

The German Health Care System

A Concise Overview

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Preface

The German health care system, established in the late 19th century, is historically the first universal health care system. After World War II, in line with the “Universal Declaration of Human Rights” of 1948, other universal health care systems emerged all over Europe, some following the German example, some coming up with new ways to administer and finance health care for their people.

The development of individual health care systems in Europe created a wide variety of variations, e.g. concerning the way systems are financed, the organization of the public health care system, the extent to which different stakeholders are involved (e.g. the state, insurance providers, professionals etc.), the main contributors and other interesting distinctions. In trying to understand the complex health care systems that have evolved, a large number of aspects need to be taken into account. On a governmental level, one of the most important aspects is cost-effectiveness. Although the German health care system is among the systems providing a very high quality of health care, it is also one of the most expensive and keeps undergoing reforms to reduce costs and maintain or improve quality.

This book aims to provide an interested international audience with insight into the “German way” of providing universal health care with all its advantages and disadvantages. We hope it will contribute to facilitating a better understanding of the German health care system by providing information on a multitude of aspects for scientific and practical discussions and exchange.



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Foreword

Over the years, all of us have had numerous occasions where we were asked to provide an overview or details about the German health care system. This happened during teaching, when exploring business opportunities in one of the world's largest health care markets, when debating the merits and disadvantages of social health insurances, or when it came to technical issues about quality, access to care, and the like.

We realized that firstly, the German system was rather complex and could only be understood when combining a historical perspective with major current approaches to reform. Secondly, we were not well prepared to give answers that would put things into perspective. When searching for a concise overview, it became clear that there was a gap between brief overviews (in leaflets and brochures) and scholarly, in-depth presentations. In addition, publications in English were even more rare.

None of the literature we found, however, provided graphical presentations that would give a quick overview and pointed towards major distinguishing elements of the German system.

With this book, we aim to present a novel approach that will hopefully allow students, foreign scholars, and practitioners alike to gain a quick grasp and understanding. We present sets of graphics/tables with short explanations of key aspects of the health care system that will allow the reader to put any particular aspect into perspective and have a solid basic understanding before reaching out for more detailed accounts.

Obviously, we had to limit the amount of information and data in this book. Experts in any of the fields will notice limitations and we could not cover all intricate and interesting

details. For this, we refer to the scholarly accounts and detailed papers on specific aspects of the German system.

Our heartfelt thanks go to the students with whom we had an intense workshop on the German health care system; from this workshop the book subsequently developed.

Jasper Scheppe provided invaluable research assistance.

We learned new things and got a better understanding when putting together the overview. We hope the reader will benefit from reading and browsing through this book.

Finally, our deep gratitude goes to pfm medical Institute GmbH, Cologne, which provided generous and unrestricted financing for making this booklet possible.

*Konrad Obermann
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1

How the System Evolved: History, Principles, and Reforms

- 1.1 History
- 1.2 Principles & Corporatistic Structures
- 1.3 Recent Reforms

1.1 History

The Need to Provide Social Security

The earliest forms of (health) insurance developed during medieval times in the form of guilds and miners' associations. This was due to a combination of facing substantial risks, being relatively well off, and for trying to instill some form of solidarity.

Major reforms were undertaken in the 1880s amidst a turbulent industrial development.

Industrialization had led to a massive labor migration from the countryside to the cities. Large parts of the population suffered from insufficient health care, which led to pauperisation due to the inability to work.

The traditional systems of social support, e.g. family, village communities or feudal systems, could not handle the "industrialized population", and improved health care became a focus of the labor movement.

The "social question" also was raised by an encyclical of Pope Leo XIII in 1891. In addition there was a strong movement from academics, mostly economists, ("Kathedersozialisten" e.g. Gustav von Schmoller, Werner Sombart) to

