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The German health care system in a nutshell

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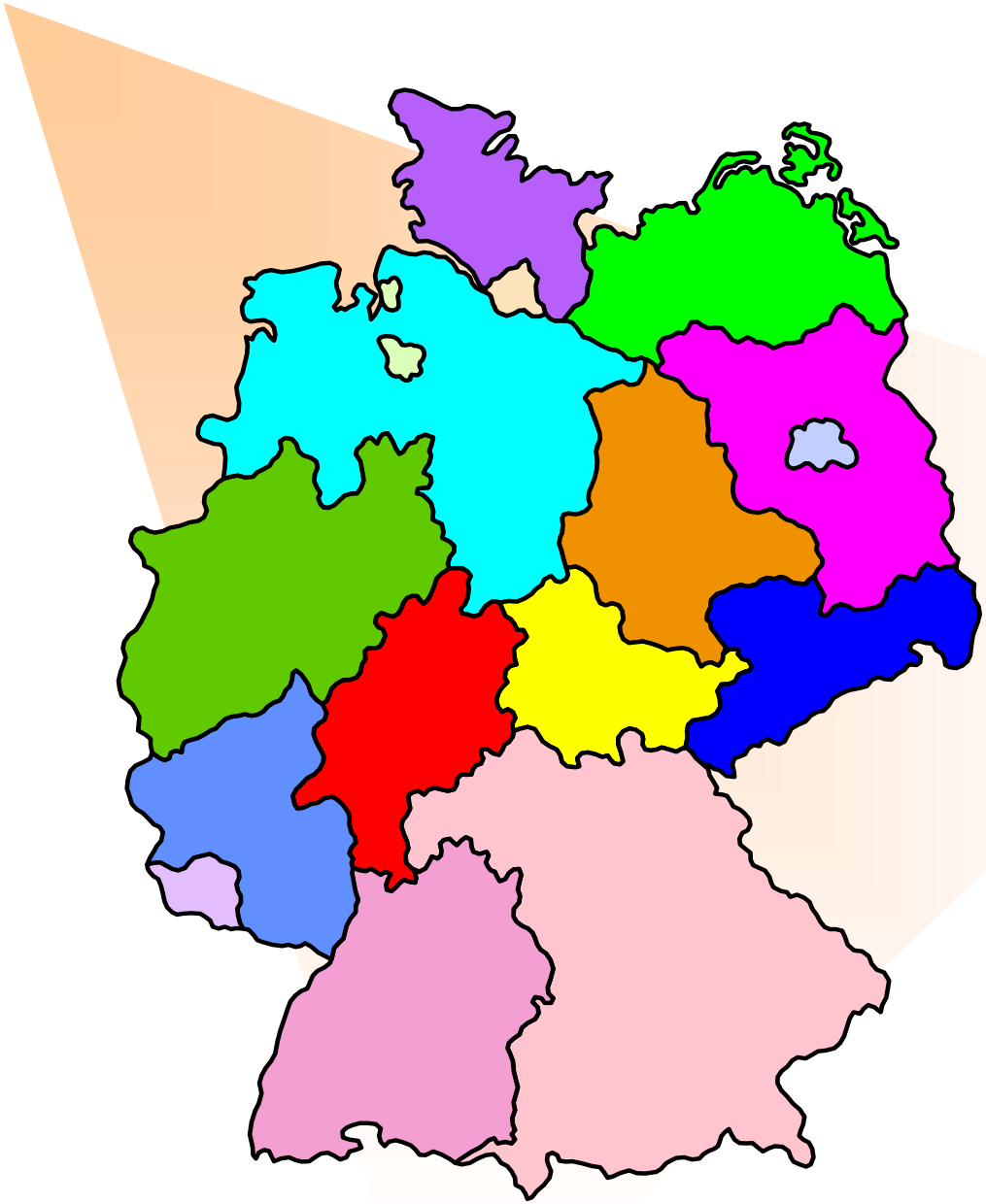

Federalism,

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

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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.

