

The German Health Care System

Reinhard Busse, M.D. M.P.H.

Professor of Health Care Management, Berlin University of Technology & Charité – University Medicine Berlin

Who is covered?

Public (“social”) health insurance (SHI) is compulsory for people earning up to around €48,000 per year, including dependents who are included in the insurance. This applies to around 75% of the population. Individuals with earnings above €48,000 per year (around 20% of the population) are currently not required to be covered. If they wish, they can remain in the publicly-financed scheme on a voluntary basis (and 75% of them do), they can purchase private health insurance, or they can theoretically be uninsured. The publicly-financed scheme covers about 88% of the population. In total, 10% of the population are covered by private health insurance, with civil servants and self-employed being the largest groups (both of which are excluded from SHI). Less than 1% of the population has no insurance coverage. From 2009, health insurance will be mandatory, depending on previous insurance and/or job status either in the social or in the private health insurance scheme.

What is covered?

Services: The SHI benefits package covers preventive services; inpatient and outpatient hospital care; physician services; mental health care; dental care; prescription drugs; medical aids; rehabilitation; and sick leave compensation. Since 1995, long-term care is covered by a separate insurance scheme, which is mandatory for the whole population.

Cost-sharing: Traditionally, the SHI scheme has imposed few cost-sharing provisions (mainly for pharmaceuticals and dental care). However, in 2004 co-payments were introduced for visits by adults

aged 18 years and older to physicians and dentists (€10 each for the first visit per quarter or subsequent visits without referral); other co-payments were made more uniform: €5 to €10 per pack of outpatient medications (except if the price is at least 30% below the so-called reference price, i.e. the maximum reimbursable amount for drugs of equivalent effectiveness, which is the case for more than 12,000 drugs), €10 per inpatient day (up to 28 days per year), and €5 to €10 for prescribed medical aids. For dental prostheses, patients receive a lump sum which on average covers 50% of costs. In total, out-of-pocket payments accounted for 13.8% of total health expenditure in 2005.

Safety Nets: Cost-sharing is generally limited to 2% of household income. For additional family members, part of the household income is excluded from this calculation. For the chronically ill, the cost-sharing limit is 1%. A directive sets out the conditions for qualifying as chronically ill; since 2008 it is also necessary to demonstrate that the person has received counselling on screening measures prior to the illness.

How is the health system financed?

Publicly-Financed Scheme (SHI): The SHI scheme is operated by over 200 competing health insurance funds (sickness funds; SFs): autonomous, not-for-profit, non-governmental bodies regulated by law. The scheme is funded by compulsory contributions based on wages up to a limit of around €43,000 per year. For 2008, the average insured employee (or pensioner) contributes almost 8% of the gross wage, while the employer (or the pension fund) adds another 7% on top of the gross wage, so the combined maximum contribution is around €540 per month. This includes dependents (non-earning spouses and children)

who are covered through the primary SF member. Unemployed people contribute in proportion to their unemployment entitlements, but for long-term unemployed people with a fixed low entitlement (so-called “Hartz IV”), the government employment agency pays a fixed per capita premium. Currently, SFs are free to set their own contribution rates for all other insured. Beginning in 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 health fund, which will allocate resources to each SF based on an improved risk-adjusted capitation formula. This formula will, in addition to age and sex, take morbidity from 80 chronic and/or serious illnesses into account, i.e. SFs will receive considerably more for patients with cancer, AIDS or cystic fibrosis than for “ordinary” insured. In 2009, SFs may charge an additional nominal premium if the received resources are insufficient. In 2005, public sources of finance accounted for 77.2% of total health expenditure.

Private health insurance (PHI): Private health insurance plays a substitutive role in covering the two groups excluded from SHI (civil servants, who are refunded parts of their health care costs by their employer, and the self-employed), as well as high earners who choose to opt out of the publicly-financed scheme. All pay a risk-related premium, with separate premiums paid for dependents; the risk is assessed upon entry only, though as contracts are based on life-time underwriting. Substitutive private health insurance is regulated by the government to ensure that the insured do not face massively increasing premiums by age and that they are not overburdened by premiums if their income decreases. Starting in 2009, private insurers offering substitutive cover will be required to take part in a risk adjustment scheme (separate from SHI) to be able to offer insurance for persons with ill health who could otherwise not afford a risk-related premium. PHI also plays a mixed complementary and supplementary role, adding certain minor benefits to the SHI basket, providing access to better amenities, such as single/double rooms, and covering some co-

payments, especially for dental care. In 2005, PHI accounted for 9.1% of total health expenditure.

