Health Insurance in Germany: Challenges and current developments

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Ca. 250 sickness funds with self-government, organised in 7 associations

Wage-related contribution ca. 13.4% (50/50) +0.9%

Insured since 2005

Choice of fund since 1996

“Risk-structure compensation” since 1994/95

Strong delegation & limited governmental control

Free access

Cost-sharing

Providers

Public-private mix, organised in associations

The German system at a glance ...
Main cost-sharing requirements since 2004

- **Pharmaceuticals:**
  prescription drugs 10%, min. € 5 (750 yen), max. € 10 (1,500 yen) + amount above reference price, 0 if price max. 80% of reference price; over-the-counter drugs normally 100%

- **Inpatient treatment:**
  € 10 (1,500 yen)/ day for max. 28 days/ year

- **Ambulatory medical and dental treatment:**
  € 10 (1,500 yen) per first visit in every quarter and for visits without referral

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Fear “chronically ill don’t go to physicians“ was not true!

<table>
<thead>
<tr>
<th></th>
<th>Not chronically ill</th>
<th>Chronically ill</th>
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<tbody>
<tr>
<td>With visit 2003</td>
<td>69.4%</td>
<td>92.2%</td>
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<tr>
<td>2004</td>
<td>68.2%</td>
<td>93.6%</td>
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<tr>
<td>Number of visits 2003</td>
<td>2.51</td>
<td>6.09</td>
</tr>
<tr>
<td>2004</td>
<td>2.28</td>
<td>6.06</td>
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Grabka, Schreyögg, Busse 2006
Problem 1: Rising expenditure = rising contribution rates

Problem 2: Pharmaceutical expenditure
Spending caps: effective for cost-containment but politically unsustainable

Problem 3: Quality and cost-effectiveness

- Germany always knew that its health care system was expensive, but was sure it was worth it (“the best system“)
- Quality assurance was introduced early but concentrated on structure
- Increasing doubts since late 1990s: Health Technology Assessment introduced since 1997
- World Health Report 2000: Germany only # 25 in terms of performance (efficiency)
- International comparative studies demonstrate only average quality (especially low for chronically ill)
Problem 4: Strict separation between ambulatory and hospital (inpatient) care with different regulatory environment and rules
Disease Management Programmes (since 2002)

- Compensate sickness funds for chronically ill better (make them attractive) = reduce faulty incentives to attract young & healthy
- Address quality problems by guidelines/pathways
- Tackle trans-sectoral problems by “integrated” contracts
- = introduce Disease Management Programs meeting certain minimum criteria and compensate sickness funds for average expenditure of those enrolling (new RSC categories)

**double incentive for sickness funds:** potentially lower costs + extra compensation!

Problem 5:
Financial incentives vary between sectors/providers and are changed frequently – „solutions“ to old problems create new ones
Hospital Income from 2004 (fully from 2009)

**Case fees based on DRGs**

- additional fees
- surcharges and discounts
- fees for new treatments and diagnosis
- DRG systems surcharge
- additional payment if LOS is longer than the max. LOS in DRG-calculation

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Population Providers

- Ca. 250 sickness funds with self-government, organised in 7 associations
- Wage-related contribution ca. 13.4% (50/50) +0.9% insured since 2005
- SHI insures 87% (75% mandatorily, 12% voluntarily)

Choice of fund since 1996

- Public-private mix, organised in associations
- Free access
- Strong delegation & limited governmental control

Providers

- Contracts, mostly collective
- Multi-level funding, tax funding of children

"Risk-structure compensation" since 1994/95

- New payment systems, esp. DRGs in hospitals
- Disease Management Programmes, selective contracts (GP models, "integrated care")
- Benefit evaluation/ Health Technology Assessment

"More morbidity orientation? Or less RSC?"

Universal coverage?

- "Bürgerversicherung"

Decision-making: government vs. self-governing actors; patient groups

Choice of fund since 1996

Ca. 250 sickness funds

- Strong delegation

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"Health fund" [Contributor collector]

Third-party payer

Population

Providers

Risk-adjusted allocation to sickness funds

Sickness funds, organized in ONE association

Uniform contribution rate (determined by government)

Federal Joint Committee = full-time members

Mostly collective but more "selective" contracts (?)

Extra premium (positive or negative)

Sickness funds, organized in ONE association

"Health fund"

Uniform contribution rate (determined by government)

Federal Joint Committee = full-time members

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Population

Providers

Act to Increase Competition in Statutory Health Insurance = Act to weaken self-government in favour of "state medicine"?

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PHI remains but will be obliged to accept everybody (for a standard premium?)