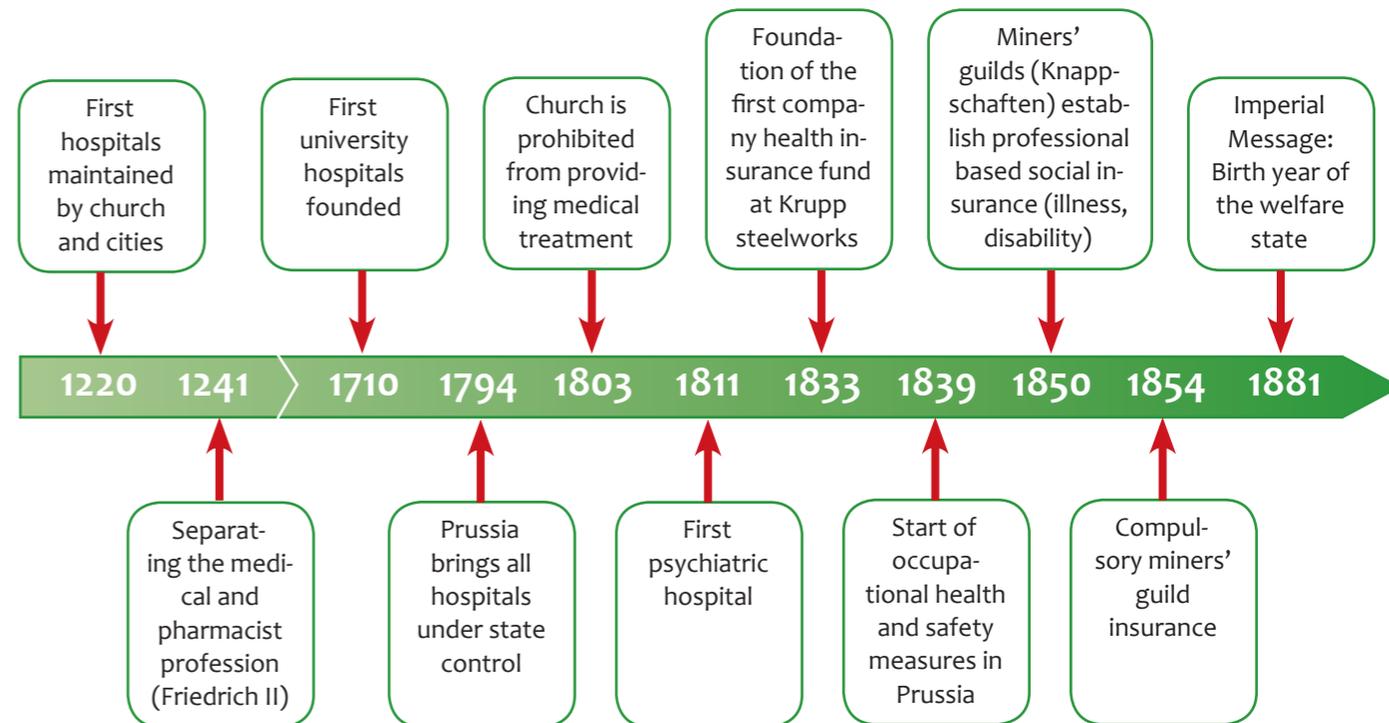
develop a coherent social policy in order to curtail the influence of revolutionary social democrats.

Chancellor Bismarck, under political pressure from workers' associations, initiated legislation for social security systems. A tax-financed system was not viewed favorably by the influential East-Elbian nobility as they feared increased responsibility and correspondingly, higher taxes.

Bismarck himself, although deeply rooted in Christian tradition, looked at social policy primarily from a state perspective: "What is favorable for the Prussian State and the German Empire?" was his guiding principle and overarching goal.

Also, he felt that it would be prudent to allow for participation and self-administration in order to reconcile workers to the established political and economic order.

Health Care Before Bismarck



The 1881 Imperial Message (“Kaiserliche Botschaft”)

“Already in February of this year We voiced our conviction that the healing of the social damage cannot only be sought through the repression of social riots, but equally on the positive promotion of the welfare of the workers. We consider it our Imperial obligation to again recommend warmly this task to the Reichstag, and We would look back with much greater satisfaction to all the success with which God has obviously blessed Our government, if We were to raise awareness on this issue and bring the fatherland new and permanent guarantees of its internal peace and to help those in need with greater security and efficiency of the assistance to which they are entitled.

[...]

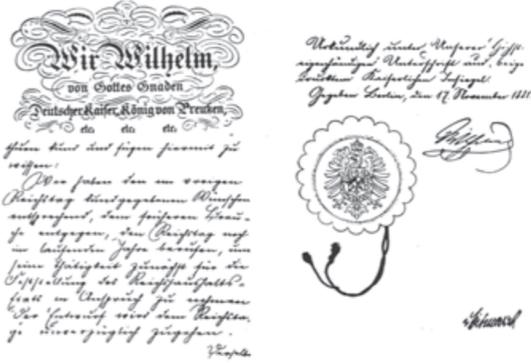
For such assistance it is a difficult task to find the right ways and means, but also one of the highest responsibilities of any community, based on the moral foundations of Christianity. The close connection to real life forces of this nation and the merging of the latter in the form of corporate co-operatives under state protection and state support will, as We hope, make the solution of tasks possible that the state alone to the same extent could not provide.”

[...]

A Clear-Cut Conceptual and Ethical Basis to Establish Social Protection



Wilhelm I, German Emperor



Otto von Bismarck, Chancellor

Social Security Develops

- 1881: “Imperial Message” as foundation of social security system
- 1883: Establishment of statutory health funds by Bismarck.
- Establishment of the “Accident Fund” in 1885 and the “Pension Fund” in 1891.
- In 1885: about 11% of the total population is covered by more than 18 000 sickness funds – the average number of contributing members per fund was below 300.
- At the beginning, payments primarily covered loss of income during sickness – the ratio between monetary payments and medical service costs was 1.7 to 1
- In 1892, first comprehensive regulations between health funds and health care providers were established. Health funds could decide whom to contract as a statutory health insurance physician (SHI-physician).
- 1896: The Prussian medical fee schedule came into effect.
- From then on, coverage was continuously expanded with major parts of the population, e.g. students and farmers, included up until the 1960s and 1970s.

Health, pension and accident insurance became integrated into the “Imperial Insurance Code” (“Reichsversicherungsordnung”, RVO) of 1914. As of 1989, the RVO was transformed into the Code of Social Law (“Sozialgesetzbuch”, SGB), divided into 12 sections. The fifth section (SGB V) covers social health insurance.

