HiT summary

Germany

Introduction

Government and recent political history

The Federal Republic of Germany is a democratic and social federal state. Since the German reunification in 1990, when the former German Democratic Republic (GDR) accessed the old Federal Republic of Germany, the Federal Republic of Germany (FRG) consists of 16 states (*Länder* in German).

Population

Of the 82.5 million inhabitants in 2003, 3.4 million lived in the formerly divided capital of Berlin, another 13.5 million lived in the 5 Länder succeeding the former GDR, situated in the eastern part of the country, and 66.6 million lived in the old FRG, situated in the western part. From 1993 until 2003, the share of elderly above 65 years increased from 15% to 18%; the share of elderly above 80 years remained at around 3.8%, yet is expected to increase.

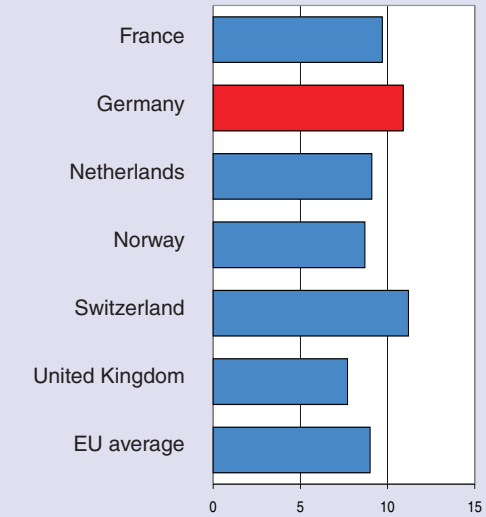
Average life expectancy

By 2001/2003, life expectancy had increased to 75.6 years in men and 81.6 years in women. The east/west gap had narrowed to 1.5 years among men and 0.5 years among women by 2000/2002.

Leading causes of death

Between 1991 and 2001, age-standardized mortality decreased from 780 to 658 per 100 000 inhabitants. This is true for almost all causes of death (except e.g. for infectious diseases). In 2001, the overall standardized mortality ranked slightly above the EU average for the 15 Member States prior to 1 May 2004 of 655.3 per 100 000 which was mainly due to a higher mortality from cardiovascular diseases (286.7 vs. 275.1). At the same time, age-standardized mortality from neoplasms ranked below EU average (176.6 vs. 181.0).

Fig. 1. Total health care expenditure as % of GDP, comparing Germany, selected countries and EU average, 2002



Source: WHO Regional Office for Europe health for all database, June 2004.

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Recent history of the health care system

As agreed in the treaties of reunification, the national health insurance type of health system of the former GDR was quickly transformed to adopt the pluralist system of the old FRG with statutory health insurance (SHI) as the dominant source of finance. Since then, most formal differences between the eastern and the western part concerning the levels of contributory income, co-payments, risk structure compensation and payment of providers have gradually been adjusted.

Reform trends

The leading reform principles after reunification have been to reduce structural east-west differences and to contain costs through expenditure control, prospective provider payment and regulated competition among sickness funds, while securing quality and avoiding adverse effects on equity. Rationalization was given priority over rationing. While cost-sharing was enhanced, few benefits were excluded until 2004. At the same time, new benefits and a separate mandatory long-term care insurance were introduced to meet the changing needs of the population more appropriately. In recent years, reorganization of the pharmaceutical market and the bridging of sectoral boundaries have gained importance. Currently, the revenue side of statutory health and long-term care insurance are under discussion.

Health expenditure and GDP

In 2002, Germany spent 11.1% of the GDP on health according to national figures and 10.9% according to figures of WHO and OECD. This represents the highest share in the European Union (Fig. 1) and the third rank among OECD countries.

Overview

The German health care system is characterized by a predominance of mandatory SHI with multiple competing sickness funds and a private/public mix of providers (Bismarck model): In 2003, nearly 88% of the population were covered by comprehensive SHI (78% mandatorily and 10% voluntarily).

This is complemented by three co-existing schemes of health security coverage: In 2003, approximately 6% took out (mostly comprehensive) private health insurance. Another 4% received governmental schemes (as officials, pensioners or their family) complemented by private health insurance. 2% were covered by specific free governmental schemes. 0.2% of the population were not covered by any third-party payer scheme.

