

Private Health Insurance in Germany: Consequences of a Dual System

Assurance-maladie privée en Allemagne :
conséquences d'un système à deux vitesses



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Abstract

A variety of financial and non-financial incentives has resulted in a considerable degree of adverse selection against social health insurance in Germany. Enrollees in private health insurance are healthier, have higher incomes and have fewer dependents than enrollees in social health insurance. Adverse selection decreases average premium income and at the same time increases average healthcare expenditures in social health insurance. As a consequence, financial sustainability of the public system declines. Moreover, financial incentives for healthcare providers have led to preferential treatment for privately insured patients in outpatient care. The dual health insurance system in Germany is therefore inequitable as well as inefficient, and cannot be considered a role model for post-*Chaoulli* Canada.

Résumé

Diverses mesures incitatives financières ont entraîné un haut niveau d'antisélection contre l'assurance-maladie publique en Allemagne. Les personnes qui se prévalent d'une assurance-maladie privée sont en meilleure santé, ont un revenu plus élevé et moins de personnes à charge que celles qui participent au système d'assurance-maladie public. L'antisélection fait baisser les recettes moyennes provenant des cotisations, tout en faisant augmenter les dépenses moyennes du système de santé public, compromettant ainsi la durabilité financière de ce dernier. De plus, les encouragements financiers offerts aux fournisseurs de services de santé ont mené à un traitement préférentiel des patients détenant une assurance privée dans les soins en clinique externe. Le système d'assurance-maladie à deux vitesses d'Allemagne est donc inéquitable et inefficace et ne peut être considéré comme un modèle valable pour l'ère post-Chaoulli au Canada.

IN POST-CHAULLI CANADA, THE DEMAND FOR INFORMATION ON THE CONSEQUENCES of private health insurance arrangements is high. In this paper I analyze the German experience with a dual (private and public) health insurance system. I conclude that this experience cannot be considered a role model for Canadian provinces.

Private health insurance serves three distinct functions. The first is as an *alternative* to social health insurance arrangements. In Germany, some people are permitted to choose between joining private health insurance and remaining in social health insurance. The second function is to *supplement* basic health insurance, providing coverage for services not covered by social insurance or to cover the financial risks of co-payments and co-insurance. A third function of private insurance is to provide what can be termed *complementary* or *double-cover* coverage, in which individuals purchase additional private insurance even while they have to participate in existing public schemes.

This terminology is not standardized. Sometimes the term “substitute private health insurance” is used instead of “alternative private health insurance” (Mossialos and Thomson 2004), and the term “complementary private health insurance” is sometimes used instead of “supplementary private health insurance” (Colombo and Tapay 2004). Double-cover private health insurance is rather rare in social health insurance countries. As a rule, budgetary constraints – especially with regard to capacity planning (number of physicians, number of hospitals, etc.) – are less severe in social health insurance countries than in tax-financed countries. If waiting times are not a severe problem, there is no demand for double-cover private health insurance. Double-cover private health insurance, however, would be allowed in Quebec after the Supreme Court of Canada’s decision in *Chaoulli*.

Although almost 90% of the population in Germany is covered by social health insurance, there is also a considerable market for alternative private health insurance

(Wasem et al. 2004). About 10% of the population has taken out alternative private health insurance as a substitute for social health insurance. In contrast, the market for supplementary health insurance, providing coverage for services not covered by social insurance or to cover the financial risks of co-payments and co-insurance, is less pronounced than in Canada. This is the consequence of a more comprehensive standardized benefits package in the German social health insurance schemes, which includes prescription drugs as well as long-term care. Moreover, there is no market for double-cover private health insurance in Germany (Greß 2005). If people are unsatisfied with the public system and they are eligible to opt out, they take out alternative private health insurance and leave the public system entirely. Obviously, the latter course is almost impossible in tax-financed Canadian medicare.

In this paper I will focus only on the duality of social health insurance and alternative private health insurance. The purpose in doing so is to illustrate the mechanisms and the consequences of private health insurance and to do some myth busting

about the alleged benefits of double-cover private health insurance in Canada. The next section describes the basic features of both systems (opting-out provisions, premium calculation, benefits and provider reimbursement). Then, I will present evidence of adverse selection against the public system,

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which is the consequence of financial and non-financial incentives. Thus, financial sustainability of the public system declines. Moreover, financial incentives for healthcare providers have resulted in preferential treatment for privately insured patients in outpatient care. In the final section, I will discuss the implications of the German experience with a dual health insurance system for Canadian provinces.

