

Key features and data of the German Health Care System **By Klausdieter Tschöpe**

Thank you for the opportunity to speak to you.

Introduction

All European health care systems face the problem of financing continuously rising demands on medical services of an aging population. As I am informed, to meet an increasing need of medical services with limited resources, not only for an aging, but also over and above that for a growing population is the problem in Mexico. By means of decentralizing resources and better allocation is aimed to expand and to improve the delivery of health care.

Decentralization is considered a remedy mainly in health systems, where services and medical care are financed by taxation or delivered directly by state institutions (Great Britain, Canada and to a certain extent Mexico). In Germany it is not like this. The health care system is highly decentralized and broadly diversified.

The striking component in it is the delegation of state power to corporations under public law, which are the main actors in the frame of the German statutory health insurance (SHI). They constitute the so-called corporatist level of decision-making and ensure financing and quality of health care as well as equitable access to it and to all necessary and adequate services and treatments (Fig.1).

Privatization is another important feature of the German system. As we will see more in detail later, the office-based ambulatory and dental care sectors are entirely based on private providers. Pharmaceuticals are distributed through private pharmacies. Hospitals are only partly run in public ownership by states, counties or municipalities.

Organizational structure and management

Federal level

The Federal Republic of Germany is constituted by 16 states (in German Länder). The federal constitution (known as Basic Law) requires equal living conditions throughout the federal territory. Nevertheless, health promotion, protection or care is not mentioned as a goal and not, as a whole, subject of federal legislation. However, specified topics relevant to ensure organization, financing and quality of health care as well as to protect against dangerous diseases and some other areas related to human health and environmental protection are reserved to regulation by federal law. The followings are to be pointed out:

- Social security and occupational safety and health
- Economic viability of hospitals and the regulation of hospital charges
- Admission to medical professions and to ancillary professions
- Certification of and trade in pharmaceuticals and drugs

In these areas federal law takes precedence over states' legislation. Thereby federal law regulates exclusively all statutory social insurance schemes through the Social Code Book – the cornerstone of social legislation. Health-related social services are regulated through several statutory insurance schemes (health, work-related accidents, retirement and long-term nursing care) with statutory health insurance being the most important one. In the frame of the Social Code it is Book V, which contains the legal framework of the German statutory health insurance, of its organization, of its mission and way of working, of its services and benefits.

While the function of passing laws is given to the parliament, namely the Federal Assembly (Bundestag) consisting of members elected by general elections, the states participate in the federal legislation through the Federal Council (Bundesrat). It does not consist of elected members but of representatives of the sixteen state governments. Joint discharge or financing of state functions is admitted in certain areas defined by the Basic Law in order to secure important investments such as investments for university hospitals or for restructuring the hospital care sector of the eastern part after reunification of Germany.

According to the power of legislation described above the federation is responsible in specific areas for administration. Main actor is the federal ministry of health assisted by several subordinate authorities, which are responsible for the performance of certain tasks throughout the federal territory:

- Detection, prevention and control of communicable and not communicable diseases
- Licensing pharmaceuticals and medical devices, supervising the safety of both, licensing sera and vaccines
- Maintaining and promoting human health and improving consumer protection
- Providing public and professional information in all fields of life sciences
- Supervision of the statutory health insurance sector

In 1977, an advisory body to the federal government was created consisting of about 65 members of all relevant organizations in the German health care system, representatives of the states and experts. Its main task is presenting data on the medical and economic situation of the system with the aim of advising both the government and the corporatist organizations on improving effectiveness and efficiency of health care. Later on it has been backed by an advisory council, which produces reports if the Minister of Health has posed specific questions. It consists of seven medical, economics and nursing experts in the field of health care. However, insurances or patients are not represented directly by any powerful organization.

