

Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self- governance, and competition

Reinhard Busse
Miriam Blümel
Franz Knieps
Till Bärnighausen



2002 - 2017

Health Care
Management

Author team's experience

Reinhard Busse, Chair Health Care Management, TU Berlin & Co-Director of European Observatory on Health Systems and Policies, lead author of “HiT” on Germany (2000, 2004, 2014) and many other articles on German health system

Miriam Blümel, TU Berlin, co-author of “HiT”

Franz Knieps, Director, Association of BKK sickness funds, 2001-2009 Dept. Head for SHI in MoH, author of a reflective book on German health policy

Till Bärnighausen, Chair Public Health, University Heidelberg, expertise in many health systems in middle- and low-income countries, author of “One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?” (2002)



Background of paper

- 1. Germany hosting G20 summit this week**
- 2. Large interest in original SHI/ Bismarckian system (not the least because of UHC) around the world – and 135th birthday very soon**
- 3. Basic principles of German-style SHI not well understood (regulation is sometimes simply copied); while lots of details are available (“HiT”)**
- 4. Growing interest in performance assessment and need to link it to health system context**
- 5. Aim therefore to: focus on “recent” developments (not individual reforms) of German health system, put/explain them in historic perspective and assess current system regarding performance**

Structure of paper

1. Introduction

2. The first 110 years (1883-1993)

2.1 From compulsory workers' insurance to population health coverage

2.2 From cash-benefits to services-in-kind

2.3 Self-governmental structures: from appeasement of workers to joint decision-making bodies

3. The past 25 years (1993-2017)

3.1 The attempt to improve a solidarity-based system through competition

3.2 From cost-containment to quality (and achieving universal coverage along the way)

3.3 Self-governance and the Federal Joint Committee

3.4 The German health insurance system in 2017

4. Balancing solidarity and competition (*How does the German health care system perform?*)

5. Conclusions and recommendations

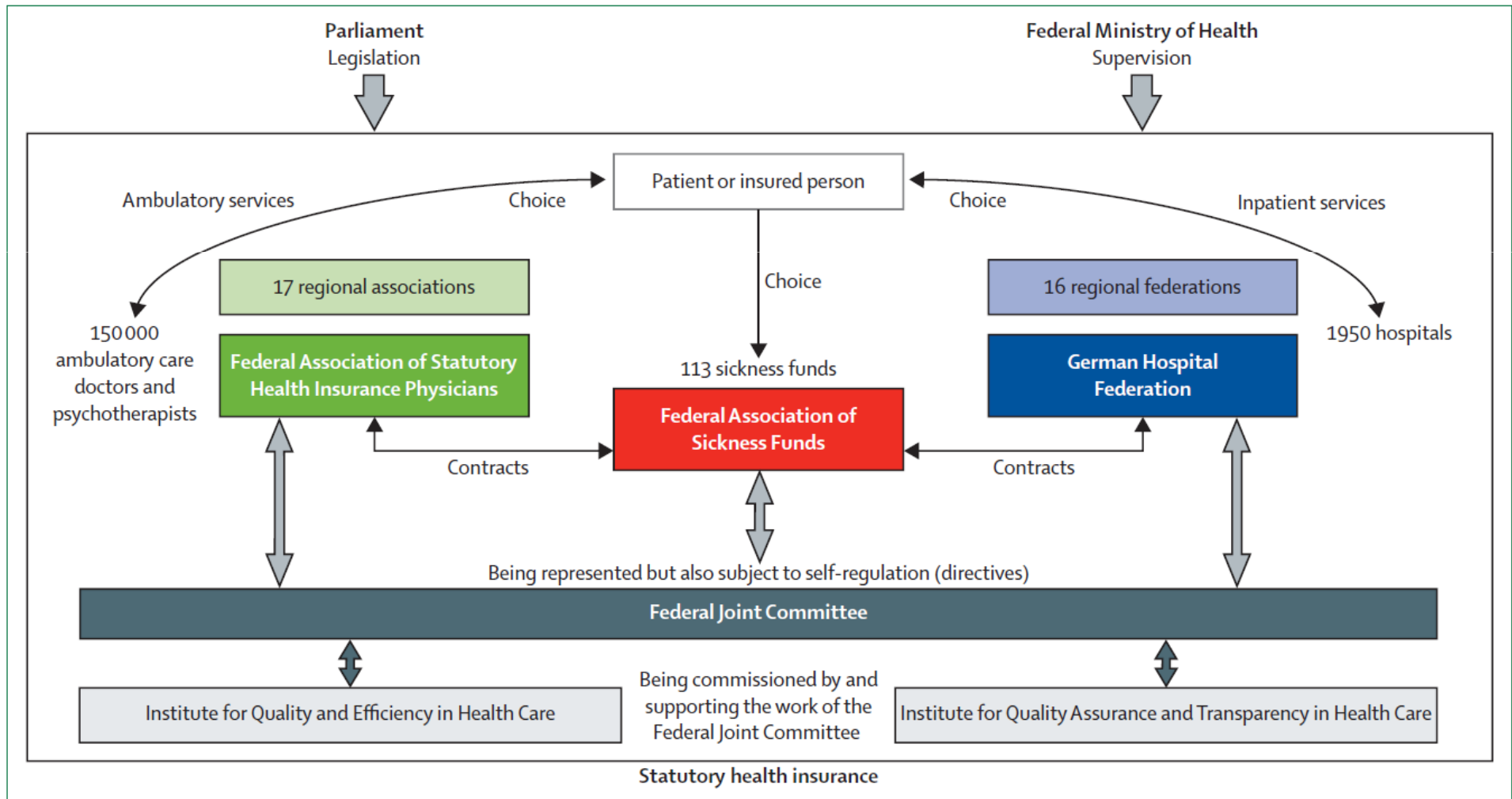
+ boxes on public health, the system in 1933-45 and in East Germany ...

