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The End of the Welfare State – The View of the Health Insurance System

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25th March 2014, Nice, France
European Heart Rhythm Association Summit 2014

Agenda

1. Welfare State and Statutory Health Insurance (SHI)
2. Challenges Facing the Contributory Revenues for SHI
3. Challenges Facing The Expenditures of SHI
4. Focus: Structure and Efficiency of the Hospital Industry
5. Conclusions

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The AOK System – a SHI Institution

- More than 125 years of experience in health insurance
- Currently 11 independent regional AOK subsidiaries with more than 1,150 branch offices and 53,500 employees
- 24.3 mill. insurees = close to a third of the German population
- 65.8 bn. Euros of total financial volume of benefits (2012)
- The Federal Association of the AOK (AOK-Bundesverband) in Berlin is the political umbrella organization of the regional AOKs

Federal Association of the AOK – Function and Tasks

Strategic Tasks

→ Lobbying as well as development of policies and political strategy

→ Financial risk management for the internal settlement of the AOK group

→ Marketing for a universal and unified brand

→ Data warehouse, central data management

→ Support health programs, benefits, contracts with care providers

→ Financial management of risk structure compensation scheme

Welfare State and Social State –
Social Insurance for Social Security

Five pillars of social security	Funding of the social network
■ Statutory unemployment insurance ■ Statutory pension insurance ■ Statutory health insurance ■ Statutory long-term care insurance ■ Statutory accident insurance	Pay-as-you-go-funding

High Level of Care and Health Coverage in Germany

- Universal access to health insurance with generous coverage
- Strong solidarity principle regardless of financial means
- Life expectancy: 80.8 (+ 5.5 years since 1990; OECD average: 80.3)
- No waiting times for elective surgeries
- Nationwide provision of care and high level of personnel input:
  - → Hospital beds: 8.3 per 1,000 residents (OECD average: 5 beds)
  - → Doctors: 3.8 per 1,000 residents (OECD average: 3.2)
  - → Nurses: 11.4 per 1,000 residents (OECD average 8.8)

Source: Health at a Glance, OECD (2013)

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Pressure of Consolidation – Decreasing Number of SHI Funds

1223 1221 1152 960 642 554 482 455 420 396 355 324 280 267 257 242 221 202 169 156 146 134 132

1200
1000
800
600
400
200

1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

Source: National Association of SHI Funds (2014)

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Challenges for Contributory Revenues – Future Trends

- Demographic change:
  - → Less employed people and contributors
  - → Diminishing productive share of population
- Euro crisis:
  - → Decrasing wages in crisis countries
  - → Transfer payments by strong economic countries
- Debt limits:
  - → Federal state (2016: <0.35 of GDP)
  - → Regional states (2020)
- Political gifts after election 2013
- Possibility for financial aid for the health care system declines

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Contribution Rate* of SHI (1991–2060)

Beiträge (% der durchschn. beitragspflichtigen Einnahmen)

35%
30%
25%
20%
15%
10%
5%
0%

1990 1995 2000 2005 2010 2015 2020 2025 2030 2035 2040 2045 2050 2055 2060

Innovation: medical and technical progress

Demographic change

Compression „Costs of death“

Source: MoH; Projections: SIM.11 (Werding 2012).

* including additional contribution (average contribution by average income)

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Health Expenditure in Relation to GDP

Current | Capital

% of GDP

Country	% of GDP
United States	17.7
Netherlands	11.9
France	11.6
Germany	11.3
Canada	11.2
Switzerland[1]	11.0
Denmark	10.9
Austria	10.8
Belgium	10.5
New Zealand	10.3
Portugal	10.2
Japan[2]	9.6
Sweden	9.5
United Kingdom	9.4
OECD34	**9.3**
Spain	9.3
Norway	9.3
Italy	9.2
Greece	9.1
Iceland[1]	9.0
Finland	9.0
Australia[2]	8.9
Ireland	8.9
Brazil[1]	8.9
Slovenia	8.9
South Africa[1]	8.5
Slovak Rep.	7.9
Hungary	7.9
Israel[1]	7.7
Chile	7.5
Czech Rep.	7.5
Korea	7.4
Poland	6.9
Luxembourg	6.6
Russian Fed.[1]	6.2
Mexico[1,2]	6.2
Turkey[3]	6.1
Estonia	5.9
China[1]	5.2
India[1]	3.9
Indonesia[1]	2.7