State level

The exercise of state powers is constitutionally allocated to the federation and the states following the principle, that all state functions are a matter for the states, except as otherwise federation powers are specifically provided or admitted. However, between the federal legislation and administration on one side and the self-regulation and self-government of the statutory corporate institutions on the other side the responsibilities of the states for health care, its delivery and financing, has been relatively narrowed. The followings are to be pointed out:

- Hospital planning and maintaining hospital infrastructure
- Operating state-owned hospitals such as university hospitals
- Providing public health services responsible for health promotion and prevention of communicable diseases, for supervision of health professions and their institutions as well as for supervision of commercial activities involving pharmaceuticals and food

Planning hospitals and funding their investments the states are subject to the federal Hospital Financing Act. The public health services have to deal partly with the execution of federal laws concerning subjects mentioned before. About half of the states operate the services themselves while the others delegate responsibility to local governments. However, most of the preventive medical measures, such as screening measures and health checkups, are included in the sickness funds' benefit package and thus are carried out by office-based physicians.

Corporatist level

This level is constituted of the sickness funds and their associations on the purchasers' side and the legal associations of the physicians and the dentists on the provider side. The hospitals are not represented by any corporate institution. Their associations are based on private law, but they are charged increasingly with legal responsibilities as well.

The payers' side is made up of around 450 autonomous funds with about 72 million insured persons, organized on a regional or a federal basis. All funds have non-profit status and are based on the principle of self-government, elected by the membership. They have a central position in the SHI system. Their status, rights and responsibilities are defined in the Social Code Book. They are responsible to ensure that the legal social rights and benefits of health care services of their membership are realized. They have the right and obligation to raise contributions from their members and to determine what contribution rate is necessary to cover expenditure. This includes negotiating prices, quantities and quality of assurance measures with providers. Services covered by those contracts are usually accessible to all fund members without any prior permission of the fund.

The legal associations of physicians and dental physicians have to provide all personal acute health care services. They have both a corporate monopoly and the mission to secure ambulatory care. The monopoly means that hospitals, communities, sickness funds and others do not have the right to offer ambulatory medical care. The mission includes the obligation to meet the health needs of the population, to guarantee provision of statewide services in all medical specialties and to obtain a prospectively negotiated budget from the sickness funds, which the associations distribute among their members.

For joint negotiations of sickness funds and physicians several joint committees are established. The most important is the Federal Committee of Physicians and Sickness Funds. They have to issue guidelines valid on federal level, to define the benefit package, to assess technologies of ambulatory benefits and to make decisions on the relative value of all services

Health care expenditure and finance

Expenditure and cost-containment

Germany's health care system is expensive by international comparison, both in absolute figures and – even more visibly – as a percentage of GDP (fig. 2). While health care expenditure had remained stable at around 8.7% in the Federal Republic of Germany between 1975 and 1990, it has risen considerably since reunification, bypassed that of the other European countries and peaked at nearly 11% at now. A main reason is due to the fact that in the eastern part health expenditure is almost as high as in the western while the GDP is still much lower. Public expenditure's percentage share of total health expenditure has remained constant since thirty years and is comparable to most other countries with SHI (80%).

Germany does not have one only budget for health care. There are 450 sickness fund budgets and, to the extent of which the federation and the states contribute to expenditure, 17 tax-based budgets, over and above that several other sources of financing. Sickness funds do not have pre-determined budgets. As sickness funds have to cover all the expenses of their insured members, the contribution rate has to be adjusted if income of the funds does not match expenditure. The main political goal has been, in particular in the last decade, to restrict the sickness funds' expenditure to a level where it matches income, and to keep contribution rates stable. Besides other measures to that end, sectoral budgets and spending caps were introduced.

Main system of finance and coverage

Contributions towards statutory health insurance (SHI) constitute the major system of financing health care in Germany. Those contributions are shared equally between the compulsory insured and their employers. Membership in a sickness fund and paying contributions to it is compulsory for employees not exceeding a certain limit of yearly gross income. Income is liable to contributions up to this legally fixed limit. The total sum of the income of all the insured up to that level (the so-called contributory income) is among the most important figures in health policy. The growth rate of the contributory income from year to year determines the level of cost- containment.

