The German Health Care System: A (Very) Short Introduction

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The German system at a glance ...

- Population
  - SHI insures 87% (75% mandatorily, 12% voluntarily)
- Providers
  - Public-private mix, organised in associations
  - ambulatory care/ hospitals
- Third-party payer
  - Ca. 250 sickness funds with self-government, organised in 7 associations
- Strong delegation & limited governmental control
- Contribution collector
  - Wage-related contribution ca. 13.4% (50/50) +0.9%
  - insured since 2005
- "Risk-structure compensation" since 1994/95
- Free access
- Cost-sharing
Joint self-government  Statutory health insurance early 2007

Even though certain regulatory institutions and programmes have become trans-sectoral …

Members: 9 sickness funds
9 providers
3 neutral
+ 9 patients
(no voting rights)
Problem: 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)

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!*
Private health and long-term care insurers
Statutory sickness funds
Federal and state governments
Voluntary private insurance

Voluntary private insurance
Premiums 9.0%
Contributions 7.5%
General taxation 6.2%

Public health services 0.9%
Ambulatory nursing care providers 2.9%
Nursing homes 7.6%
Public, private non-profit and private for-profit hospitals 27.0%
Pharmacies 13.6%
Dentists 7.0%
Ambulatory care physicians 14.8%

... many others are still sector-specific (which is especially problematic for intersectoral “integrated“ care)

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Federal Office for Quality Assurance (BQS): mandatory for all 1800 hospitals, 170 indicators, with feedback and “structured dialogue”

Is the appropriate thing done?
- Indikationsstellung: 13%

Is it done correctly?
- Prozesse: 27%

With what (short-term) results?
- Ergebnisse: 60%

An example (with slow progress):
**Documentation of operation distance to (breast) cancer**

- 2003: 72.52%
- 2004: 75.67%
- 2005: 83.19%

Mammachiurgie 2005: Angabe Sicherheitsabstand bei BET (KoZ 68098)
Contribution collector  Third-party payer

Risk-adjusted allocation to sickness funds

„Health fund“

Uniform contribution rate (determined by government)

Extra premium (positive or negative)

Sickness funds, organized in ONE association

Federal Joint Committee = full-time members

Mostly collective but more „selective“ contracts (?)

Population

Providers

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

Act to Strengthen Competition in Statutory Health Insurance = Act to weaken self-government in favour of „state medicine“?
“Do the thing right“: Benchmarking/league tables; registers

“Do the right thing“: *ex ante* Guidelines/disease management programmes/reminders; *ex post* Review

Educational tools

Professional (re-)certification
Provider (re-)accreditation
Health Technology Assessment
Concentration of services

Environment
Nutrition/agriculture
Other sectors

Health care system

Population health status (need)

Human resources

Technologies

Financial resources

Patients' demand/access

Structures and organisation

Process

Health care outcome: satisfaction, complications etc.

Health gain/Outcome