Key messages (I)

- In 1883, Germany became the first country in the world to establish a social health insurance system based on solidarity; continued expansion and improvement over 135 years have shaped a system with universal coverage and a generous benefits basket.
- The key principle of self-governance initially applied only on the payer's side; a payer-provider joint system of governance was introduced in 1913, and further developments culminated in the founding of the Federal Joint Committee in 2004.
- Beginning with the introduction of choice among payers (sickness funds) in 1993, elements of competition and a market orientation have been gaining momentum but have not threatened the principle of solidarity and the strong degree of self-governance of the system.

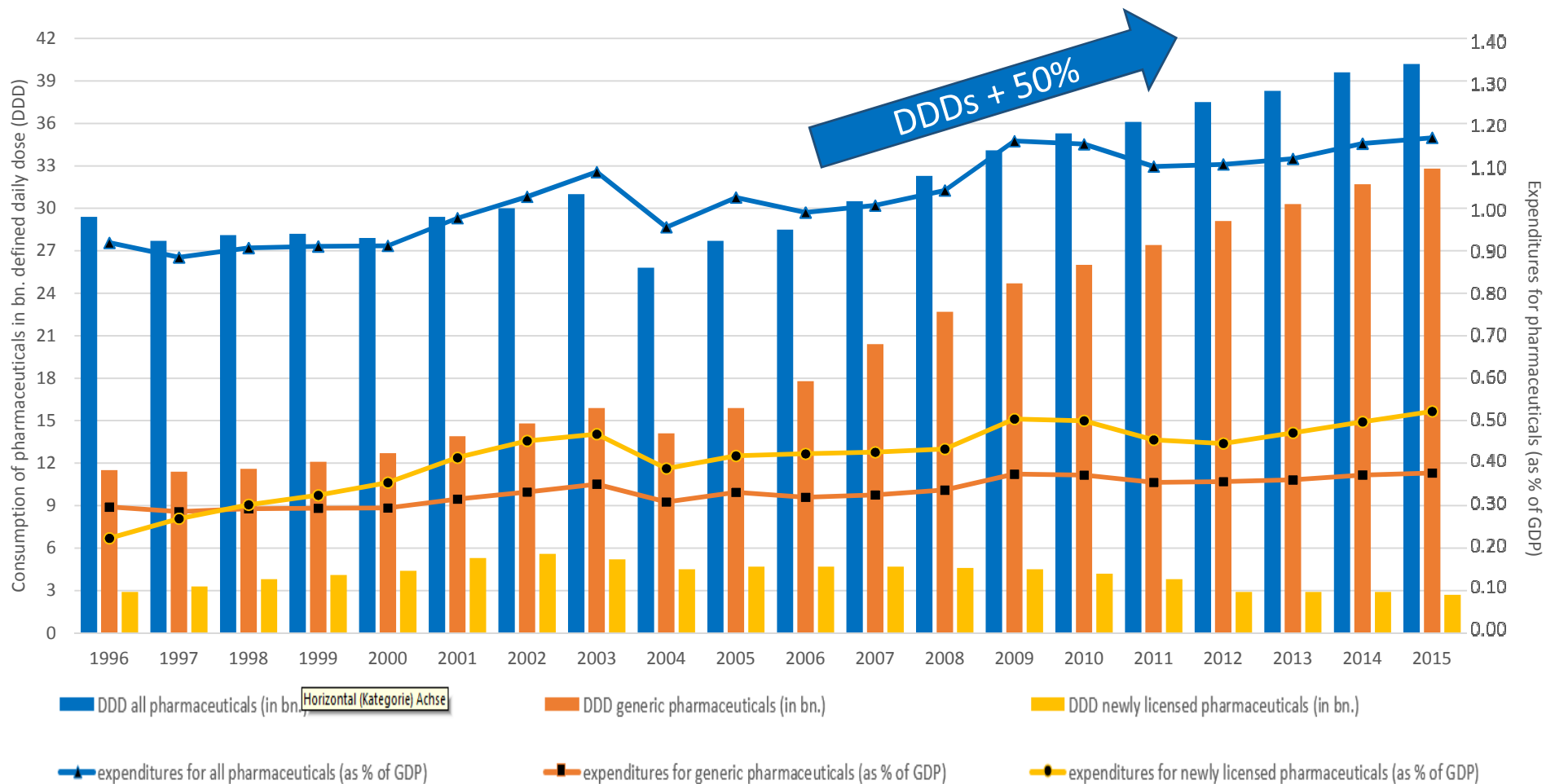
Year	Reform	Contents and selected measures
Christian Democratic–Liberal coalition (Chancellor: Helmut Kohl, CDU); Health Minister: Horst Seehofer (CSU)		
1993	Health Care Structure Act	<ul style="list-style-type: none"> • Free choice of sickness funds for most members of the statutory health insurance, supported by the introduction of a risk-adjusted compensation scheme to redistribute contributions equitably among sickness funds (as of 1996) • Needs-based health workforce planning for ambulatory care doctors and accreditation requirements for statutory health insurance doctors • Abolition of full-cost cover principle for hospitals • Introduction of legally fixed budgets or spending caps for the major sectors of health care • Increased copayments for pharmaceutical products and differentiation according to price (1993) and pack size (1994) • Introduction of a positive list of pharmaceutical products
1994	Statutory Long-Term Care Insurance Act	<ul style="list-style-type: none"> • Introduction of statutory long-term care insurance as of 1996 managed by sickness funds or private health insurance companies
1996, 1997	Health Insurance Contribution Rate Exoneration Act; First and Second Statutory Health Insurance Restructuring Acts	<ul style="list-style-type: none"> • Reduction of all contribution rates by 0.4% percentage points • Reduction of benefits (eg, rehabilitative care, health promotion, dentures for persons born after 1978) • Increased copayments (eg, hospital care, pharmaceutical products, medical aids, ambulance transportation, and dentures) • Introduction of hospice care benefit • Increased possibilities for non-collective contracts between sickness funds and providers