The average rate of contributions that are levied by all individual funds amounts to nearly 14% at present. Contributions are dependent on income from wages and salaries only, not on savings, interests or possessions and not on risk. They include non-earning spouses and children without any surcharges. The new government will raise the limit of yearly income liable to contributions in order to pour new money into the system and to hold continuously growth of contribution rates in check.

Currently, 88% of the population are members of the SHI, among them 14% voluntary members after having exceeded the limit of income liable to contributions. 9% of the population are fully or partly covered by private health insurance, 2% are completely covered by governmental health care. For retired and unemployed people the retirement and unemployment funds respectively take over the financing role of the employer.

In order to achieve competition between sickness funds and to keep contributions in check two measures were taken by federal law in the nineties. Almost every insured person was given the right to choose a sickness fund freely and to change it. A compensation scheme was introduced to equalize differences in expenditure, which are based on a different risk structure of the individual fund and its membership. Contribution rates narrowed, an equalization of risk structures however, is not seen yet.

Benefits

In generic terms, currently the following types of benefits are legally included in the benefit package of the SHI:

- Prevention of diseases
- Screening for diseases
- Ambulatory medical care, dental care, drugs, non physician care, medical devices, hospital care, nursing care hat home and certain areas of rehabilitative care
- Transportation

In addition, sickness funds have to give cash benefits to sick insurees up to 78 weeks. They have to be paid after the first six weeks of illness during which employers are responsible for sick pay. Benefits include also certain health promotion measures. Further regulations have been left to the Federal Committee of Physicians and Sickness Funds, mentioned above. It has considerable latitude in defining the benefits catalogue for all procedures and medical services. All covered procedures are listed in the Uniform Value Scale together with their relative weights for reimbursement. As the committee is mandated to evaluate medical care and services, procedures can also be explicitly excluded.

Complementary sources of finance

Statutory social insurance as a whole has been the source for nearly 70% of total health expenditure in Germany for many years. Even though health insurance dominates the discussion on expenditure and reforms, SHI actually contributes to overall expenditure only a little more than 60%. Three other main sources of finance can be identified: taxes contributing 10%, co-payments 11% and private insurance 7% to overall expenditure.

Taxes are used for capital investment costs of hospitals, public health services, persons on welfare, free or partly free governmental health care of civil servants and public employees. Within the SHI cost sharing has a long tradition. As a percentage of total costs co-payments remained stable for a long time. In the last decade they were increased markedly, not merely to shift spending from the sickness funds to patients. Regulations of co-payments were re-structured also to reward good preventive practice with lower co-payments in the sector of crown and denture treatment. People who are unemployed, are on social welfare or have very low income are largely exempted from cost-sharing requirements.

Formerly SHI-insured persons and self-employed people are in general privately insured with full-coverage. Fully or partly private insured patients enjoy benefits equal to or better than those covered by SHI, dependent on the insurance package chosen. However unlike to statutory insurance schemes, separate premiums have to be paid for spouses and children. The fee-for-service reimbursement for privately insured people has led to cost increases in the last fifteen years, which are on average two thirds higher than in the SHI – and in ambulatory care even twice as high.

Health care delivery and payment

A key feature of the health care system in Germany is the clear separation between hospital care, which has been traditionally confined to outpatient care, and primary and secondary ambulatory care through office-based physicians. The separation is stricter than in all other countries. Only university hospitals have outpatient facilities, originally for research and teaching purposes.

Hospital care (Fig.3)

By international comparison, the German hospital sector appears oversized. The total number of beds, admissions and length of stay are well above average in the European region. The hospital capacity is 7 beds per 1000 inhabitants with an average occupancy rate of little over 80%. Hospitals in public ownership provide a bed share of 53%, hospitals with non-profit status in ownership of churches and charity organizations a share of 38% and private for-profit hospitals a share of 7%. In addition, 2,3 beds per 1000 inhabitants are dedicated to preventive and rehabilitative care.