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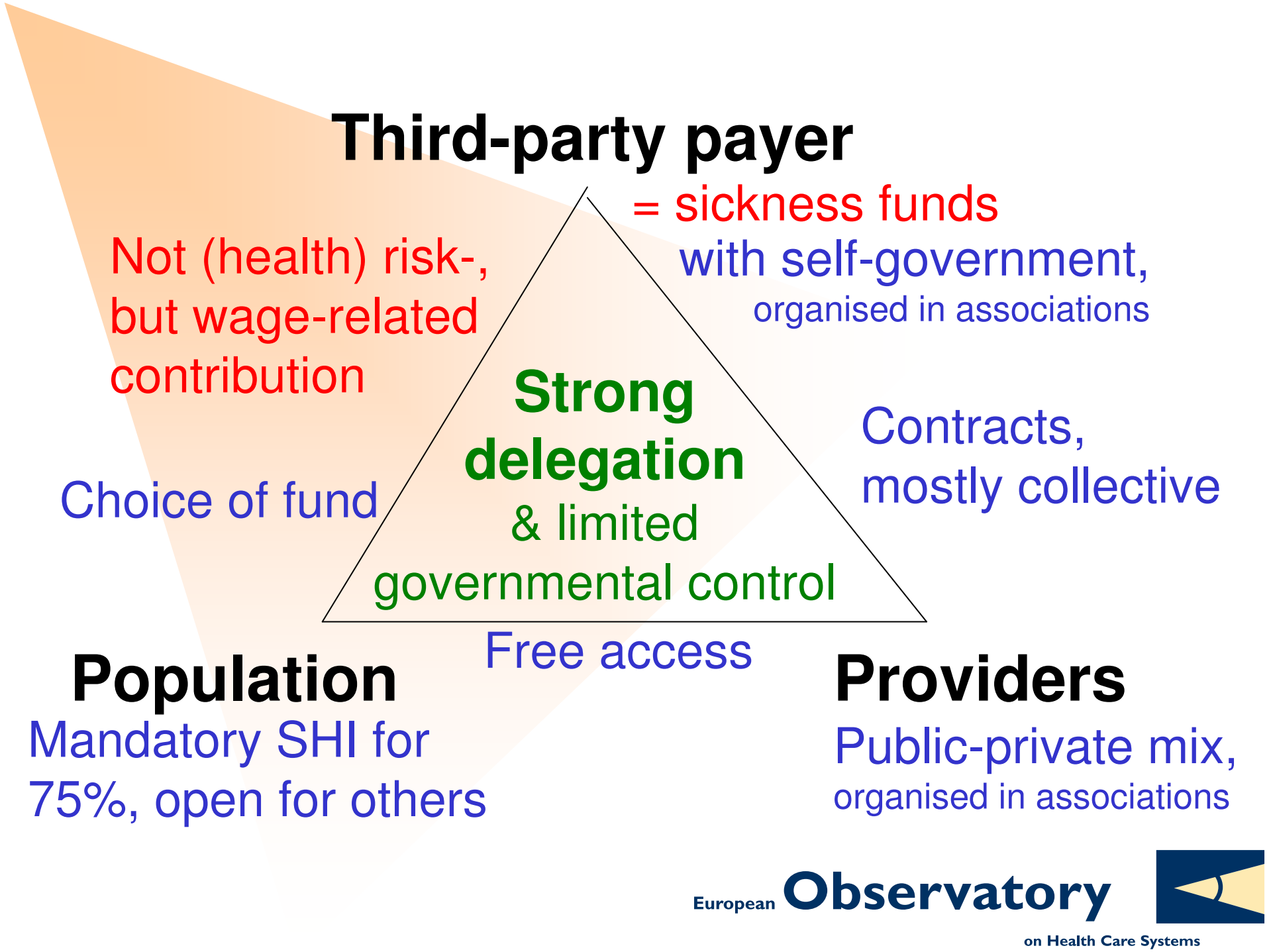