Organizational structure and management

Organizational structure

At the national level, the Federal Assembly, the Federal Council and the Federal Ministry for Health and Social Security are the key actors, responsible for passing health reforms concerning statutory insurance. The *Länder* are responsible for planning inpatient capacities and financing investments in hospitals, nursing homes and institutions for social care. In addition, they supervise corporatist actors and pharmaceutical manufacturers in their constituency.

The corporatist level is represented by the non-profit, quasi-public sickness funds and their associations and associations of SHI-affiliated physicians' and dentists' on the provider side. The sickness funds are the collectors, purchasers and payers of statutory health and long-term care insurance. Their number decreased from more than 1200 in 1993 to 292 in 2004, mainly as a result of mergers. Physicians treating SHI-insured patients are organized in regional physicians' associations, based on obligatory membership and democratically elected representation. The German Hospital Organization has increasingly

been integrated into decision-making bodies of the SHI structures.

Professional "chambers" with mandatory membership exist for physicians, dentists, pharmacists, veterinarians, and since 2003 for psychologists providing psychotherapy. They are responsible for secondary training and accreditation and continuing education, setting professional and ethical and community relations standards.

In addition, there are a vast number of organizations representing professional and manufacturers interests and welfare organizations. There are about 40 000 to 60 000 health-related self-help groups with about 3 million members.

Planning, regulation and management

A fundamental facet of the German health care system is the sharing of decision-making powers between the federal government, the *Länder*, corporatist organizations of sickness funds, physicians and dentists as well as other legitimized civil society organizations. While legislation is passed at federal or *Länder* level, a large number of regulatory, managerial and even planning competences in SHI are delegated to the corporatist level of self-governmental sickness funds and provider associations or to joint committees of these actors.

The joint committees have the duty and right to define benefits, prices and standards (federal level) and to negotiate horizontal contracts, to control and sanction their members (regional level). The vertical implementation of decisions taken by higher levels is combined with a strong horizontal decision-making and contracting involving elected representatives of actors involved in the actual care process. Their directives are legally binding for actors in SHI although subject to complaints at social courts.

Since 2004, SHI decision-making has been integrated into the trans-sectoral Federal Joint Committee. Traditionally, regulations and actors responsible for decision-making differed by sector, the most strongly regulated being the ambulatory sector. Legitimized patient organizations have been given the right to participate in consultations but not to vote.

Decentralization of the health care system

Health care for the populous country has traditionally been organized on a decentralized basis, characterized by a federal distribution of state functions, the subsidiarity principle of private over public providers, and a comparably strong delegation of competences to self-governmental actors in SHI. While ambulatory care is almost exclusively delivered by strictly regulated private for-profit providers, hospital care is delivered by a mixture of public and private providers with increasing tendency. Most acute hospitals are enlisted in "hospital plans" and are thereby regulated and financed basically by the same mechanisms regardless of ownership. From 1991 to 2001, the number of beds in private for-profit hospitals increased from 4% to 8% in general (acute) hospitals. However, 99% of hospital beds are accessible to SHI-insured since they are contracted by the sickness funds.

Health care financing and expenditure

Main system: Statutory health insurance

Although it dominates public debates, SHI financed 57% of total health expenditure in 2002. Contributions for SHI are not dependent on risk and proportional to income from gainful employment up to a level (€3487.50 in 2004, €3525 in 2005). They include non-earning spouses and children without any surcharges. From 1949 until 2004, contributions have been shared equally between the SHI-insured employees and their employers. Contribution

rates vary between sickness funds; the average contribution rate amounted to 14.2% of gross income in 2004. From July 2005, the parity shall be shifted towards employees, reaching a financing mix of approximately 54:46.

The SHI operates on a benefit-in-kind basis, although since 2004, following verdicts of the European Court of Justice, all SHI-insureds have the option to subscribe to a reimbursement plan under certain conditions.

Since 1996 almost every SHI-insured person has the right to freely choose a sickness fund, while funds are obliged to contract with any applicant. The introduction of a risk structure compensation scheme since 1994 has led to a narrowing of contribution rate differences but did not equalize risk structures. In contrast, since especially the healthier, younger, better-earning people have moved to other (mostly cheaper) funds the transfer sum to be redistributed among funds via the risk structure compensation scheme has increased from 7.9% of total SHI expenditure in 1995 to 10.9% in 2002. To improve the mechanism and avoid risk selection, the risk structure compensation scheme, accounting for differences in the income of funds and the age, sex and invalidity, was complemented by a high risk pool (2002) and the number of chronically ill enrolled in disease-management programmes (2003). From 2007, the risk structure compensation scheme shall be transformed to better compensate for differences in actual morbidity and need of care.