Basic Features of the Dual Health Insurance System

Social health insurance coverage in Germany is voluntary only for the self-employed and high-income employees (47,700 € per year or more). As a consequence, only these groups may opt out of social health insurance. In contrast, social health insurance is mandatory for most low- and middle-income employees, students, pensioners and recipients of unemployment benefits (Busse and Riesberg 2004). Whether or not individuals who are eligible to opt out of the public system actually do so is determined by financial and non-financial incentives.

Probably the most important difference between social health insurance and private health insurance is the method of premium calculation. Social health insurers in Germany charge premiums that are not related to individual health risk but to the income of the insured. Income-related premiums lead to income solidarity, which is equivalent to redistribution from the rich to the poor. More importantly, there is also risk solidarity – which is equivalent to redistribution from the healthy to the sick – as premiums do not depend on health status. Moreover, free coverage for non-working spouses and children of enrollees leads to solidarity between single persons and families, another dimension of redistribution.

In contrast, private health insurers charge risk-related premiums. Individuals pay a premium according to individual risk: people with high health risks (typically, the old, the sick and the chronically ill) pay high premiums; people with low health risks (typically, the young and healthy) pay low premiums. Private health insurance therefore achieves neither risk solidarity nor income solidarity. What is more, each family member must be insured separately in private health insurance, and women pay higher premiums than men, which is not the case in social health insurance. Table 1 illustrates the financial consequences for a single person and a hypothetical family.

TABLE 1. Illustration: premium calculation

	Social Health Insurance	Private Health Insurance
Man, 35 years, healthy, income p.a. 60,000 euros	506 €	230 €
Employer's contribution	237 €	115 €
Out-of-pocket premium (single)	269 €	115 €
Dependent 1: Woman, 35 years, healthy, no income	—	325 €
Dependent 2: Child, 5 years, healthy	—	130 €
Dependent 3: Child, 2 years, chronic condition	—	200 €
Employer's contribution	237 €	237 €
Out-of-pocket premium (family)	269 €	648 €

All sums per month. Employer's contribution in private health insurance is 50% per enrollee (including dependents). However, the maximum employer's contribution is 237 € per month. The chosen benefits package of private health insurance is roughly comparable to social health insurance (no supplementary benefits).

Source: Market Research

Table 1 shows clearly that the diverging methods of premium calculation determine the financial incentives for remaining in or opting out of the public system.

However, the decision of individuals to opt out of social health insurance is also determined by non-financial incentives: the range of benefits and provider reimbursement.

In social health insurance, benefits are standardized for all enrollees. Moreover, as in other countries, new technologies – including pharmaceuticals – increasingly are scrutinized by health technology assessment (Greß et al. 2005): new technologies with little or no incremental clinical effectiveness may be excluded from reimbursement in social health insurance. Since private health insurers do not apply health technology assessment, benefits in private health insurance are more comprehensive. As a consequence, enrollees with private health insurance probably gain higher benefits from new, and more expensive, prescription drugs than individuals in social health insurance (Ziegenhagen et al. 2004).

Except for a small minority, healthcare providers – outpatient as well as inpatient – treat patients from both health insurance systems. Thus, privately insured patients and social insurance patients will be treated in the same hospital and by the same general practitioner or specialist. The payment system in hospitals is identical

in both insurance systems.

In contrast, reimbursement for general practitioners and outpatient specialists depends on the insurance status of patients. Social health insurers as well as private health insurers pay general practitioners and specialists on a fee-for-service basis. However,

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private health insurers pay higher prices or tariffs than social health insurers do. More importantly, they do not impose volume restrictions on GPs as social health insurers do. This difference in payment systems creates tremendous incentives for preferential treatment of individuals with alternative private health insurance in the outpatient setting (Greß et al. 2006). Moreover, it also creates another non-financial incentive for individuals to opt out of the public system.

Adverse Selection and Preferential Treatment

It is hardly surprising that enrollees in alternative private health insurance have different characteristics than enrollees in social health insurance (see Table 2). First, they are healthier, which is due to the fact that bad health risks have no incentive to leave the public system. The average number of acute and chronic conditions is higher for enrollees with social health insurance. Moreover, the proportion of respondents with

a poor self-assessed health status is considerably higher in social health insurance (Kriwy and Mielck 2006; Mielck and Helmert 2006). Although benefits in private health insurance are more comprehensive than in social health insurance, consumption of healthcare services is lower (Leinert 2006b; Lungen et al. 2005). Second, average income is considerably higher for enrollees with private health insurance (Kriwy and Mielck 2006; Leinert 2006a). The reason for income differences is straightforward: only high-income employees are eligible to opt out of social health insurance. Income differences are somewhat moderated by the fact that the income ceiling does not apply to self-employed individuals.

