rushed into before other financing systems are considered. This brief describes the UHC systems in Austria and Germany.

In Austria and Germany, health insurance is part of the social security system. Both countries make use of an insurance mandate mechanism for health care financing. This is often referred to as the Bismarck model. [1] In this system, all employees and their dependents must have some form of insurance – be that public, private, or a combination of both.

However, there are differences between the two countries. For example, in Austria the insurer list is limited (in 2011 there were 19 funds) and one's choice is further restricted as each fund is tied to a specific employment sector. Conversely, in Germany there are 166 competing non-profit sickness funds to choose from, and one can change from one to another every year.

Who's covered?

Austria

All citizens that work must make social health insurance (SHI) contributions to one of 19 sickness funds. In 2011, 99.9% of the population had health insurance. [2] Roughly 80% were insured under the ASVG (General Social Security Act). This works by using regional SHI funds. All employees and the self-employed not covered by other funds, freelancers, apprentices and those claiming benefits or pensions are covered under the ASVG. Those residents who do not work – i.e. pensioners and dependents – are covered by tax-financed federal budget contributions, also under ASVG.

Specialist laws based on specific employment cover the remaining 20%: for example, the GSVG for the self-employed; the BSVG for farmers; and the B-KUVG for civil servants. There is therefore no consumer choice

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regarding which fund one is allocated to – it is determined by either geographical or occupational criteria. There is therefore no competition between insurers.

Germany

In 2012, SHI covered 70 million people or 85% of population. [3] Since 2009, health insurance has been mandatory. Anyone earning less than €54 000 per annum (around 75% of the total population) is required to have SHI. This includes students, pensioners, and the unemployed.

Those earning above the threshold are not required to do so, and can choose to take out private health insurance (PHI). However around 75% of the high income group choose voluntarily to remain in the publicly financed scheme. In total, by 2012 approximately 11% of the total population (or 9 million) was entirely privately insured. [4]

Until 1996, German citizens had no choice as to which fund they were allocated. The system was restrictive and highly regulated – like Austria. Since 1996, however, Germans have been allowed to switch between the 166 sickness funds. Although privately operated and competitive, the funds are non-profit and obliged to accept everyone that applies for membership regardless of risk. This prevents them from 'creaming' and helps pool risk equally.

What's covered?

Austria

The relevant insurance legislation provides for cover in the event of illness, pregnancy and incapacity for work. Services covered are extensive: from primary health care and emergency treatment to most dental services, speech therapy, rehabilitation and long-term care for people with disabilities. The guiding principle is: "the provision of treatment must be sufficient and appropriate, but should not exceed what is necessary". [5]

In 2011, about 35% or 2.85 million of the population had some form of private health insurance. [6] Only a further 5% of that 2.85 million (approximately 150 000) had opted out of SHI altogether – this choice is only available to physicians, pharmacists, lawyers, architects, public accountants, veterinarians and notaries. The vast majority rather supplement their mandated insurance plans. Supplementary private insurance gives benefits

like shorter wait times, greater in hospital comfort, and the ability to choose one's physician.

Patients are required to make out-of-pocket payments (OOP) for services such as over the counter medicines, cosmetic procedures including orthodontics, and daily allowances for inpatient care. Private insurance can provide co-payment options for such services. Those who earn under a certain income threshold are exempted from OTC medicine and inpatient costs and subsidized by the government.

Germany

Private health insurance is split into two broad types of plan in Germany – full cover and supplementary/complementary. The 42 private health insurers currently operating provide both. The 9 million with full cover PHI fall into three main groups: civil servants, the self employed, and around 25% of those above the income threshold choose PHI over SHI. Since 2009, PHI plans have had to offer a basic tariff equivalent to that of the SHI – this was introduced to protect those who are excluded from SHI but may not have previously been able to purchase a comprehensive plan.

In 2012, about 25% of the population (23 million) took out some form of supplementary or complementary insurance. [7] The former gives benefits such as in hospital comforts, and the prerogative and ability to request that one's treatment is provided by, for example, the head of department. The latter covers co-payments for services not included on the SHI plan. Almost half (13.5 million) chose dental care tariffs.

Financing

Austria

On average, €30 – 33 billion are spent annually on health care. This equates to 11% of the country's GDP. In 2010, the split was 75/25 between public and private funding of total health expenditure. SHI covers around 50% of total health costs. The state, through taxation, covers around 22% of health costs and 80+% of long term care costs. Cost sharing and OOP payments contributed 18% each to both health and long term care costs respectively. PHI covers 5% of health care. NGO's and other companies paid for the remaining costs.

Both employer and employee, paying 50% each, make payments to the SHI funds. The amount one contributes is dependent on income, and is a direct deduction from salary. On the other hand, one's contribution is

independent of personal risk. Moreover, the funds are non-profit, and are obliged to accept every individual that applies.

As each fund's revenues come from either the specific region or employment sector that it serves, there is no formal attempt to affect transfers between plans – either in terms or revenue sources or health care needs. [8] Because of this, risk pools in Austria are extremely fragmented, which leads to substantial variations in contribution rates required from both employers and employees. This in turn negatively affects the efficiency and equality of service provision across the health care system.

Germany

Germany spent roughly €300 billion on health care in 2012. This equates to 11.4% of the country's GDP. In 2012, public sources accounted for 73% of total health expenditure. Of this, 57% was contributed by SHI. Retirement insurance (1.4%), insurance for occupational accidents and diseases (1.6%) and long-term care insurance (7.7%) contributed an additional 10.7% whilst the government accounted for 4.8%. [9] The remaining 27% was covered by private sources – both through insurance and out of pocket payments.

Both employer and employee, paying 50% each, make payments to the SHI funds. Federal law has set the contribution rate since 2011. The SHI funds themselves collect contributions directly from employers, and then transfer them to a central pool. The Federal Insurance Authority administers this pool, which then redistributes contributions back to the funds. The funds essentially operate on a pay as you go principle – i.e. they may not incur deficits or accumulate debts. [10]

As in Austria, contributions are risk-independent, and based solely on income from gainful employment. Similarly, funds are non-profit and accept all applicants. The fundamental difference is lies in the centralised pooling mechanism. Contributions are distributed according to a morbidity-based risk-adjustment scheme. Introduced in 2009, designed to improve efficiency in resource allocation. Each fund receives a basic flat rate per insured person of the amount of the average per capita expenditure. [11] In addition, however, the funds also receive premiums based on age, sex and morbidity to adjust payments according to age. The mechanism also accounts for special health care needs for serious and chronic diseases.

Conclusion

The Austrian and German systems are both highly successful in providing UHC. The German system has two advantages over the Austrian one: it provides for risk pooling and it promotes efficiency through competition between SHI schemes.

The next brief in this series will look at and compare the two tier systems in place in Israel and the Netherlands.

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