Health care benefits and rationing

The package of benefits covered by SHI is very comprehensive. It is defined in Social Code Book V and specified by the Federal Joint Committee. In 2004, funeral benefits, patient transport, over-the-counter medications, life-style medications, glasses and a few other medical aids were excluded by law; exceptions were defined by the Federal Joint Committee. Furthermore, family-policy-related benefits were shifted towards federal government. Formal waiting lists exist only for transplantations.

Complementary sources of financing

Other types of social insurance

Statutory retirement insurance contributes 1.8% of total health expenditure, mainly for medical rehabilitation of employees, while statutory (work-related) accident insurance finances 1.7%. Since 1995, long-term care has been financed as a separate branch of statutory insurance (see *Social care*).

Taxes

In 2002, 8% of total expenditures were financed by governmental sources at the level of federal government, the *Länder* and the municipalities. Most of the relative deficits in the eastern states concerning technological equipment, building standards or nursing home capacities, have been compensated by substantial investment from federal and *Länder* governments.

Out-of-pocket payments

Private households (and non-profit organizations) contributed 12% of the total expenditure on health in 2002. This includes direct payments and co-payments, informal payments are uncommon. In 2004, co-payment amounts have been increased and standardized to €10 per inpatient day and to €5–10 for services and products in ambulatory care. Co-payments of €10 per quarter now also apply to the first contact at a physician's (not necessarily a GP) or dentist's office and when other physicians are seen without referral during the same quarter. Exemptions apply once more than 2% of the gross household income per annum has been spent on co-payments, or 1% of the gross household income for a sufferer from a serious chronic illness. Coupled with increased direct payments for excluded benefits, out-of-pocket payments are therefore expected to rise further from 2004.

Private health insurance

8% of total expenditures were spent by private health insurers in 2002. This includes substitutive health insurance for approximately 10% of the population (incl. self-employed and high earning voluntarily insured) and supplementary health insurance for another 9% of the population with SHI coverage. There are 49 private health insurers providing mainly substitutive and supplementary coverage through risk-oriented premiums. The role of complementary coverage is small (except for civil servants and their dependents).

Private insurers have gained in membership and revenues but have been less successful in curbing health expenditures (+58% per capita between 1992 and 2002) than sickness funds (+45%).

Health care expenditure

In 2002, total health expenditure accounted for €234 billion or €2840 per inhabitant according to national figures. WHO and OECD put figures slightly lower at €230 billion and €2789. Adjusted for purchasing power parities (PPP) total and public per capita expenditures (US $PPP 2817) ranked fifth among OECD countries. Germany occupies a middle or relatively high position in the public share of funding depending whether national health accounts (75%) or WHO sources (78%) are used.

While total health expenditure increased from 9.9% to 10.9% of GDP between 1992 and 2002, SHI expenditures increased much less as a share of GDP. This was achieved by a variety of cost-containment measures including sectoral budgets, rational prescribing, price reductions and downsizing.

Health care delivery system

Public health services

Public health is mainly the competence of the *Länder*. However, 14 out of 16 *Länder* have devolved public health functions to municipalities. 274 out of 350 public health offices in 2002 were run by local governments. Public health offices are responsible for surveillance and health reporting, for the supervision of environmental and infectious hygiene of health care personnel and institutions in inpatient and outpatient care. They are restricted to delivering a limited scope of preventive services, since most preventive services, e.g. immunization, are provided by ambulatory physicians. Expenditures on public health offices decreased from 0.12% to 0.09% of GDP between 1992 and 2002.

Primary and secondary ambulatory care

Ambulatory health care is mainly delivered by private for-profit providers working in single practice. Patients have free choice of physicians, psychotherapists (since 1998), dentists, pharmacists and emergency care. SHI-insureds have basically free access to 96% of all ambulatory physicians, while 4% are not SHI-affiliated and treat only patients who are privately insured or pay directly.