1. Total expenditure only.
2. Data refers to 2010.
3. Data refers to 2008.

Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en; *WHO Global Health Expenditure Database.*

Trends for Expenditures – Increasing Demand and Rising Costs

- Aging population:
  - → One of the highest shares of the population over 80 years old
  - → This share is expected to triple in coming decades to reach 15% by 2050
- Considerable challenge in maintaining and preparing the long-term care system for this demographic change

Source: Health at a Glance, OECD (2013)

Rising Costs – Health Spending Has Risen Fastly

35,0
30,0
25,0
20,0
15,0
10,0
5,0
0,0
-5,0

2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012

Health spending SHI

Nominal GDP

Nominal wages

Contributory revenues

Source: Balling (2014)

Financial Gap

Demand for health care ↑↑

Contributions (revenues) ↓

Financial gap

Rationing / Reduction of benefits	Rationalisation / efficiency	Higher charging	Cost coverage
„riot of the elderly“	Re(action) of health care providers	„riot of the young“	„riot of the young“

Source: according to Augurzky (2014)

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Hospital Spending in Selected European Countries*

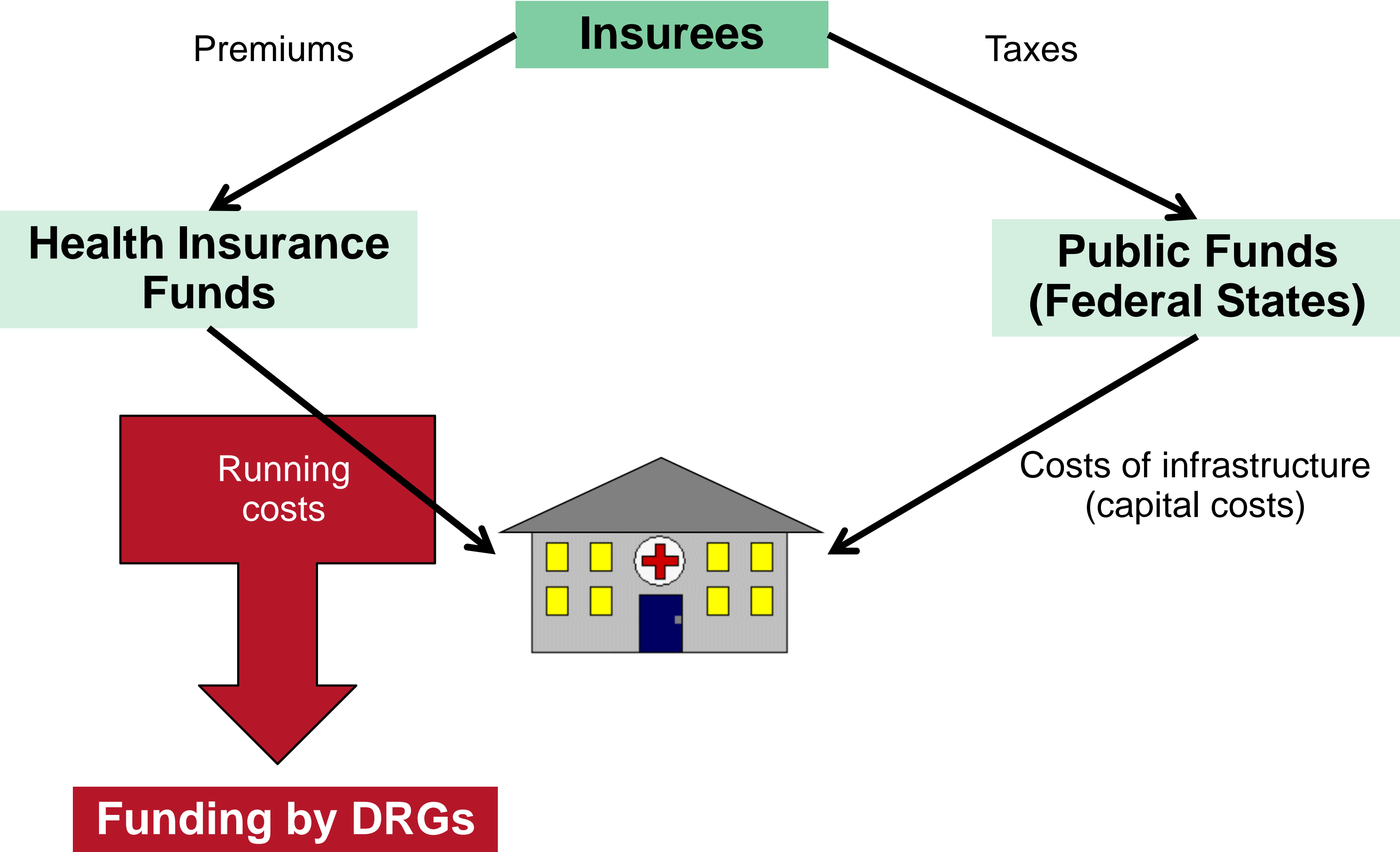
	Hospital spending as a % share of total current expenditure on health	Hospital spending per capita, US$, Purchasing Power Parity	Hospital payment scheme	DRG
