Interview with Jürgen Fritze, Head of Medical Affairs, PKV

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As part of the PKV – the German Association of Private Health Insurance – could you briefly introduce to our readers the German private health care system and its main particularities?

The German private health care system has no comparable system worldwide. In Germany only ten percent of the population is covered by private health care funds, which represents around 8.6 million people. Half of them are civil servants who get 50 to 70 percent of their health care expenses reimbursed by the federal and local governments. Therefore civil servants have private health care insurance to cover the remaining 30 to 50 percent of health care expenses left uncovered. However, the access to the private health care insurance in Germany is limited by law. This is rooted in the long-standing principle of subsidiarity – which determines that everybody has to be taken care of even if he or she is unable to do so for economic reasons. With the current system, 90 percent of the German population is somehow considered to be unable to entirely cover its health care expenses and are therefore covered by the Statutory Health Insurance (SHI) system.In fact, the current legislation states that people may access private health insurance only if they are working on an independent position or if they are working in a dependant position with earnings exceeding a certain amount redefined every year – around €49000 in 2009. This limit has to be exceeded for a period of at least three years.

What are the main differences between the German public and private health care system?

The public health care funds are directly regulated by the legislators, which have delegated part of their regulatory responsibilities to the G-BA. As a result, public coverage changes over time.In contrast, private health care insurers are entirely entitled to the private contract they have with their clients, which is individualized and can not be changed by the insurer over time. Whatever is medically necessary is covered by private health insurance, from diagnosis to therapy regardless of the economic costs of the treatment. Besides, what is medically necessary is defined by the present state of the art. In case there is a rare disease where there is neither existing guidelines nor randomized controlled trials e.g. for drugs the privately insured person has the right to claim for a treatment which conforms to the expert's opinion. This is again a fundamental difference in comparison with the public system.The last basic difference between the public and private system is that the premiums from the private health care insurers are calculated on the basis of individual risks while in the public sickness funds the premium is based on the individual income.The premium calculation on the basis of the personal risks means that the premiums to be paid by a person over its life time in principle have to the sum of health care expenditure over the remaining lifespan. Therefore, in the private health care system a person pays every year an extra premium that works as a bank account saved for the time of old age when the expenditures on health care will be much higher. This is known as the equivalence principle. In contrast, in the public sickness funds there is a system of redistribution; every year the premiums that are collected from all different ages are used. In the end, one generation finances the other.

How the last health care reform act from 2007 affected the private health care system?

The last health care reform act from 2007 was a step backward for the German health care system. Concerning the private health care system, the main change was the introduction of the basic tariff that forces private insurers to offer identical or comparable services to those of the public sickness funds with the premiums limited to the so-called assessable income ceiling of the public system.One of the main arguments used by politicians to defend the reform is that it would increase the competition between private heath insurers. From now on clients can switch between different private health funds that provide basic tariffs and their savings from the equivalence principle could be partially transferred from one fund to the other, facilitating the move and making it cheaper.However, only about two thousand individuals from the 8.6 million private health care universe made use of the option opened to move from their current plans to the basic tariff. At present (mid 2009) there are only about 9.800 people covered by the basic tariff – 7000 of those are people who had no insurance at all before the new legislation introduced compulsory insurance for every citizen.Naturally, these 9.800 people are not a burden. The real threat to the private health care insurers is the will of some policy makers to abolish the German private health care

system. In the last two decades the expenditures of the private health insurers increased more then 130 percent per insured person while in the public sickness funds they increased only by about 50 percent. This is the result of economically motivated interventions of the legislator that allow public health providers to cut costs while private insures fulfil the conditions of the individual contract.As a consequence, the premiums of the private health funds have increased substantially and the competition with the public sickness funds is increasingly difficult. Since most of the people that are covered are healthy, their main concern is over prices.

If some players are subsidised while others are not, how can the government talk about fair competition?

However, some say that part of the reform from 2007 was done to alleviate the burden on both private and public health care insurers by allowing them to have direct rebates with the pharmaceutical companies in order to lower the prices of medicines.

Do you believe this measure was effective in order to alleviate the burden in the health care system?

It might have been effective but it wasn’t efficient. It was very positive that in the last health care reform private health insurers had also the option to negotiate discounts. However private insurers only made minor use of that – the money they could save from those deals represented less then 1 percent of overall expenditure on drug treatments while generating additional administrative costs. This was an interesting option with a small impact on the health care system.

The perspective of the pharmaceutical industry is that this measure is creating an over competition that is threatening the long term sustainability of the German pharmaceutical industry. How do you assess this issue?

In a market with free competition it is completely normal that the different parties negotiate discounts. Whenever prices fall, sales increase. However, it is true that in Germany the public sickness funds are not normal market participants, they are monopolists. For instance, the AOK covers 35% of the population; therefore discounts negotiated by them can indeed be unfair.The overall behaviour of the German pharmaceutical industry is not the wisest when one company agrees to profoundly reduce their prices in order to secure a big part of the market hoping to push competitors out of the market. Besides, generic pharmaceutical companies – among those that complain the most – have benefited immensely of the German openness to generic medicines and have had a great profitability in the last 15 years. It’s natural that they have now to lower their profits and suffer a process of consolidation.Unfortunately, once more this measure had an unequal

impact on the public and private health care insurers, since the first ones had a bigger bargain power. This only increased the artificial differences that impede fair competition between private and public health care funds in Germany.

In your opinion, what are the main challenges for the future of the German private health care industry and how it can overcome them?

The main challenges for the future of the German private health care industry derive from an aging society and the continuous medical progress. For instance, nowadays a year of treatment with biologicals can cost around fifteen to twenty thousand euros, and the ladder will keep on rising.In principle, the adaptation to those challenges by the private health insurers is easy – if costs rise their premiums increase accordingly. The problem of course is people's willingness to pay. Unfortunately, politicians are only concerned with the willingness to pay of the population covered by the public sickness funds, imposing tight limits on their premiums. They don't seem to understand the damaging impacts that such measures have on the private health care funds. Therefore, for the future, private health care insurers have to be more creative then ever to stay competitive and survive. This is an even bigger challenge since our contracts are valid for the whole life time of our clients. As you can see, we are in need of very intelligent solutions, and we are working hard to get them.

If you were the minister of health for one day, what reforms would you do in order to have a sustainable health care system in Germany?

I don't believe there is one reform that would solve all the problems at once. The German health care system is so complex that whenever new legislation sets in new conditions the health care industry will find its way out. There will always be opportunities for profit and people smart enough to take advantage of them.However, Germany needs to start a process of reforms that would ultimately create a fair system where each generation pays for their own health care costs. This solution is already offered nowadays by the private health care funds. This is why the right direction to go is to increase the proportion of privately covered population, not the contrary.

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