SHI-affiliated physicians offer almost all medical specialities in ambulatory care. Family physicians (general practitioners and internists and pædiatricians in family practice, that is, about half of SHI-affiliated ambulatory physicians) are not generally gate-keepers. Yet, their coordinating competence has been strengthened in recent years. Since 2004, sickness funds have been obliged to offer gate-keeping models to their insured. Also, a user charge of €10 for the first physician contact per 3 months and any further non-referred visit has been introduced to raise funding and reduce unnecessary or non-coordinated visits.

All SHI-affiliated physicians and (since 1998) psychological therapists are mandatory members of regional physicians' associations. These are obliged to secure the provision of ambulatory care during practice hours and out-of-hour in their particular region. In turn they traditionally have a monopoly to provide ambulatory primary and secondary care and negotiate collective contracts with the various sickness funds.

Although sickness funds may contract selectively with provider networks for disease-management programmes, most programmes hitherto accredited were negotiated collectively with regional physicians' associations. Their ambulatory monopoly has been decreased in recent years, e.g. for day-case surgery and certain diseases requiring highly specialized care.

Secondary and tertiary hospital care

Acute inpatient care is delivered by a mix of public, private non-profit and for-profit providers (54%, 38% and 8% of acute hospital beds in 2002). Although the number of beds and average length of stay in acute hospitals have been reduced substantially (to 627 per 100 000 and 9.3 days in 2001), capacities still rank high by EU-comparison (Fig. 2, Table 1).

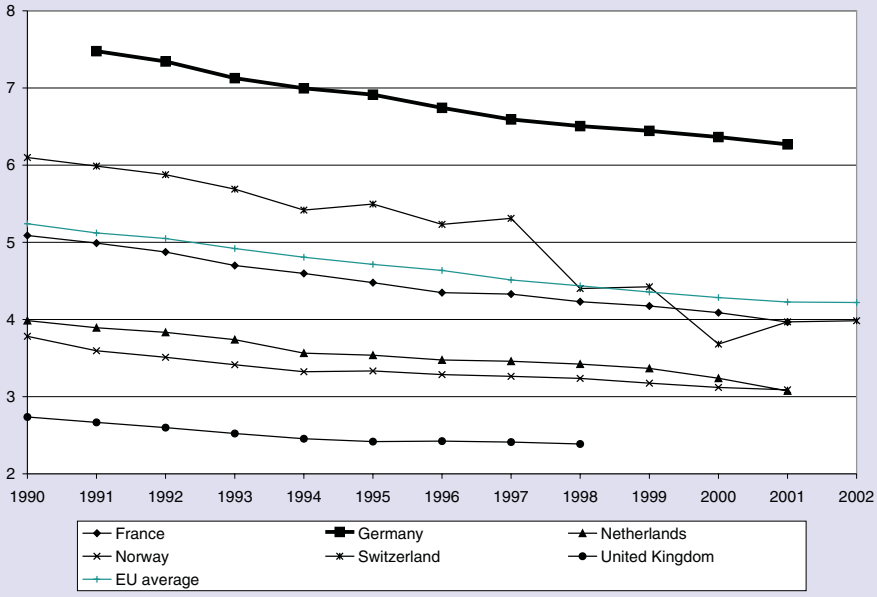
The traditional strict separation between ambulatory and hospital care has been eased in recent years by promoting ambulatory surgery and certain outpatient clinics at hospitals as well as trans-sectoral disease-management programmes and trans-sectoral integrated delivery networks. Yet, in 2002 only 5% of hospital physicians were accredited for SHI-affiliated ambulatory care.

Social care

Since 1995, long-term care insurance is mandatory for nearly the whole population and is operated either by long-term care funds or private health insurance companies. It provides capped rather than comprehensive support for entitled people and their informal care-givers.

The contribution rate to statutory long-term care insurance has remained at 1.7% of gross salaries and is paid equally by employers and members. Retired members pay the entire contribution of 1.7%. Entitlement to long-term care benefits depends on need (assessed in three grades), when care is expected to be necessary for at least 6 months. About 2.3% of the population

Fig. 2. Hospital beds in acute hospitals per 1000 population, Germany, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2002 or latest available year

	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
France	4.0	20.4[c]	5.5[c]	77.4[c]
Germany	6.3[a]	20.5[a]	9.3[a]	80.1[a]
Netherlands	3.1[a]	8.8[a]	7.4[a]	58.4[a]
Norway	3.1[a]	16.0[a]	5.8[a]	87.2[a]
Switzerland	4.0	16.3[d]	9.2	84.6
United Kingdom	2.4	21.4[f]	5.0[f]	80.8[d]
EU average	4.2	18.1[a]	7.0[a]	77.1[a]

Source: WHO Regional Office for Europe health for all database, June 2004.
Notes: [a] 2001, [b] 2000, [c] 1999, [d] 1998, [e] 1997 [f] 1996.