How is the delivery system organised?

Physicians: General practitioners have no formal gatekeeper function. However, in 2004 SFs were required to offer their members the option to enroll in a “family physician care model” which provides a bonus for complying with gatekeeping rules. Ambulatory care in all specialities is mainly delivered by physicians working in solo practices, although polyclinic-type ambulatory care centres with employed physicians have been allowed since 2004. Physicians in the outpatient sector are paid by a mixture of fees per time period and per medical procedure. SFs annually negotiate with the regional associations of physicians to determine aggregate payments, which ensures cost control.

Hospitals: Hospitals are mainly non-profit, both public (about half of all beds) and private (around one-third of all beds). The private, for-profit segment has been growing over the last years (around one-sixth of all 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. Exceptions have been made if necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals may also provide certain highly specialized services on an outpatient basis. Inpatient care is paid through a system of diagnosis-related groups (DRG) per admission, currently based on around 1,100 DRG categories. The system was introduced in 2004 and is revised annually to take new technologies, changes in treatment patterns, and associated costs into account.

Individuals have free choice of ambulatory care physicians and, if referred to inpatient care, of hospitals.

Disease Management Programs (DMPs): Legislation in 2002 created DMPs for chronic illnesses in order to give the SFs an incentive to care for chronically ill patients. DMPs currently exist for diabetes types 1 and 2, breast cancer, coronary heart disease, asthma and chronic obstructive lung disease. DMP participants are accounted separately in the risk-adjusted reallocation mechanism between SFs, i.e. they generally receive higher per-capita allocations than for non-DMP participants. Through that mechanism, SFs with higher shares of DMP patients receive higher compensation. There are currently 14,000 regional DMPs with 3.8 million enrolled patients (as of late 2007).

Government: The German government delegates regulation to the self-governing corporatist bodies of both the SFs and the medical providers' associations. The most important body is the Federal Joint Committee, created in 2004 to increase efficacy and compliance; it replaced several sectoral committees. However, more purchasing powers are also given directly to the individual SFs, e.g. to contract providers directly, to negotiate rebates with pharmaceutical companies or to procure medical aids.

What is being done to ensure quality of care?

Quality of care is addressed through a range of measures: *Structural quality* is addressed by the requirement to have a quality management system for all providers, the obligation for continuous medical education for all physicians, and health technology assessment for drugs and procedures (for which the Institute for Quality and Efficiency, IQWiG, was founded in 2004), while hospital accreditation is voluntary. Minimum volume requirements were introduced for a number of complex procedures (e.g. transplantations), thereby requiring hospitals to provide this number in order to be reimbursed. *Process and partly outcome quality* is addressed through the mandatory quality reporting system for all 1800+ acute care hospitals. Under this system, more than 150 indicators are measured for 30 indications covering

about one-sixth of all inpatients in Germany. Hospitals receive an individual feedback. Since 2007, around 30 indicators are made public in annual, mandatory hospital quality reports.

What is being done to improve efficiency?

Besides the measures to increase quality listed above, a set of other measures addresses efficiency more directly. All drugs, both patented and generic, have been subject to reference prices since 2004, unless they can demonstrate a clear added medical benefit. From 2008, IQWiG will explicitly evaluate the cost-effectiveness of drugs, thereby adding pressure on pharmaceutical prices. As mentioned, all hospitals are reimbursed through DRGs, so hospitals are paid the same for the same type of patient. As DRGs weights are calculated based on average costs, this puts enormous pressure on less efficient hospitals.

How are costs controlled?

In line with placing more emphasis on quality and efficiency, the previously imposed, relatively crude, but successful cost-containment measures (especially sector-wide budgets for ambulatory physicians, hospital budgets, collective prescription caps for physicians on a regional basis) are carefully revised. The prescription cap, which complemented the reference prices for pharmaceuticals, was lifted in 2001, initially leading to an unprecedented increase in spending on pharmaceuticals by the SFs. Then, prescription caps with individual liabilities were introduced. More recently negotiated rebates between SFs and pharmaceutical manufacturers and incentives to lower prices below the reference prices are the major instruments. Hospital budgets are being phased out between 2005 and 2008, while per-case DRGs become the main instrument to reimburse inpatient care. From 2009, the fixed budgets for ambulatory care will be replaced by more flexible budgets that take population morbidity into account.