German Social Security Viewed as Strong and Encompassing



Strengthening Physicians (1900–1930)

Hermann Hartmann founded the “Hartmann-Bund” in 1900 as a medical self-help organization. In 2009, its membership stood at around 62 000.

The “Berlin Treaty” of 1913 regulated for the first time the number of insured per statutory health insurance (hereafter also “SHI physician”) with one doctor per 1 350 insured persons and thus limited the influence of the funds.

Creed: “The patient is the one to choose the doctor, not the insurance company.”

In 1932, the “Berlin Treaty” expired, and doctors were asked to provide the most economic medical care. A major “strike” broke out – doctors asked patients to pay directly for services received. The health plans set up their own medical practices.

In 1932, the first collective treaties shifted the monopoly for ambulant outpatient care to the physicians. In 1933, the National Socialists established a unified association of SHI physicians.

To the present day, the Association of SHI Physicians (“Kassenärztliche Vereinigungen”, KVs) is exclusively charged with the delivery of outpatient care, but this is slowly changing.

In Germany, physicians in hospitals are not allowed to provide outpatient care unless they have special clearance and are contracted by an SHI fund.

Huge successes of scientific medicine:

- 1882 Robert Koch identifies the cause of tuberculosis
- 1893 Emil von Behring develops a serum against diphtheria
- 1895 Wilhelm Conrad Röntgen discovers X-rays
- 1899 “Aspirin” put on the market
- 1909 Paul Ehrlich develops “Salvarsan” against Syphilis
- 1924 Comprehensive regulation on the relationship between SHI and providers. An “Imperial Committee for Doctors and Health Funds” was founded.
- 1935 Discovery of sulfonamides by Gerhard Domagk

Famous German Physicians



Robert Koch



Ferdinand Sauerbruch



Gottfried Benn



August Bier



Ludolf von Krehl



Rudolf Virchow

Social Engineering (1950–1970)

An underlying assumption of this era was that an idealistic society could be designed by technocratic means (e.g., behaviorism in psychology found human behavior to be shapeable).

The main idea was to create institutions that specialize in solving specific problems in certain areas.

For the health care system, this meant the re-establishment of self-administration (1951 Law on Self-administration and 1955 Law on Association of SHI Physicians) as well as a stabilization of the welfare state (e.g. preventing old-age poverty).

1956: The Laws on Statutory Health Insurance for Pensioners came into effect.

New laws also modernized the financing and management of hospitals (1972 Hospital Financing Law KHG).

1974: Self-employed farmers, artists, students and disabled living in sheltered facilities received coverage from SHI.

The development of the welfare state was based on the optimistic assumption of continuous economic growth as well as the extensive ability to control the system and its participants.

The 1973 Oil Crisis and subsequent economic stagnation led to changes: in 1977, the first of many cost containment / cost dampening laws came into effect.

Massive State Investments into Medical Care and Effects of the the Oil Crisis

Expansion of services

Technology-driven health care – the new Göttingen University Hospital



Göttingen University Hospital



Oil crisis in Germany: empty motorway

Dealing with Limits (1970–1990)

Rising health care costs led to on-going discussions and reforms with the goal of cost containment including

- Income-oriented expenditure policy
- Reference price for pharmaceuticals
- Restrictions on high-cost equipment and treatments
- Limits on the total number of physicians
- Co-payments

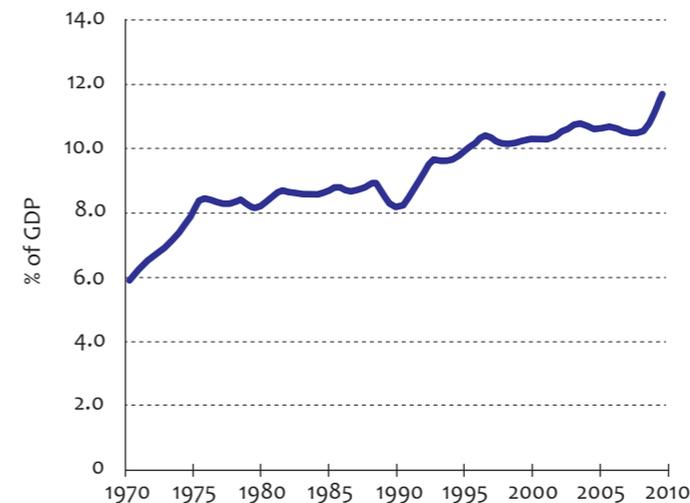
Between 1977 and 1983 several cost control laws were enacted.

The goal was to conserve the basic structure of the health care system while stabilizing non-wage labor costs.

