The German health care system
in a nutshell

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Federalism, German-style:

- Not devolved, but „bottom-up“
- Powers not explicitly given to the federal level remain with the „Länder“
- Länder have considerable power through Federal Council
Germany: A note on terminology

We will speak mainly about statutory (or social) health insurance [SHI], even though it covers “only“ 89% of the population (75% mandatorily and 14% voluntarily) and spends around 60% of all health care expenditure.
Third-party payer

= sickness funds with self-government, organised in associations

Not (health) risk-, but wage-related contribution

Choice of fund

Strong delegation & limited governmental control

Population
Mandatory SHI for 75%, open for others

Providers
Public-private mix, organised in associations

Free access
Statutory health insurance 2000
Problem 1: sectorisation of health care delivery

• state-run public health service: decreasing as many activities (immunizations, screening ...) have moved to ambulatory sector

• office-based ambulatory care: powerful and still growing with full range of specialties

• hospitals concentrating on inpatient care (no regular out-patient departments)

• plus rehabilitation etc.
Differences in planning, regulation and financing

- Benefits: A = decided jointly by physicians and sickness funds, H = not explicit
- Capacity planning & accreditation: A = jointly by physicians and sickness funds, H = by states
- Reimbursement: A = according to uniform fee schedule but depending on overall utilization, H = mainly by per-diems, differing from hospital to hospital (DRGs from 2003); both under separate budgets
Problem 2: Rising expenditure and attempts to solve the problem

- Attempt 1: budgets and spending caps (1989-1996/7 and 1999ff)
- Attempt 2: regulated competition among sickness funds (1993ff)
- Attempt 3: higher co-payments, exclusion of benefits, “privatisation“ of patient-provider-relationship (1997/98; abolished; discussed again)
  - Recently, attention is focussing at least as much on the income side.
Free choice among sickness funds but “risk structure compensation“

- sickness funds = contribution collectors;
- therefore re-distribution of money is more difficult than in all other countries as
  1. funds look at contributions as “theirs“
  2. both income of funds and “standardised“ expenditure (by sex, age and incapacity to work) vary.
Problem 3: Quality and cost-effectiveness

• Benefit catalogue is generous and includes services of unproven effectiveness > Health Technology Assessment

• Financial incentives and insufficient knowledge lead to inappropriate services > guidelines & “disease management programmes“

• In international comparison, health care is expensive and only of average quality = low cost-effectiveness > more state intervention required?
The dilemma of equality vs. competition

- **1989**: equalisation of benefits and health care provision between sickness funds
- **1994/95**: minimisation of contribution rate differences through ”risk compensation scheme”
- **1996**: free choice of sickness fund for (almost) everybody

> How to compete with (almost) identical benefit baskets, an (almost) identical system of health care provision and similar contribution rates?

> Selective contracting!?
Proposed Health Care System
“Modernisation“ Act 2003