Austria[a]	38.8	1393	Payment per case/DRG (47%)/retrospective reimbursement of costs (48%)	←
Belgium	31.2	1147	Payment per case (45%) + payment per procedure (41%) + payments for drugs (14%)	
Czech Republic	45.8	796	Prospective global budget (75%) + per case (15%) + per procedure (8%)	
Denmark[a]	46.2	1567	Prospective global budget (80%) + payment per case/DRG (20%)	←
Estonia	46.5	563	Case-based payment	
Finland	35.3	1010	Payment per case/DRG	←
France	35.0	1259	Payment per case/DRG	←
Germany	29.4	1061	Global budgets and payment per case/DRG	←
Hungary	33.1	463	Payment per case/DRG	←
Iceland	40.6	1363	Prospective global budget	
Luxembourg[c]	33.4	1322	Prospective global budget	
Netherlands	37.0	1378	Adjusted global budget (80%) + payment per case/DRG (20%)	←
Norway[b]	38.2	1613	Prospective global budget (60%) + payment per procedure (40%)	
Poland	34.5	391	Payment per case/DRG	←
Portugal[a]	37.5	796	Prospective global budget	
Slovakia	26.7	442	Payment per case/DRG	←
Slovenia	41.6	918	Global budgets and case-based payment	
Spain	39.8	1117	Line-item budget	
Sweden	46.9	1545	Payment per case/DRG (55%) + global budget	←
Switzerland[a]	35.1	1567	Payment per case/DRG (2/3 cantons) + global budget	←
United Kingdom	n/a	n/a	Payment per case/DRG (70%) + global budgets (30%)	←