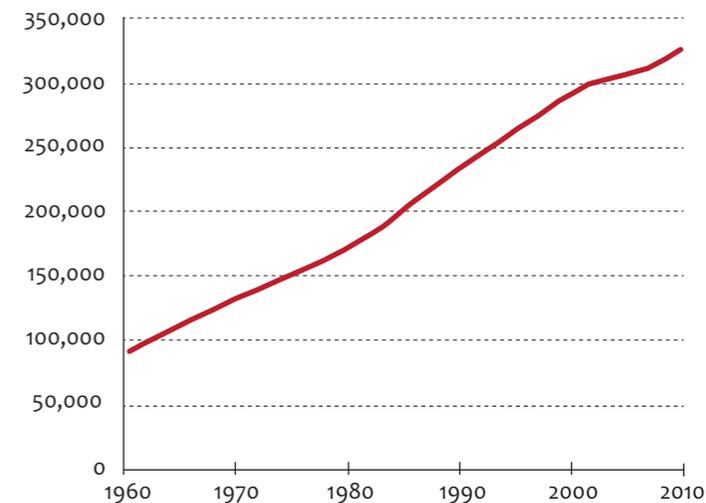
The Healthcare Reform Act (GRG) of 1989 led to the SHI being the Fifth of the 12 Books in the Code of Social Law.

Steady Growth in Health Care Expenditures

Total Health Care Expenditure, in % of GDP, 1970–2009



Total Number of Working Physicians, 1960–2009



A Different Approach: Health Care in the German Democratic Republic (GDR)

Centralized planning meant that the provision of care was organized through the state via hospitals, polyclinics and medical practice, with only few private practice physicians.

The central union and the government financed the health care system through a unified social insurance scheme.

After reunification, almost all ideas from the GDR health care system (e.g. polyclinics, public health initiatives) fell out of favor, but nowadays they are again part of the debate on improving patient-centered care in Germany.

Already in April 1945, a central committee was established for administrating health care in the Soviet occupation zone.

Health and health care was looked at in an encompassing way, and there was a close link between providing population-based care and supporting the state.



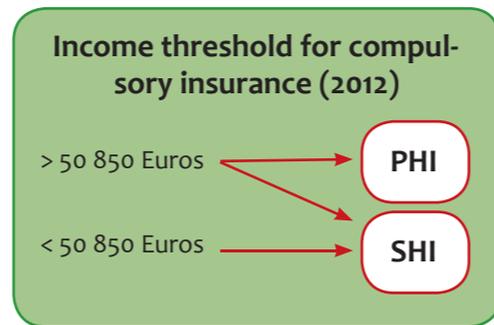
Focus on Public Health and Hospital-Based Care



1.2 Principles and Corporative Culture

Solidarity

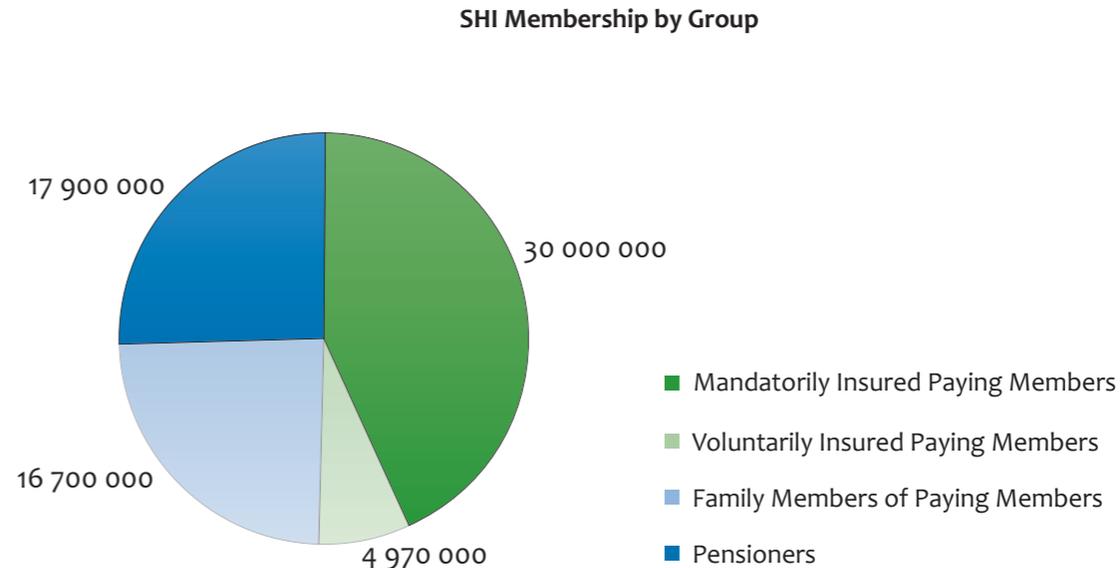
The main idea of the statutory health system is the principle of solidarity. Membership in statutory health insurance is compulsory. The contributions are based on income in order to ensure that the cost of health care is shouldered primarily by the better-off, and everybody is able to access services. However, employees with an income above a certain threshold and the self-employed can opt out of the statutory system and insure themselves privately.



| | 1880 | 2006 |
|-----------------------------|----------|----------|
| Life expectancy | 38 years | 78 years |
| Working life starts with | 15 | above 20 |
| Old age pension starts with | 70 | 65* |
| Children per woman | 3,5 | 1,3 |
| Inhabitants / km | 110 | 230 |
| Contribution rate | 3 % | 15 % |
| Coverage | < 10 % | 90 % |

* (usually earlier)