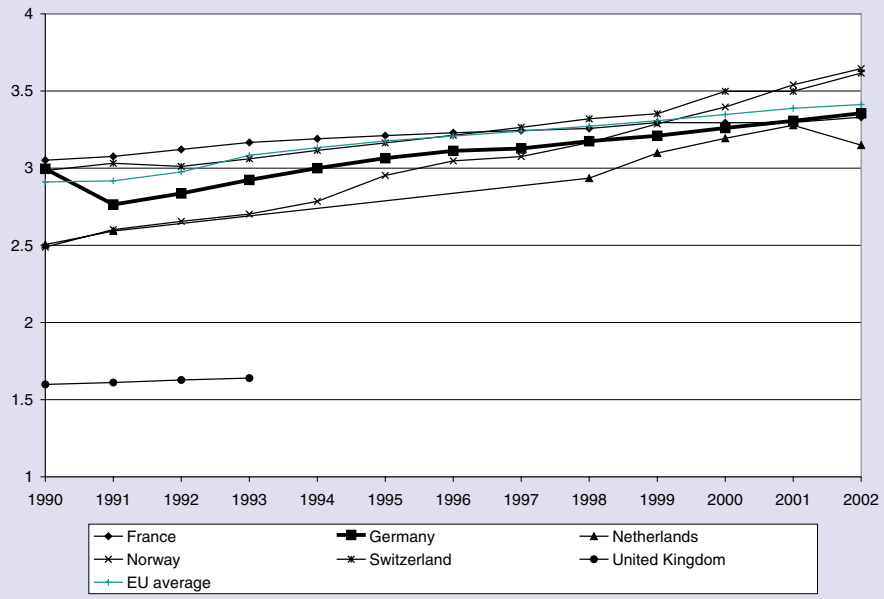
were entitled to benefits in 2002; of these one quarter was in professional institutional care and three quarters were cared for at home.

Professional long-term care in the ambulatory sector is paid on a fee-for-service basis while institutionalized care is financed by per-diem charges. The prices are negotiated between long-term care funds and provider associations at the *Länder* level.

Human resources and training

The 4.2 million working in the health sector accounted for 10.6% of total employment at the end of 2002. About half of these were salaried

Fig. 3. Physicians per 1000 population, Germany, selected countries and EU average, 1990–2002



Source: WHO Regional Office for Europe health for all database, June 2004.

employees in inpatient care. From 1990 to 2002, the number of physicians active in health services increased by 20% to 275 167 (3.4 per 1000), similar to neighbouring countries and EU average (Fig. 3).

From 1997 until 2002, the number of nurses and midwives together increased from 689 000 to 705 000, that is 8.5 per 1000 population in physical persons (7.8 in full-time equivalents). According to WHO data, the number of nurses (9.7 per 1000) ranks well above the average of both the EU countries (7.7) and the EU countries before 1 May 2004 (6.8 in 2001) respectively. Since 2004, continuing education has been made obligatory for all health professionals, to be documented every five years.

Pharmaceuticals

Until 2003, licensing of drugs generally meant SHI coverage, unless they were listed in a negative list as "inefficient" or used for "trivial" diseases by the Federal Ministry of Health. Since 2004, life-style drugs and over-the counter medications are generally excluded unless the latter are named as exceptions in a specific positive list by the Federal Joint Committee.

Pharmaceuticals became the sector with the strongest spending increases, especially as the SHI regional pharmaceutical spending caps were lifted in 2001. Consequent price-reduction measures have reduced this tendency for SHI. While the structure of prescribing has improved throughout the 1990s, this tendency slowed down although prescription-feedback to physicians was introduced.

In 2004, the pharmacy market was substantially reorganized. Pharmacists may now own up to three pharmacies, and mail-order commerce is allowed. The price-setting of over-the-counter medications was liberalized. For prescription-only drugs, pharmacists' profit margins were shifted towards a flat rate of €8.10 plus a fixed margin of 3%.