TABLE 2. Income, morbidity and consumption of healthcare services of enrollees in social health insurance and private health insurance

Characteristics	Social Health Insurance	Private Health Insurance
Individual gross income (in euros per year, average)	22,658	38,109
Number of acute and chronic conditions (average)	3.52	2.89
Poor self-assessed health status (%)	17.9	9.1
Average number of hospital nights during last 12 months	2.21	2.05
Average number of physician visits during last 12 months	6.21	5.1
Share of respondents with continuous consumption of prescription drugs (%)	47.07	41.67

Source: Kriwy and Mielck 2006; Leinert 2006b.

The consequences of adverse selection against social health insurance are twofold. First, average premium income in social health insurance goes down because premiums are income dependent and high-income earners choose to opt out. This effect is exacerbated by the fact that individuals with dependents are likely to remain in the public system (Dräther 2006). Second, average healthcare expenditure in social health insurance goes up, since good risks are likely to opt out while bad risks remain in the public system. Thus, adverse selection against social health insurance puts considerable pressure on the sustainability of the public system. Moreover, the differences in outpatient care increasingly lead to preferential treatment of patients with private health insurance (Jacobs et al. 2006; Kassenärztliche Bundesvereinigung 2006). Although waiting times are rather short compared to waiting times in Canada (Sawicki 2005), inequitable conditions in the provision of outpatient healthcare increasingly become a matter of public concern (Herbert 2006).

Implications for Canada

Obviously, the function of private health insurance in Germany is different from what the Quebec Supreme Court had in mind in its *Chaoulli* decision (Flood 2006). In Germany, individuals stop paying social health insurance premiums when they take out alternative private health insurance. In contrast, individuals who take out double-cover private health insurance in Canada do not stop paying taxes. However, the consequences of the dual system in German health insurance are relevant for Canadian provinces – at least in order to bust some myths about the superiority of private health insurance in the European context (Flood and Lewis 2005).

First, proponents of double-cover private health insurance in Canada seem to assume that queue-jumping by the wealthy will lead to a situation that economists call Pareto efficiency: nobody will be worse off, but some will be better off. On first view, this analysis has some merit. In contrast to the German situation, individuals in

Canada are not able to opt out of the public medicare system – except if they move out of the country and stop paying taxes (in which case they will not need to consume healthcare in Canada). However, the supply of healthcare providers is limited, in Canada more so than in Germany. If this is the case, and treatment of private patients is financially

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more attractive than the treatment of patients in the public system – which is the only way for private health insurers to guarantee that their clients will indeed be able to jump the queues – private health insurance will drain capacities that are available to medicare patients. As a consequence, waiting times for those unable to take out private health insurance will increase. Although some (the wealthy and the healthy) definitely will be better off, others (the not so wealthy and not so healthy) will be worse off. Therefore, the consequences of private health insurance would not only be inequitable (a situation that might be acceptable from an economic point of view); they would also be inefficient.

Second, proponents of double-cover private health insurance in Canada also seem to assume that private health insurance will provide additional funding, and that this will relieve the fiscal pressure on provincial budgets. This certainly is an argument that is made by German private health insurers. They argue that higher reimbursement rates for outpatient physicians relieve the pressure on social health insurers' budg-

ets for outpatient care (Niehaus and Weber 2005). However, this argument hardly justifies financial incentives for preferential treatment in favour of privately insured patients (remember: the healthy and the wealthy) at the expense of those patients who are forced to remain in the public system (remember: the not so wealthy and not so healthy). Private health insurance might be an easy answer to the increasing difficulty of public systems to finance healthcare. However, it is not an adequate answer – either in Canada or in Germany.

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REFERENCES

- Busse, R. and A. Riesberg. 2004. *Health Care Systems in Transition: Germany*. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies.
- Colombo, F. and N. Tapay. 2004. *Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems*. Paris: OECD Health Working Paper No. 15.
- Dräther, H. 2006. "Zur Bedeutung der Familienversicherung." In K. Jacobs, J. Klauber and J. Leinert, eds., *Fairer Wettbewerb oder Risikoselektion? Analysen zur Gesetzlichen und Privaten Krankenversicherung* (pp. 49–65). Bonn: Wissenschaftliches Institut der AOK.
- Flood, C.M. 2006. "Chaoulli's Legacy for the Future of Canadian Health Care Policy." *Osgoode Hall Law Journal*. Retrieved October 4, 2007. <<http://ssrn.com/abstract=909262>>.
- Flood, C.M. and S. Lewis. 2005. "Courting Trouble: The Supreme Court's Embrace of Private Health Insurance. Use and Misuse of Social Science Evidence by the Supreme Court – How Should Canadian Governments Respond?" *Healthcare Policy* 1(1): 26–35.
- Greß, S. 2005. "The Role of Private Health Insurance in Social Health Insurance Countries: Implications for Canada." In C. Flood, K. Roach and L. Sossin, eds., *Access to Care – Access to Justice. The Legal Debate Over Private Health Insurance in Canada* (pp. 278–95). Toronto: University of Toronto Press.
- Greß, S., D. Delnoij and P. Groenewegen. 2006. "Managing Primary Care Behaviour through Payment Systems and Financial Incentives." In W. Boerma, A. Rico and R. Saltman, eds., *Primary Care in the Driver's Seat? Organizational Reform in European Primary Care* (pp. 184–200). London, UK: Open University Press.