Sources: OECD Health Data 2010; Paris V, Devaux M, Wei L. OECD Health Working Papers No. 50, *Health Systems Institutional Characteristics: A Survey of 29 OECD Countries*. Paris, 2010; Thomson S, Foubister T, Mossialos, E. *Financing Health Care in the European Union: Challenges and Policy Responses*, World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2009.

Notes: a = 2007 data, b = 2006 data, c = 2005 data, n/a = data not available

* 2008; source: Cylus/Irwin, Euro Observer, 3/2010

Dual Hospital Financing System



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Ratio of Regional State Funding of Capital Costs by Hospital Revenues Based on Hospital Expenditures by SHI / Private Health Insurance

11%
10%
9%
8%
7%
6%
5%
4%
3%

1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014

Effect of stimulus package II

Source: DKG: Bestandsaufnahme zur Krankenhausplanung und Investitionsfinanzierung in den Bundesländern, Berichtsjahr 2011
Statistisches Handbuch des AOK-Bundesverbandes

High Level of Activity Concerning Hospital Discharges

Per 1 000 population

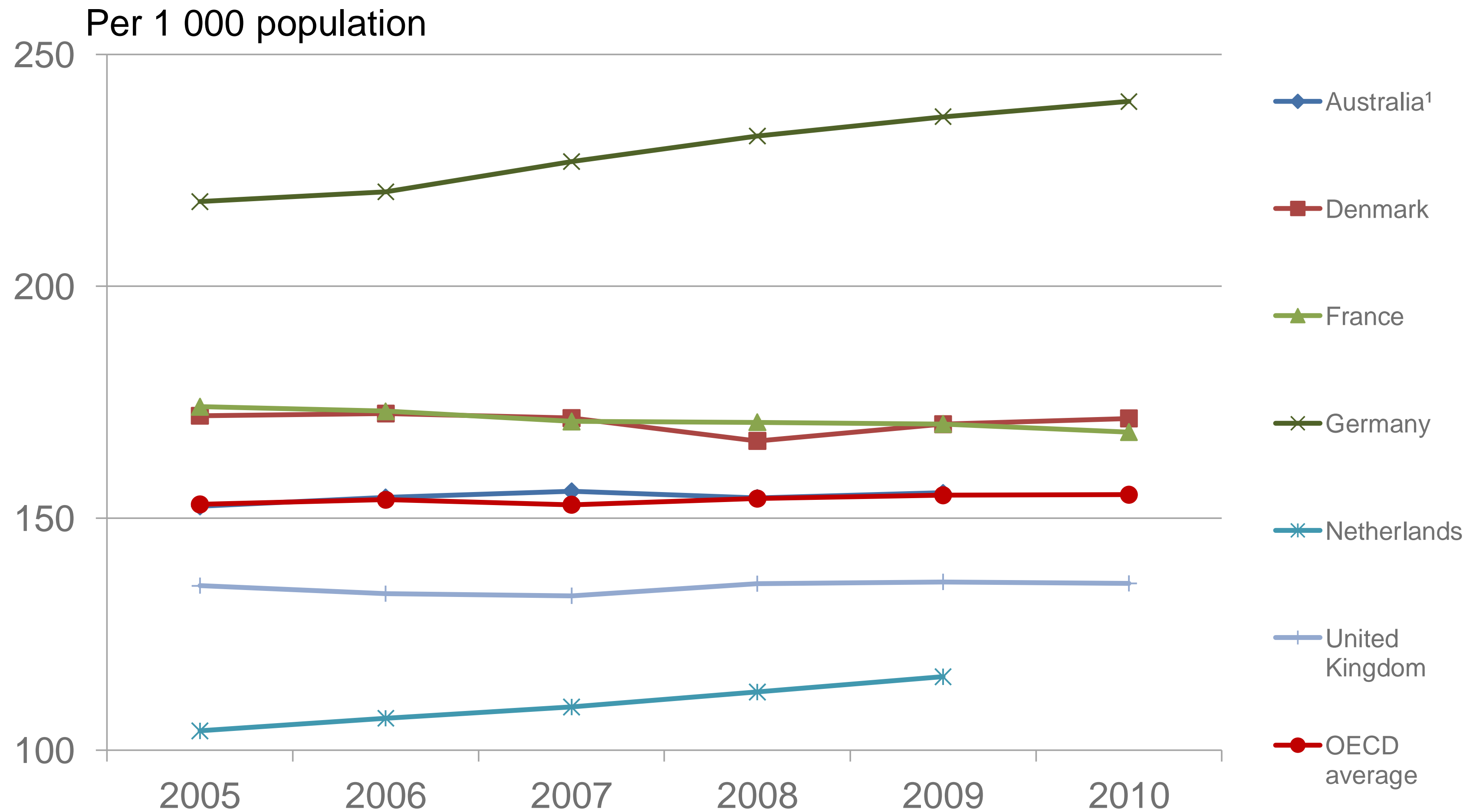
Country	Discharges
Austria[1]	273
Germany	244
Russian Fed.	219
Hungary	206
Czech Republic	202
Israel	198
Greece[1]	195
Slovak Republic[2]	184
Finland[1]	180
Norway	175
Slovenia	175
Estonia[1]	174
Denmark	172
Belgium	170
Switzerland	170
France	169
Sweden	163
Poland	161
Australia[1]	159
OECD34	**156**
Luxembourg[1]	154
Korea	147
New Zealand	147
Turkey[2]	142
Iceland	141
United Kingdom	136
Italy	129
Ireland[1]	129
United States[2]	125
Netherlands	122
Portugal	112
Japan	111
Spain[1]	104
Chile[1, 2]	95
Canada[1]	82
China	71
South Africa	61
Brazil	58
Mexico[1]	51

1. Excludes discharges of healthy babies born in hospital (between 3-10% of all discharges).

2. Includes same-day separations.

Source: OECD Health at a Glance 2013.

Strong Growth in Services Since DRG Introduction



1. *Excludes discharges of healthy babies born in hospitals (between 3-7% of all discharges)*

