The German Health Care System

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Everything you always wanted to know about European Union health policies but were afraid to ask

Bridging the gap between evidence and policy-making

www.healthobservatory.eu
Actors & Functions

Pooling & (Re-)Allocation

Collector of resources → Purchaser ("Third-party payer")

Mobilizing financial resources/ funding → "Regulator"

Purchasing services/ paying providers → Provider

Access to and provision of services → Population
The German system at a glance

**Collector of resources**

Health Fund

**"Risk-structure compensation"**

**Third-party payer**

121 sickness funds

44 private insurers

Uniform wage-related contribution
+ possibly extra contribution set by sickness funds

Risk-related premium

Choice of fund/insurer

Population

Universal coverage:
- SHI: 86%
- PHI: 11%

Provider

Public-private mix, organized in associations ambulatory care/hospitals

Choice

strong delegation & limited governmental control

contracts, mostly collective

PHI: no contracts
Key characteristics

(1) Sharing of decision-making powers between the sixteen Länder (states), the federal government and statutory civil society organizations

- Large degree of regulation is delegated to self-governing associations of sickness funds and providers with the Federal Joint Committee as the most important decision making body

(2) German health care (almost)=Statutory health insurance (SHI)

- SHI Cornerstone of health service provision is the Social Code V, i.e. it organizes and defines the self-regulated „coporatist“ structures and give them the duty and power to develop benefits, prices and standards
Decision-making in Germany

Parliament

Federal Ministry of Health

Legislation

Supervision

Patient

Federal Association of SHI Physicians (KBV)

German Hospital Federation (DKG)

150,000 ambulatory care physicians and psychotherapists

121 sickness funds

Federal Association of Sickness Funds

2,100 hospitals

Federal Joint Commitee (G-BA)

Members: 13 voting – 3 neutral + 5 sickness funds + 5 providers (+ up to 5 patient representatives)

Statutory Health Insurance
The Federal Joint Committee: objectives

- Main functions: to regulate SHI-wide issues of access, benefits and quality.

- Normative function of the G-BA by legally binding directives ("sub-law") to guarantee equal access to necessary and appropriate services for all SHI insured.

- Benefit-package decisions must be justified by an evidence-based process to determine whether services, pharmaceuticals or technologies are medically effective in terms of morbidity, mortality and quality of life.

- By law, evidence-based assessments can only be used to select the most appropriate (efficient) service etc. from others – not to prioritize among service areas: if a costly innovation has a significant additional benefit, the sickness funds must pay for it.
Federal Joint Committee: sub-committees

Decisions are prepared by 9 sub-committees:

- Pharmaceuticals
- Quality Assurance
- Disease management programs
- Methodological Evaluation (inclusion of new ambulatory care services in benefit basket)
- Highly specialized ambulatory care
- Referred Services (rehabilitation, care provided by non-physicians, ambulance transportation etc.)
- Needs-based Planning (ambulatory care; hospital capacities are planned by state governments)
- Psychotherapy
- Dental Services
Federal Joint Committee: support through institutes

Parliament

Legislation

Federal Ministry of Health

Supervision

Patient

150,000 ambulatory care physicians and psychotherapists

Federal Association of SHI Physicians (KBV)

140 sickness funds

Federal Association of Sickness Funds

German Hospital Federation (DKG)

2,100 hospitals

Federal Joint Committee (G-BA)

Institute for Quality and Efficiency in Healthcare (IQWiG) – technologies

Institute for Quality and Transparency in Healthcare (IQTiG) – focused on providers

Statutory Health Insurance

03 September 2015

The Finnish Embassy
Key characteristics

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(3) Existence of substitutive private health insurance alongside SHI
Key characteristics

