The health system in Germany

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Who is covered?

Publicly-financed ('social') health insurance is compulsory for employees earning up to €48,000 per year and their dependants. Employees with earnings above this amount are currently not obliged to be covered. If they wish, they can remain in the publicly-financed scheme on a voluntary basis, they can purchase private health insurance or they can be uninsured. The publicly-financed scheme covers about 88% of the population. Around three quarters of those who are able to choose between public or private health insurance (less than 20% of the population) opt to remain in the publicly-financed scheme, which offers free cover of dependants. Most of the remainder purchase private health insurance. In total, 10% of the population are covered by private health insurance, mainly civil servants and self-employed people who generally do not fall under social health insurance. Less than 1% of the population has no insurance coverage at all. From 2009, health insurance will be compulsory for the whole population, depending on previous insurance and/or job status.

What is covered?

Services: the publicly-financed benefits package covers preventive services; inpatient and outpatient hospital care; physician services; mental health care; dental care; prescription drugs; rehabilitation; and sick leave compensation. Long-term care is covered by a separate insurance scheme, which has been compulsory for the whole population since 1995.

Cost sharing: traditionally the publicly-financed scheme has imposed few cost sharing provisions (mainly for pharmaceuticals and dental care). However, in 2004 co-payments were introduced for adult visits to physicians and dentists (€10 each for the first visit per quarter or subsequent visits without referral), while other co-payments were made more uniform: €5 to €10 per pack of outpatient prescription drugs (except if the price is at least 30% below the reference price*, which is the case for more than 12,000 drugs), €10 per inpatient day (up to twenty-eight days per year) and €5 to €10 for prescribed medical aids. For dental prostheses, patients receive a lump sum which covers, on average, 50% of costs. In total, out-of-pocket payments accounted for 13.8% of total health expenditure in 2005.[1]

Safety nets: children up to the age of eighteen are exempt from cost sharing. Cost sharing is generally limited to an annual maximum of 2% of household income (or 1% for chronically ill people). For additional family members, a proportion of household income is excluded from this calculation.

How are revenues generated?

The publicly-financed scheme: this is operated by over two hundred competing health insurance funds (known as sickness funds – SFs): autonomous, non-profit, non-governmental bodies regulated by the government. The scheme is funded by compulsory contributions on the first €43,000 earned in a year. On average, the employee contributes almost 8% of gross earnings, while the employer contributes a further 7%. Dependants are covered through the primary SF member. Unemployed people contribute in proportion to their unemployment entitlements, but since 2004 the government employment agency has paid a flat rate per capita contribution for long-term unemployed people. Currently, SFs are free to set their own contribution rates for all other members. However, from 2009, a uniform contribution rate will be set by the government and, although SFs will continue to collect contributions, all contributions will be centrally pooled by a new national fund, which will allocate resources to each SF based on an improved risk-adjusted capitation formula. In addition to this, SFs will be allowed to charge their members a flat-rate premium. In 2005 public sources of finance accounted for 77.2% of total health expenditure.[1]

Private health insurance: private health insurance playing a substitutive role** covers groups excluded from publicly-financed health insurance (civil servants and self-employed people; the former have part of their health care costs directly reimbursed by their employers) and high earners who choose to opt out of the publicly-financed scheme. All pay a risk-rated premium, although contracts are based on life-time underwriting, so risk is assessed upon entry only. Substitutive private health insurance is regulated by the government to ensure that the insured do not face increasing premiums as they age (the old age reserves requirement) and that they are not overburdened by premiums if their income falls (access to a 'standard tariff' with benefits and premiums that match those of the publicly-financed scheme). From 2009, private insurers offering substitutive cover will be required to take part in a risk adjustment scheme to finance the costs of cover for people in ill health, who would otherwise not be able to afford a risk-rated premium. Private health insurance also plays a mixed complementary and supplementary role, providing SF members with cover for some health care costs and access to better amenities. In 2005, private health insurance accounted for 9.1% of total health expenditure.

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* The reference price is the maximum price reimbursed for a group of equal or similar drugs.

** Substitutive private health insurance covers people excluded from or allowed to opt out of the publicly-financed health insurance scheme.

How is the delivery system organised?