Source: OECD Health data 2012

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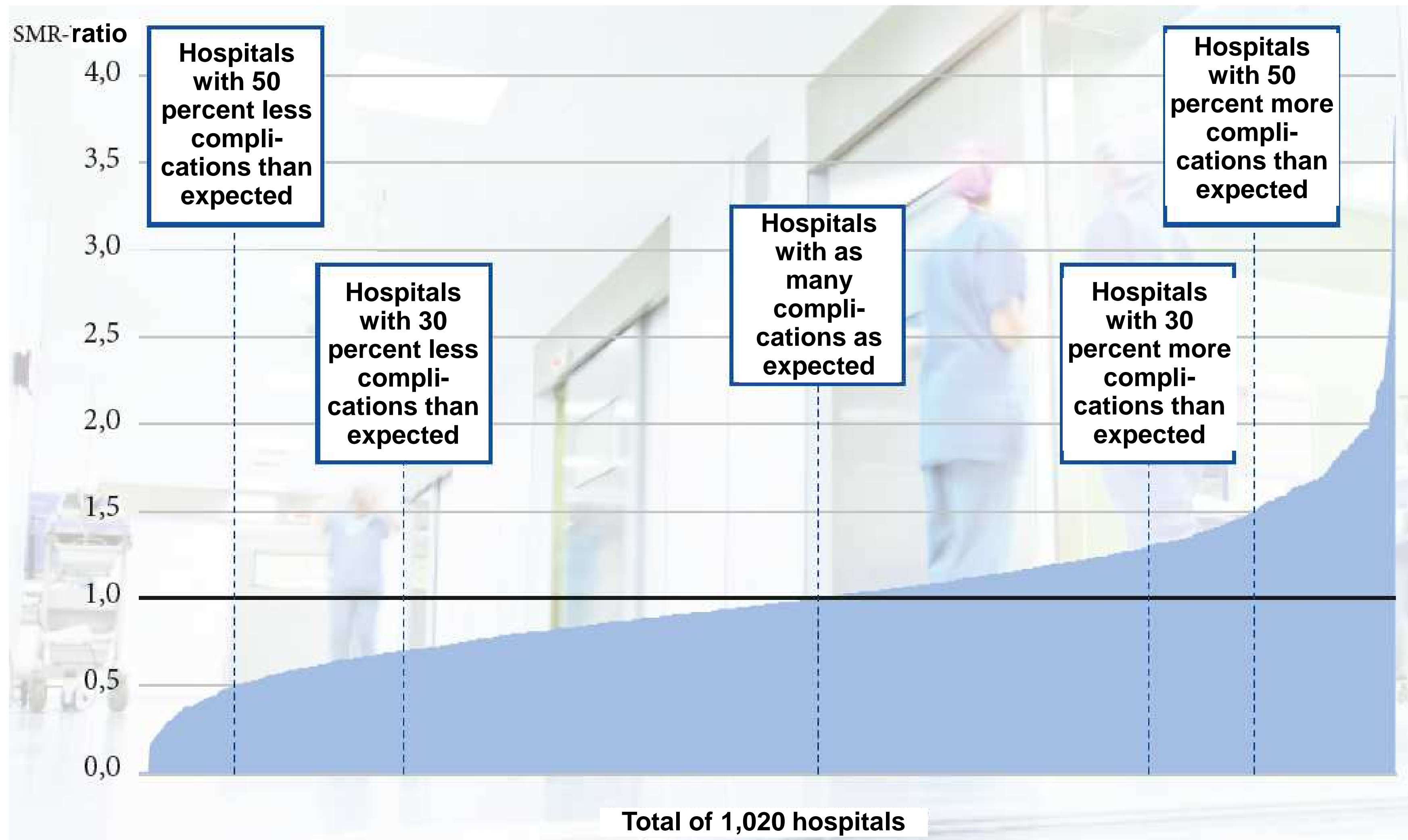
Quality Variations: e.g. Complications Cholecystectomy



Source: WIdO; AOK-Bundesverband (2014): www.blickpunkt-klinik.de

Challenges for the German Hospital Industry

- **High level of infrastructure**
  - → Excessive utilization of services with high rate of hospitalization
  - → Incompatibility of state hospital planning (provider oriented) and DRG funding (performance-oriented)
- **Competition with little focus on patient values**
  - → DRG funding based on volumes and severity instead of quality
  - → Collective contracting (all SHI need to contract with any hospital in the hospital plan)
- **Fragmentation of services across inpatient and outpatient care**
  - → Inadequate volume of patients
  - → Low level of outpatient care utilization

Source: according to Porter (2012)

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Challenges for the German Hospital Industry

- **Inconsistent quality**
  - → Large variation in quality across providers
  - → No systematic measurement of outcomes and costs and low efficiency
- **Reforms so far have focused on containing costs rather than improving value**
  - → Rising costs affect high level of care
  - → High level of hospitalization and variation of quality need to be reduced

Source: according to Porter (2012)

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Previous Actions Show Limitations

Ethically critical

Rationing, budgeting

Socially critical

Additional payments, rising contributions

Economically reasonable?