Solidarity



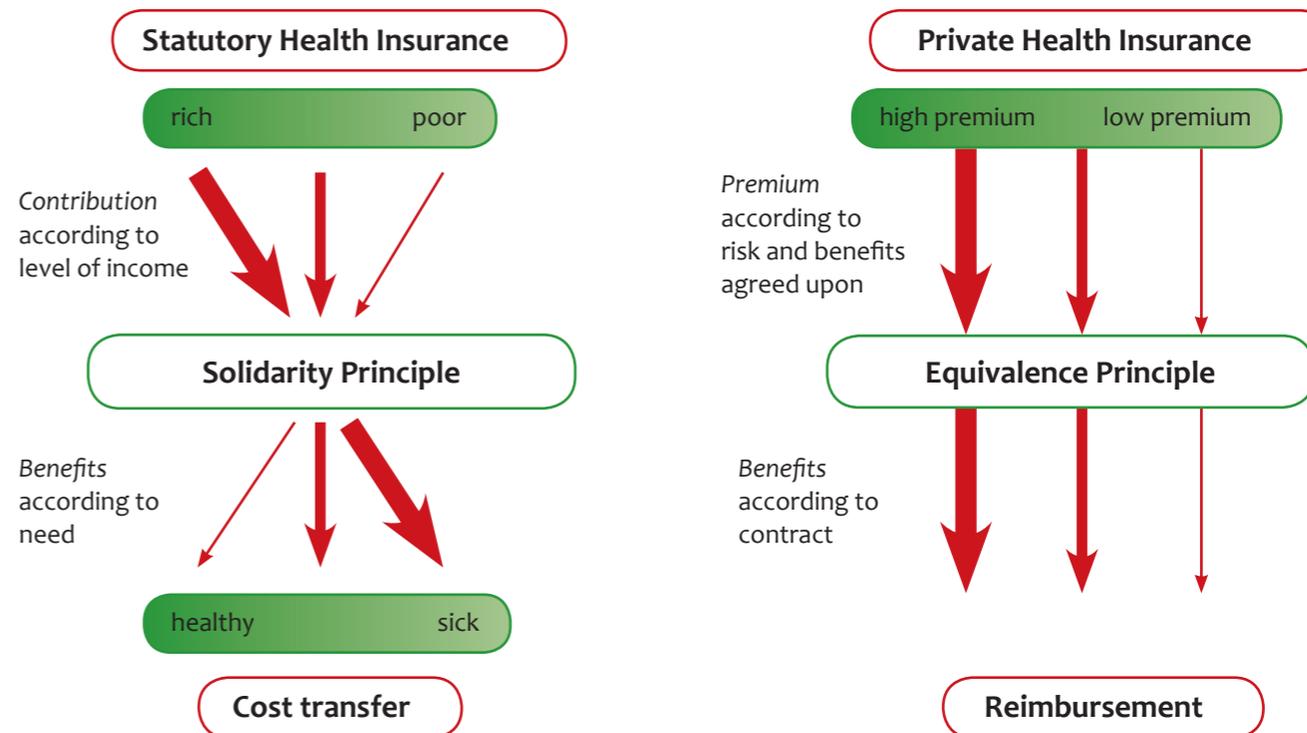
Basic Principles

German social health insurance is characterized by five structural principles.

1. Solidarity
2. Benefits in kind: Beneficiaries receive direct treatment, they do not have to pay upfront
3. Financing from employers and employees (see chapter 5)
4. Self-Administration (see above)
5. Plurality: Patients can choose amongst hospitals and private providers

In fact, SHI is less of an **insurance** (which is based on the principle of risk-equivalent premiums) but rather a **fund**, in to which member have to pay according to their ability. Thus the term “Krankenkasse” (health fund) is better suited than the nowadays predominant “social health insurance”.

Social vs. Private Health Insurance



Governing Principles: Subsidiarity, Self-Administration, and Corporatism

Subsidiarity

- Subsidiarity = the smallest and most local institution addresses a problem
- Health insurance companies are self-administrated
- State only provides framework and supervision
- Principle of decentralisation
- The “Enzyklika Quadragesimo” of the Catholic Church (1931) defines subsidiarity

Self-Administration

- The state grants autonomous regulation of a defined part in society via associations
- The state is not involved in negotiations but has a supervisory role
- Inpatient care is regulated via contracts between the Association of SHI Physicians and the regional health insurance associations
- The main actors in the German system therefore are the associations, not the insurance companies or the physicians themselves

Corporatism

- Shifting responsibilities to professional associations
- Participation of organized interests in formulating and executing political decisions
- The state is a negotiating party

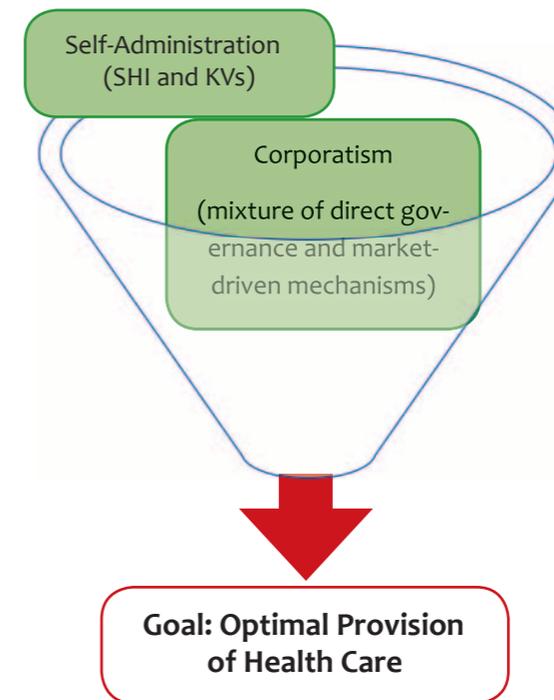
The statutory health insurance (SHI) covers about 85% of the population and thus holds a strong influence over the German health system.