- Greß, S., D. Niebuhr, H. Rothgang and J. Wasem. 2005. "Benefit Decisions in German Social Health Insurance." In T.S. Jost, ed., *Health Care Coverage Determinations: An International Comparative Study* (pp. 115–31). London, UK: Open University Press.
- Herbert, S. 2006. *Diagnose: Unbezahlbar. Aus der Praxis der Zweiklassenmedizin*. Köln: Kiepenheuer & Witsch.
- Jacobs, K., J. Klauber and J. Leinert, eds. 2006. *Fairer Wettbewerb oder Risikoselektion? Analysen zur Gesetzlichen und Privaten Krankenversicherung*. Bonn: Wissenschaftliches Institut der AOK.
- Kassenärztliche Bundesvereinigung. 2006. *Versichertenbefragung der Kassenärztlichen Bundesvereinigung*. Berlin: KBV.
- Kriwy, P. and A. Mielck. 2006. "Versicherte der Gesetzlichen Krankenversicherung und der Privaten Krankenversicherung: Unterschiede in Morbidität und Gesundheitsverhalten." *Das Gesundheitswesen* 68: 281–88.
- Leinert, J. 2006a. "Einkommensselektion und ihre Folgen." In K. Jacobs, J. Klauber and J. Leinert, eds., *Fairer Wettbewerb oder Risikoselektion? Analysen zur Gesetzlichen und Privaten Krankenversicherung* (pp. 31–48). Bonn: Wissenschaftliches Institut der AOK.
- Leinert, J. 2006b. "Morbidität als Selektionskriterium." In K. Jacobs, J. Klauber and J. Leinert, eds., *Fairer Wettbewerb oder Risikoselektion? Analysen zur Gesetzlichen und Privaten Krankenversicherung* (pp. 67–76). Bonn: Wissenschaftliches Institut der AOK.
- Lüngen, M., P. Potthoff, G. Wendland, G. Klever-Deichter and K. Lauterbach. 2005. "Unterschiede in der Inanspruchnahme von Gesundheitsleistungen und der Morbidität von Versicherten in der Gesetzlichen Krankenversicherung und Privaten Krankenversicherung." *Gesundheits- und Sozialpolitik* 3–4: 25–30.
- Mielck, A. and U. Helmert. 2006. "Vergleich zwischen GKV- und PKV-Versicherten: Unterschiede bei Morbidität und gesundheitlicher Versorgung." In J. Böcken, B. Braun, R. Amhof and M. Schnee, eds., *Gesundheitsmonitor 2006* (pp. 32–52). Gütersloh: Verlag Bertelsmann-Stiftung.
- Mossialos, E. and S. Thomson. 2004. *Voluntary Health Insurance in the European Union*. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies.
- Niehaus, F. and C. Weber. 2005. *Der überproportionale Finanzierungsbeitrag privat Versicherter Patienten zum Gesundheitswesen*. Köln: Wissenschaftliches Institut der PKV.
- Sawicki, P.T. 2005. "Qualität der Gesundheitsversorgung in Deutschland: Ein randomisierter simultaner Sechs-Länder-Vergleich aus Patientensicht." *Medizinische Klinik* 100(11): 755–68.
- Wasem, J., S. Greß and K.G.H. Okma. 2004. "The Role of Private Health Insurance in Social Health Insurance Countries." In R. Saltman, R. Busse and J. Figueras, eds., *Social Health Insurance in Western Europe* (pp. 227–47). London, UK: Open University Press.
- Ziegenhagen, D.J., G. Glaeske, A. Höer and K. Gieseler. 2004. "Arzneimittelversorgung von PKV-Versicherten im Vergleich zur GKV." *Gesundheitsökonomie und Qualitätsmanagement* 9: 108–15.