Federal grant, Rising contributions

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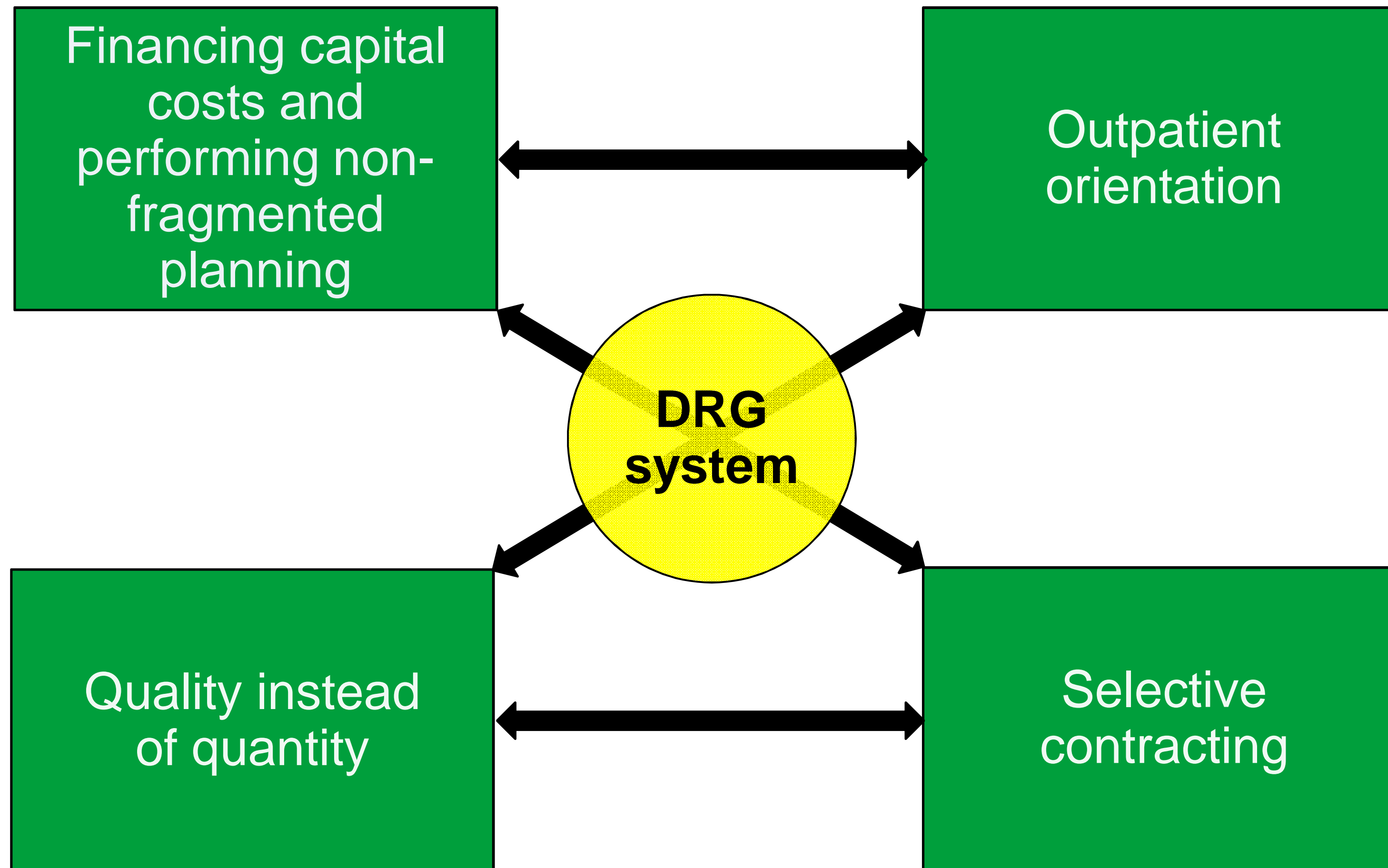
Challenges for the Hospital Industry



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Summary

- Statutory health insurance is an important pillar for securing both the welfare state and growth.
- Financing health insurance and health care will face big challenges that require actions for the contributory revenues and expenses.
- Increasing efficiency based on economization and mercantilization will become even more important due to the pressure on financing health care systems.
- The significance of quality will increase: from volume to value.

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Thank you
for your attention!

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