The SHI is predominantly financed by the income of job-holders.

The SHI and Associations of SHI Physicians (KVs) are self-administered corporate entities.

Balancing Self-Administration and Corporatism

Leave the state out of the daily management: resulting in flexibility, better understanding of local needs, less bureaucracy.



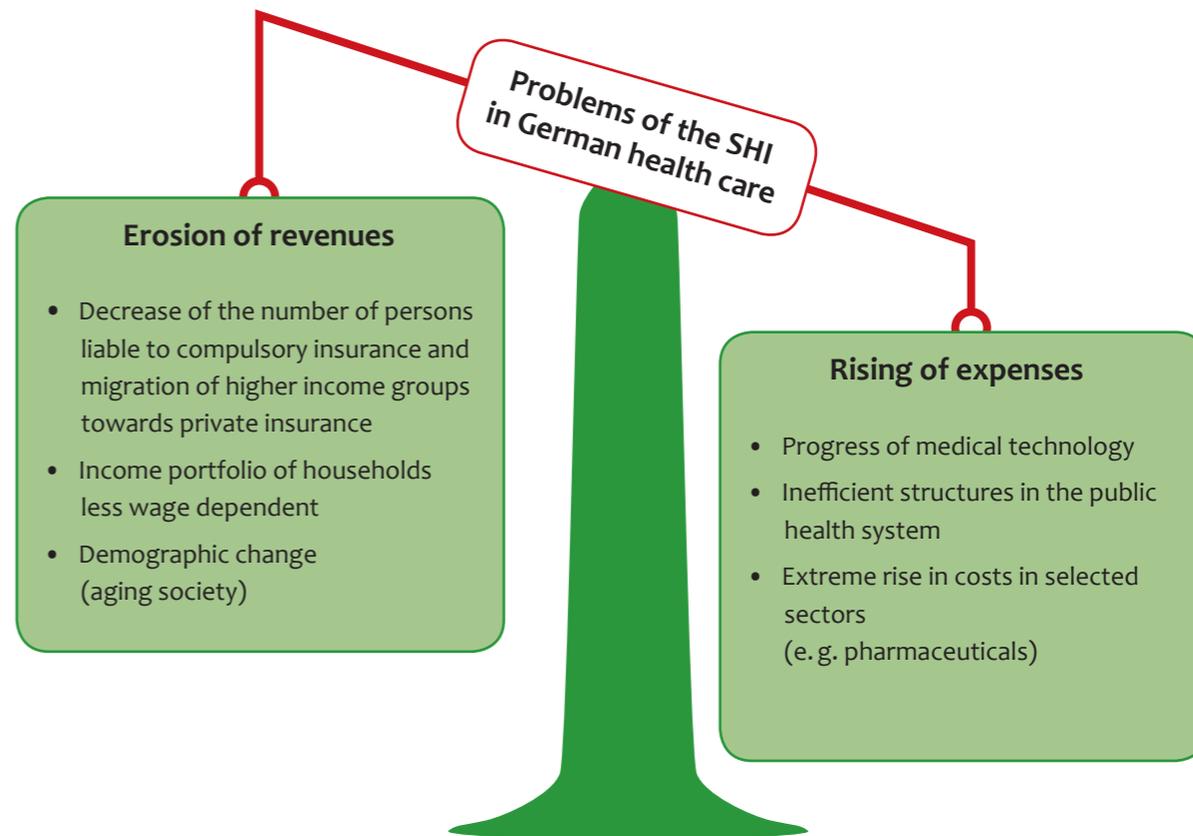
1.3 Recent Reforms

More than 35 Years of Reforms

| Year passed | Name of the Act |
|-------------|---|
| 1977 | First law regarding cost containment in health care ("Kostendämpfungsgesetz") |
| 1988 | Health Care Reform Act of 1989 |
| 1992 | Health Care Structure Act of 1993 |
| 1994 | Code of Social Law XI (Statutory Long-Term Care Insurance) |
| 1996 | Health Insurance Contribution Rate Relief Act |
| 1997 | First and Second Statutory Health Insurance Restructuring |
| 1998 | Act to Strengthen Solidarity in Statutory Health Insurance |
| 1999 | Statutory Health Insurance Reform Act of 2000 Act to Equalize Statutory Provisions in Statutory Health Insurance 2001 |
| 2000 | Infection Protection Act |
| 2001 | Code of Social Law IX (Rehabilitation and Participation of Disabled People) Reference Price Adjustment Act Act to Reform the Risk Structure Compensation Scheme in Statutory Health Insurance Act to Newly Regulate Choice of Sickness Funds |