Physicians: individuals have free choice of ambulatory physician. General practitioners have no formal gatekeeper function. However, in 2004 SFs were required to offer their members the option of enrolling in a 'family physician care model' which may provide a bonus for complying with gatekeeping rules. Ambulatory specialist care is mainly delivered by private for-profit providers working in single practice, although policlinic-type ambulatory care centres with employed physicians have been permitted since 2004. Physicians in the ambulatory sector are paid a mixture of fees per time period and per medical procedure. These are agreed following annual negotiations between SFs and regional physician associations to determine aggregate payments.

Hospitals: individuals have free choice of hospital (following referral). Hospitals are mainly non-profit, both public (about half of beds) and private (about a third of beds). The private, for-profit hospital sector has grown in recent years (about a sixth of beds), mainly through takeovers of public hospitals. Independent of ownership, hospitals are principally staffed by salaried doctors. Senior doctors may also treat privately-insured patients on a fee-for-service basis. Doctors in hospitals are typically not allowed to treat outpatients, although exceptions have been made when necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals may also provide certain highly specialised services on an outpatient basis. Inpatient care is reimbursed through a system of diagnosis-related groups (DRG) per admission, currently based on around 1,100 DRG categories. The DRG system was introduced in 2004 and is revised annually to take into account new technologies, changes in treatment patterns and associated costs into account..

Disease Management Programmes (DMPs): legislation in 2002 created DMPs for chronic illnesses in order to give SFs an incentive to care for chronically ill patients. DMPs exist for diabetes type I and II, breast cancer, coronary heart disease, asthma and chronic obstructive pulmonary disease. DMP participants are accounted for separately in the risk-adjustment mechanism for SFs, resulting in higher per capita allocations. At the end of 2007 there were 14,000 regional DMPs with 3.8 million enrolled patients.

Government: the German government delegates regulation to the self-governing corporatist bodies of the sickness funds and the providers' associations. The most important body is the Federal Joint Committee (G-BA) created in 2004 to increase efficacy and compliance. Greater purchasing power has also been given to individual SFs, for example, to contract providers directly, to negotiate rebates with pharmaceutical companies or to procure medical aids.

What is being done to ensure quality of care?

A range of measures have been introduced to ensure quality of care. Structural quality is addressed by the requirement for all providers to establish a quality management system; the obligation for continuous medical education for all physicians; health technology assessment for drugs and procedures, for which the Institute for Quality and Efficiency (IQWiG) was founded in 2004; voluntary hospital accreditation; and minimum volume requirements for a number of complex inpatient procedures (such as transplants). Process and (in part) outcome quality is addressed through the mandatory quality reporting system for all acute hospitals. Under this system, over one hundred and fifty indicators are measured for thirty medical conditions covering about a sixth of all inpatients. Hospitals receive individual feedback. Since 2007, around thirty indicators are required to be made public in the annual quality reports that all hospitals must publish.

What is being done to improve efficiency?

In addition to the quality measures noted above, a further set of measures aims to address efficiency more directly. Since 2004, all drugs (patented as well as generic) have been subject to reference prices unless they can clearly demonstrate added value. Beginning in 2008, IQWiG will explicitly evaluate the cost-effectiveness of drugs, putting pressure on pharmaceutical prices. The DRG system for paying hospitals is based on average costs.

How are costs controlled?

In line with a greater emphasis on quality and efficiency, the cruder cost containment measures used in the past have been revised (notably, the use of sector-wide budgets for ambulatory physicians, hospital budgets and the collective regional drug prescription cap for physicians). The drug prescription cap, which complemented reference pricing for pharmaceuticals, was lifted in 2001, initially leading to an unprecedented increase in spending on pharmaceuticals by SFs. Following this, drug prescription caps with individual physician liabilities were introduced. More recently, contracts involving rebates and incentives to lower prices below the reference price are being used to control pharmaceutical spending. In 2009 hospital budgets will be fully replaced by the DRG system (using state-wide base rates). From 2009, budgets for ambulatory care will be replaced by a more sophisticated resource allocation mechanism that accounts for population morbidity.

REFERENCES

1. World Health Organization. *World Health Statistics 2007*. Geneva: World Health Organization, 2007.

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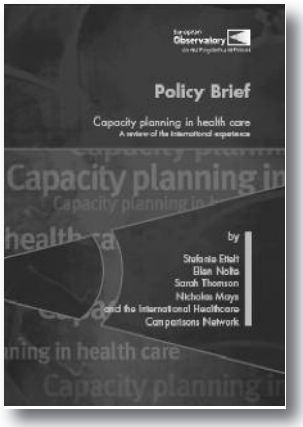

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