(4) Sectoral borders

- Provision of ambulatory and inpatient services.
- Planning, resource allocation, provision and financing are separate for office-based physicians and hospital sector.
  - Complicates the provision of health care delivery, especially for chronically ill (answers: Disease Management Programs and selective „integrated care“ contracts)
  - Increases the amount of specialists
  - Increases health care expenditures
- Various reforms have tried to lessen sectoral borders
  - 2012: creating a new in-between sector for highly specialized ambulatory care
  - 2015: innovation fund (financial support of €225 million per year for integrated care)
The ambulatory sector

c. 145,000 physicians, of which c. 130,000 self-employed

c. 83,000 single-handed practices (79%)
c. 83,000 physicians (58%)

c. 20,500 group practices (19%)
c. 51,500 physicians (36%)

c. 1,750 health centers (2%)
c. 9,500 physicians (6%)

Mandatory membership in 17 regional associations
2-step payment of ambulatory care physicians

Sickness fund X

Sickness fund Y

Sickness fund Z

Capitation based on previous year's utilisation, increase factor, adjustments

Physicians’ association (KV)

GP budget (ca. 1/3)

Specialists’ budget (ca. 2/3)

Capped FFS (e.g. specialty-specific case-volume age-based caps for basic (RLV) and groups of special services (QZV))

GP 1

GP 2

GP 3

Spec1

Spec2

Spec3
The hospital sector: many beds

Source: WHO HFA-Database, 2015
The hospital sector: many cases

Source: WHO HFA-Database, 2015
Hospital payment

- Operating costs (investment costs are covered through taxes by the Länder)
- Sickness funds negotiating activity based DRG budgets every year with every “planned” Hospital

\[
\text{Casemix} \times \text{Base rate} + \text{Supplementar y fees} = \text{Hospital budget} + \text{Extra- budgetary payments (e.g. for innovations)}
\]

- Budget over-run adjustment (hospital pays back):
  - 65% (standard DRGs), 25% (drugs, medical, polytrauma and burns DRGs), Negotiation for hardly predictable DRGs

- Budget under-run adjustment (hospital receives compensation):
  - 20% (standard DRGs)
Long-term Care

- Introduced in 1994
- Contribution of 2.35% (plus 0.25% for childless adults)
- Benefits upon application
- Decision through the Medical Review Board
## Long-term Care: recipients

### Recipients of LTC: number and proportion (%) according to grade and max. benefits in €

<table>
<thead>
<tr>
<th>Grade</th>
<th>Home care by relatives:</th>
<th>Home care supplied by ambulatory care services</th>
<th>Inpatient care in nursing homes</th>
<th>People in need of care total (2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade I</td>
<td>762 000 (65%)</td>
<td>324 000 (56%)</td>
<td>283 000 (38%)</td>
<td>1.37 Mio. (55%)</td>
</tr>
<tr>
<td></td>
<td>€ 235</td>
<td>€ 450</td>
<td>€ 1 023</td>
<td></td>
</tr>
<tr>
<td>Grade II</td>
<td>330 000 (28%)</td>
<td>189 000 (33%)</td>
<td>299 000 (40%)</td>
<td>818 000 (33%)</td>
</tr>
<tr>
<td></td>
<td>€ 440</td>
<td>€ 1 100</td>
<td>€ 1 279</td>
<td></td>
</tr>
<tr>
<td>Grade III</td>
<td>90 000 (7%)</td>
<td>63 000 (11%)</td>
<td>152 000 (22%)</td>
<td>305 000 (12%)</td>
</tr>
<tr>
<td></td>
<td>€ 700</td>
<td>€ 1 550</td>
<td>€ 1 550</td>
<td></td>
</tr>
</tbody>
</table>
## Long-term Care: providers

### Providers of LTC according to ownership and number of employees

<table>
<thead>
<tr>
<th>Number and ownership (private/non-profit/public)</th>
<th>12 349 ambulatory care services (63%/36%/1%)</th>
<th>12 354 nursing homes (40%/54%/6%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees</td>
<td>290 700 (73% part-time/88% female)</td>
<td>661 200 (68% in part-time/85% female)</td>
</tr>
</tbody>
</table>
Thank you very much!

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