| Year passed | Name of the Act |
|-------------|---|
| 2002 | Pharmaceutical Expenditure Limitation Act Case Fees Act Contribution Rate Stabilization Act |
| 2003 | Twelfth Code of Social Law V Amendment Act First Case Fees Amendment Act Statutory Health Insurance Modernization Act |
| 2004 | Act to Adjust the Financing of Dentures Second Case Fees Amendment Act |
| 2007 | Act to Strengthen Competition in Statutory Health Insurance |
| 2009 | Introduction of the Health Fund |
| 2010 | Act for Sustainable and Socially Balanced Financing of Statutory Health Insurance |
| 2011 | Act on the Reform of the Pharmaceutical Market (AMNOG) |
| 2012 | SHI Health Care Delivery Structure Act, Rural Physician Act ("GKV-Versorgungsstrukturgesetz, Landarztgesetz") |
| 2012 | Act to Reimburse Psychiatric Care ("Psych-Entgeltgesetz") |

Markets and Pushing for Competition



The Need for Reform Remains

Challenges

Oversupply

Undersupply

Wrong incentives

Separation between outpatient and inpatient care

Quality and outcomes neglected

Possible Options

Selected contracting of providers, coupled with outcome indicators

Innovative health care approaches in rural areas and underserved urban areas

Budgets, coupling payment with results

Flexible integrated care and disease management

Standards, directives, quality management

At Present, Three Reform Thrusts

Manage Competition

Since 1995, free choice amongst health funds

Elaborate structural risk adjustment scheme

Selective contracting

Negotiation with physicians about providing defined outpatient care

Improve Efficiency

Health technology assessment

Gain and retain qualified staff

Further development of DRGs including psychiatric care

Use of internet and telemedicine

Local solutions and exchange of ideas

Secure Quality

Mandatory quality management in inpatient and outpatient settings

Additional payments (pay-for-performance)

Quality circles, continuous medical education

Current Reforms and Discussions

Before the most recent reform in 2011, SHI contributions were split almost equally between employers and employees. In light of rising health care expenditures, and thus rising non-wage labor costs, the reform froze the employers' share of SHI contributions. There is now a difference of around 0.9 %. The employer pays 7.3 % and the employee 8.2 % of pre-tax income into SHI. All future cost increases will have to be borne by the insured.

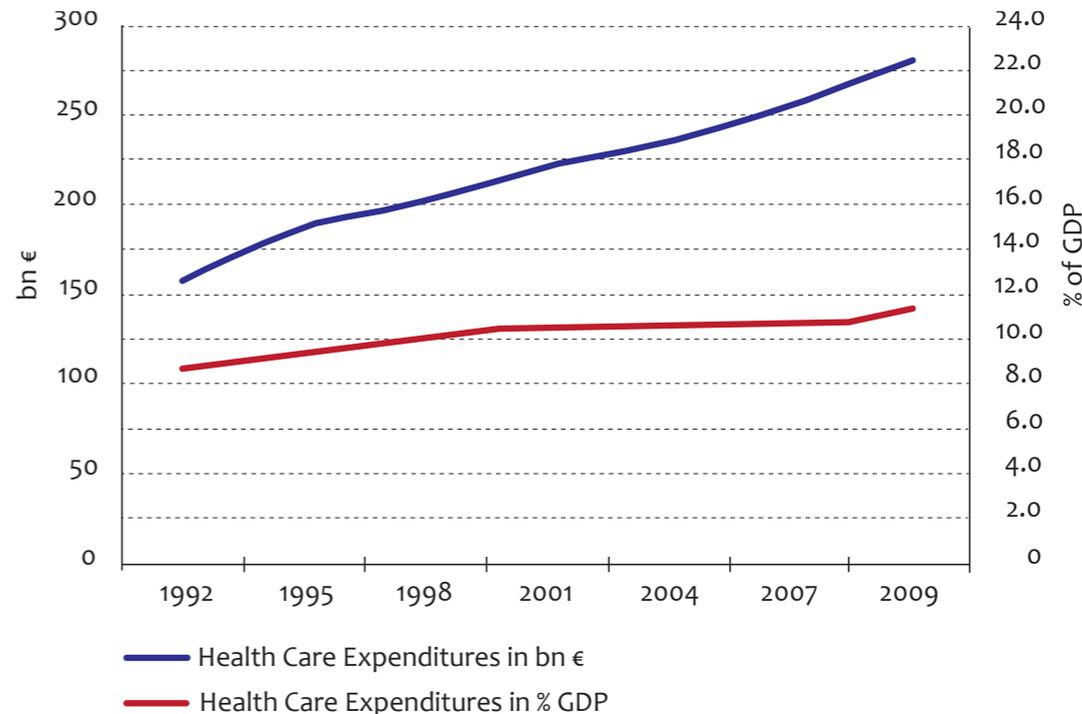
The often quoted “cost explosion” in health care is a myth. Health care costs do rise but at a rate similar to overall economic growth. The key issue is the relative reduction in the sum of gross wages, which is the payroll tax base from which SHI contributions are deducted. In addition, the SHI Health Care Delivery Structure Act aims to improve the medical care in rural areas, whereas the Psych-Reimbursement Act incorporates psychiatric care into the Diagnosis Related Groups (DRG)-system.