Investments of acute hospitals have to be funded through the states, independently of the ownership. In order to receive payments for investments, hospitals have to be listed in the hospital plans, which are set by the states. These plans list the number of beds, which are necessary for every hospital, and list even those of specialties. Hospitals listed in the plans are given the legal right by the federal Hospital Financing Act to claim subsidies for their investments.

Running costs, including all personnel costs, of those hospitals, which are listed in the plans, are financed through the sickness funds. Hospitals and sickness funds contract individually both the range and number of services offered and the remuneration rates. Initially, running

costs were reimbursed following the principle of full cost cover. This meant that whatever the hospitals spent had to be reimbursed, and resulted in continuously rising expenditure with increases over those of the contributory income. On the other hand capital investments provided by subsidies of the states decreased steadily.

In the last decade reform measures concentrated on the hospital sector to control better and to contain expenditure for running costs. The full-cost cover principle was abolished. Hospitals were allowed to offer ambulatory surgery and to make both profits and deficits. Prospective budgets and remuneration of prospective case-fees were introduced. After a time of adjustment, sickness funds shall pay all hospital services only by remunerating uniform case-fees, which are based on diagnosis related groups (DRG) taking complexities and comorbidities into account. The method of defining DRG's was adopted from Australia. The new system starts 2003 and shall be completely accomplished at the end of 2007.

Ambulatory care

All ambulatory care has been organized almost exclusively on the basis of office-based physicians. As health promoting and disease prevention measures were transferred from the public health services to office-based physicians, they control a large share of preventive services. However, the shift in responsibilities had the result that immunization rates are rather low by international comparison.

Around 120 000 ambulatory physicians offer almost all specialties. Around 5% of them have the right to treat patients inside the hospital. All others transfer their patients to hospital physicians and receive them back. That means, post-surgical care is usually done by office-based physicians and not by the hospital surgeon.

Germany has no gatekeeping system; instead patients are free to select a sickness-fund-affiliated doctor of their choice. Patients choose frequently office-based specialists directly. This is important with regard to costs of the ambulatory care sector, since specialists and family practitioners have different reimbursable service profiles. Despite efforts to improve the status of family practice, the number of office-based specialists has increased more rapidly than that of general practitioners over the past decades so that GP's, as a share of all office-based physicians, dropped to less than 40%.

The payment of physicians is subject to a process of two major steps. Firstly, the sickness funds make total payments to the physicians' associations for the remuneration of all SHI-affiliated doctors. Secondly, the physicians' associations have to distribute these total payments among their members according to the mentioned Uniform Value Scale, which lists all services which can be provided by physicians for remuneration. The calculation of the physicians' quarterly remuneration is based on the monetary value of the number of his service points delivered. The monetary value results from the budget, negotiated with the sickness funds, divided by the total number of delivered points within the association.

Outlook

The German system appears to work well. It puts emphasis on free access, high numbers of providers and high technological equipment. Waiting lists and explicit rationing decisions are virtually unknown. The public supports these priorities.

However, maintaining contribution stability through measures of cost-containment in health care was a main goal of health policy in the past and will remain high on the political agenda. Since contributions are based only on labour and labour is responsible for an ever-decreasing share of the national income, rises in contribution rates became and will be a question of international competitiveness.

In the past, a series of cost-containment acts employing various tools was used. They succeeded relatively in stabilizing health care expenditure as a percentage of GDP, although the absolute amount of health care expenditure has increased fivefold in the last thirty years. Nevertheless, slowly and regularly increases of contribution rates could not be prevented. Viewing those measures, budgets of varying forms and efficacy have been generally more successful in containing costs than other supply- or demand-side measures, which largely failed. Table 4 provides an overview of the rise, fall and resurrection of budgets and spending caps. Those kinds of tools appear to remain here for the foreseeable future. Over and above that more market competition between sickness funds on one side, office-based specialists and the hospital sector on the other side should be achieved. The role of general practitioners requires a strengthening of their position.

Thank you