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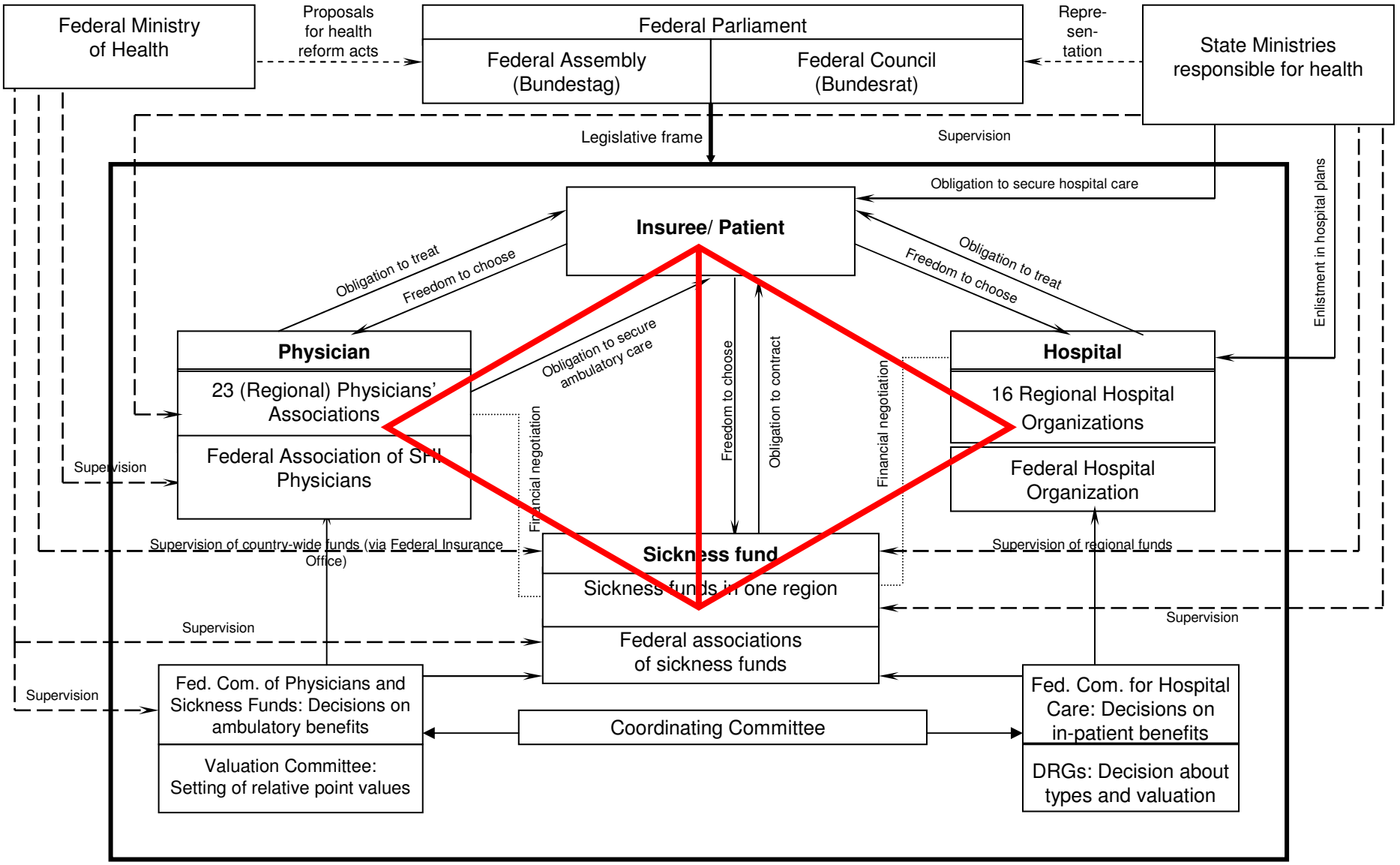

Statutory health insurance 2000

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 inapproriate 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!?