Current ongoing discussions are about ...

- ... eHealth
- ... universal SHI (encompassing all citizens) and health premium (standard premium per head, subsidies based on income)
- ... prioritization of special medical services
- ... the role of the European Union in health care regulation
- ... competition between statutory and private health insurance
- ... introducing innovative care and stronger competition

Rising Expenditures but at a Rate Similar to Economic Growth

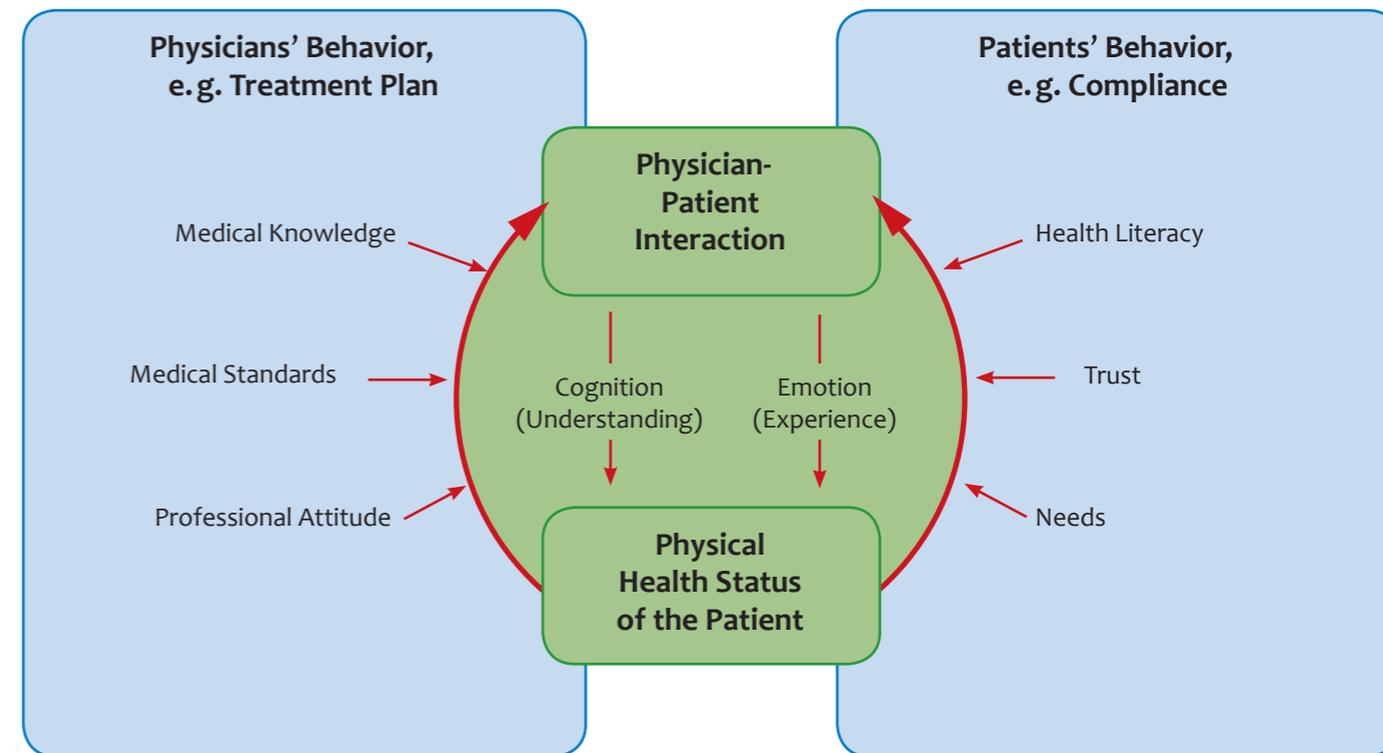
Health Care Expenditures in bn € and in % of GDP
1992–2009



Incentive Systems as the Basis to Combine the Art of Medicine with the Need for Efficiency

| Traditional model | New paradigm |
|---|--|
| <p>Incentives are primarily based on collective goals and are to a large extent monetary. Results are predominantly economically defined and measured; these indicators are used for policy and management purposes.</p> <p>Physicians and patients as actors in a health care market based on the following principles:</p> <ul style="list-style-type: none"> • The market is solely comprised of individuals • Individual behaviour determines cost <p>At the same time, individuals are categorized and treated as members of defined groups</p> <p>Management is top-down: the general, collective perspective determines rules and regulations for the treatment of individual patients</p> | <p>Incentives are holistic and are primarily non-monetary; there is no one overall control-indicator</p> <p>Appropriate resources are determined by the individual patient-physician relationship (bottom-up)</p> <p>Holistic view of utility, taking into account the individual biography and needs of participants (the art of medicine)</p> <p>Expenditures are determined by perceived responsibility for the patient coupled with appropriate medical care which leads to optimal results for the individual patient</p> |
| <p align="center">Combining both approaches via congruent incentive systems for all relevant participants in the health care system</p> | |

Modeling Patient-Physician Interaction as the Basis for a New Health Care Paradigm



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