Specifically for SHI, rebates were (transiently) increased and reference prices for patented drugs were reintroduced.

Financial resource allocation

Third-party budget setting and resource allocation

Statutory health insurance sectoral budgets have been a central element of cost-containment policies. The introduction of competition among the many funds was accompanied by risk structure compensation mechanisms requiring repeated modification to avoid risk selection.

Payment of hospitals

Hospitals are financed on a dual basis: Investments for hospitals enlisted in hospital plans are planned by the 16 state governments and financed by state and federal governments jointly, while sickness funds finance recurrent expenditures and maintenance costs of hospitals.

The German adaptation of the Australian system of diagnosis-related groups (DRG) is becoming the sole system of paying for recurrent hospital expenditures (except mainly for psychiatric care), replacing the previous mixed payment system. Since January 2004, hospitals have been requested to document their care activities according to the DRG scheme. From 2005, payment will be adjusted gradually from individual hospital budgets, which vary greatly, to uniform base rates by 2009. The DRG-payment system was developed step by step and will be adjusted continuously by the stakeholders involved with technical support from the Institute for the Development of the Hospital Payment System. Since 2003, regulations for minimal volumes apply in major surgery.

Payment of physicians

Regional physicians' associations negotiate contracts for ambulatory services collectively for all SHI-affiliated physicians in their region on an annual basis. Sickness funds transfer fixed per-capita amounts according to the number of SHI-insured living in the region to the physicians'

associations, which leads to de facto budgets for ambulatory physician services. The regional physicians' associations divide the financial resources in separate funds for family physicians and specialist physicians and distribute the resources among their members according to the nationally uniform scale of relative point values and regionally adapted rules.

SHI-affiliated physicians receive their income from the regional physicians' associations (for SHI-insureds), private health insurers and other sources mainly on a fee-for-service basis although elements of per-capita and case-fee payments have been increased in recent years. Limitations of service (and prescription) volumes apply by speciality and age structure of the patients treated. They are controlled and sanctioned by regional physicians' associations or joint committees with sickness funds. Documented exceptions due to patients' needs are respected. Reimbursement accounts for the depreciation of investments. From 2005, a substantially revised fee schedule will be introduced to allow for higher transparency and accountability.

Health care reforms

Health care reforms have been driven by the major objective of cost-containment. Increasingly, other objectives such as effectiveness, appropriateness, quality and cost-effectiveness as well as patient involvement have gained importance and have shaped the behaviour of health care providers and payers. Additionally, developments such as German reunification or EU directives and jurisdictions as well as welfare reforms not primarily driven by the health sector have provided important challenges for German health care financing and delivery.

Health care reforms between 1989 and 1995 were characterized by strong expenditure control in all sectors of care. On the other hand pro-competitive regulations among payers and in the hospital sector were introduced, buffered by measures to avoid adverse effects on equity and quality. In addition, new benefits were introduced to meet health needs of the population more appropriately and at efficient points of care. In particular, access to long-term care benefits was extended substantially by introducing statutory long-term care insurance as a new fifth pillar of social insurance.

Reform acts in 1996 and 1997 aimed at lessening provider budgets and increasing out-of-pocket payments, both by raising co-payments and reducing certain benefits in the areas of prevention, rehabilitation and dentures.

The Social Democratic-Green government (since 1998) quickly removed the majority of these 1996/97 changes, and strict cost-containment measures targeting all sectors of provision were re-introduced. Additional measures included the mandate for a stepwise introduction of a DRG payment system in hospitals, a lessening of the strict ambulatory-inpatient separation by allowing "integrated care" contracts as well as various regulations aiming at an improvement of quality.

Between 2000 and 2003, a variety of small acts were introduced: the pharmaceutical spending caps were lifted and replaced by price controls, rebates for SHI, negotiation powers for the actors of the SHI self-governance and finally prescription feed-back for physicians. In addition, the DRG introduction was prepared through a series of acts, ordinances and new institutions. Another area was the reform of the risk structure compensation scheme, especially through the introduction of disease management programmes.

The Statutory Health Insurance Modernization Act pushed many of these reforms a step further or made them obligatory from 2004. Innovative delivery models of care were given a firm basis, thereby diversifying the delivery landscape of health care. The law required e.g. that all sickness funds now have to offer primary-care models where family physicians act as gate-keepers.