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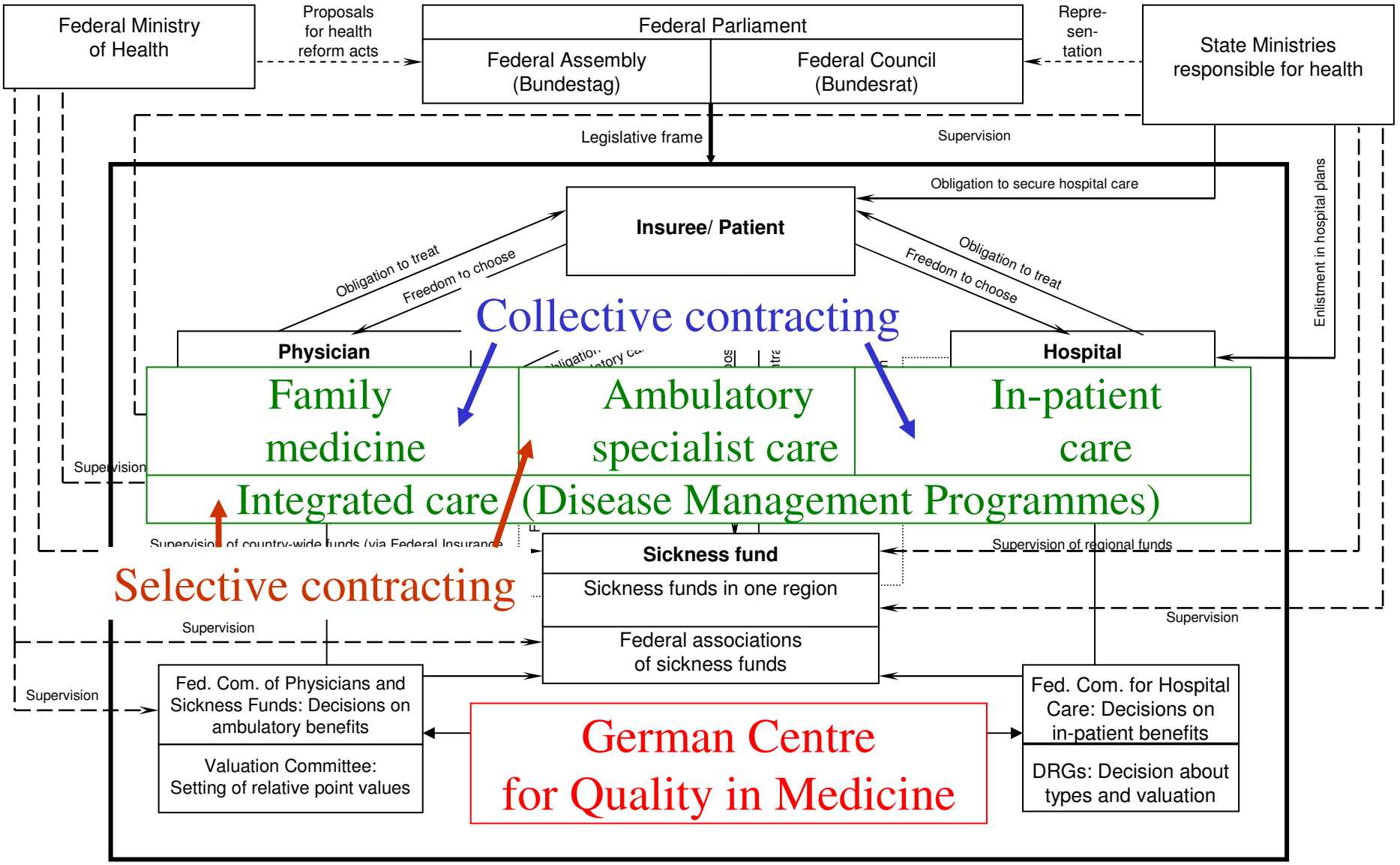

Proposed Health Care System "Modernisation" Act 2003