The coordination of decision-making powers of SHI was strengthened by unifying the various sectoral committees into the new Federal Joint

Committee. Furthermore the act introduced an array of cost-containment measures and structural changes in the pharmaceutical sector. Publicly most visible was the policy turn towards private financing through co-payments (e.g. for physician visits) and benefit exclusions; i.e. it partly reverted on solutions of the 1996–1997 reforms.

Since January 2004, sickness funds have made substantial savings particularly due to the increase of co-payments, the reduction of benefits, and rebates in the drug sector, yet, contribution rates have not been reduced as much as expected by federal government.

Future reforms are already underway. They include the enactment of a governmental bill to strengthen prevention and help to coordinate activities of the various actors involved. However, public reform debates focus mainly on the revenue side of SHI as well as long-term care schemes. The major political parties are at odds with each other (and within their membership) about the future funding of the health care system. Policy proposals range basically between alternative concepts: 1) introducing a flat-rate health premium for people currently covered by SHI with tax-support for the poor or 2) extending the contribution-based insurance to the entire population and including non-salary-based types of income. While the first aims at decoupling insurance contributions from cost of labour, the latter aims at extending the contribution base beyond the shrinking contributory basis of wages and transfer payments.

Conclusions

The plural health care system of Germany places a high emphasis on free choice of providers and insurers. This is coupled with a – by international comparison – high level of financial, physical and also human resources which allows for ready access to ambulatory as well as inpatient care. Health and care inequities between the eastern part and the western part have been reduced substantially since reunification. Overall, life expectancy and most indicators available for health have improved substantially during the last 15 years.

The various SHI stake-holders have managed to maintain comprehensive health care coverage despite the economic challenges of reunification, decreasing SHI revenues, and ongoing cost-containment policies. Residents experience comparably little waiting time and have equal access to comprehensive health care, although to a lesser degree in rural areas.

Various cost-containment measures – including sectoral budgets, reference prices, rational prescription and user charges – have kept statutory health expenditures close to the level of GDP growth. However, cost-containment measures alone have not been able to prevent sickness funds from having to raise their contribution rates or even from running into deficit. It has been widely recognized by now that – even when cost-containment policies are continued – the crisis on the income side may overshadow the expenditure crisis.

One weakness of the German system, the fragmentation of care across sectors, has been addressed by several recent reforms, e.g. integrated delivery networks. While this will open new opportunities for the hospitals, it might also aggravate the problem of large, often duplicate capacities for specialized ambulatory care. Also, it is expected that earlier discharges from acute care will pose substantial challenges to the ambulatory sector and e.g. institutions for rehabilitation.

Related areas for future reform are the development of appropriate and cost-conscious reimbursement mechanisms for ambulatory physicians, balancing the interplay of incentives across levels of care as well as the degree of sickness funds to selectively contract providers.

Health technology assessment and quality assurance have gained ground but are still not undisputed. It remains to be seen which impact the Federal Joint Committee and the new Institute for Quality and Efficiency will have on effectiveness, appropriateness, quality and cost-effectiveness of care.

HiT summary

Germany

The Health Care Systems in Transition profile on Germany 2004 was written by Reinhard Busse and Annette Riesberg (European Observatory on Health Systems and Policies, Technische Universität Berlin). It is based on the HiT profile 2000 which was written by Reinhard Busse (then European Observatory on Health Care Systems, Madrid) in collaboration with Annette Riesberg (Federal Ministry of Health) and edited by Anna Dixon (European Observatory on Health Care Systems, London School of Economics).

The European Observatory on Health Systems and Policies is grateful to Martin Schölkopf (Federal Ministry of Health and Social Security) and Markus Wörz (Technische Universität Berlin) for reviewing the report. Thanks are also extended to Helmut Brand (State Public Health Office, North Rhine-Westphalia), Dorothea Bronner (Office of the Federal Joint Committee), Eva Susanne Dietrich (Federal Association of Statutory Health Insurance Physicians), Christian Gawlik (Federal Insurance Authority), Pekka Helstelä (Federal Association of Regional Sickness Funds), Regina Kunz (Office of the Federal Joint Committee) and Matthias Perleth (Federal Association of Regional Sickness Funds) who reviewed the HiT profile concerning specific aspects and provided valuable information.

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Systems and Policies.

The Observatory is a unique undertaking that brings together the WHO Regional Office for Europe, the governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health care systems in Europe.