Social Democratic–Green coalition (Chancellor: Gerhard Schröder, SPD); Health Ministers: Andrea Fischer (Greens, 1998–2000), Ursula Schmidt (SPD, 2001–05)		
1998	Act to Strengthen Solidarity in Statutory Health Insurance	<ul style="list-style-type: none"> • Dentures for persons born after 1978 reintroduced • Lowering copayment rates for pharmaceuticals and dentures
2000	Statutory Health Insurance Reform Act of 2000	<ul style="list-style-type: none"> • Removal of ineffective or disputed technologies and pharmaceuticals from the statutory health insurance benefit package • Option for selective contracting (integrated care) • Separate budgets for general practitioners and specialists in ambulatory care • Mandatory collection of quality indicators for hospitals
2001	Act to Reform the Risk Structure Compensation Scheme in Statutory Health Insurance	<ul style="list-style-type: none"> • Introduction of disease management programmes and linkage to risk-structure compensation scheme
2002	Case Fees Act	<ul style="list-style-type: none"> • Introduction of German-styled diagnosis-related group system for inpatient services as of 2003
2004	Statutory Health Insurance Modernisation Act	<ul style="list-style-type: none"> • Exclusion of over-the-counter drugs and prescription eyeglasses from the statutory health insurance benefit package • Transferring financing of family planning and family policy services not related to insurance to the federal budget • Copayment of €10 per quarter for the first doctor or dentist visit (abolished in 2012) and other increases in copayments • Option for supplementary insurance within statutory health insurance (in cooperation with private health insurers) • Shifting the contribution rate towards the insured (by charging them 0.9% extra, thereby moving away from the 50:50 employee-employer split) • Creation of the Federal Joint Committee (replacing the Federal Committee of Physicians and Sickness Funds and similar entities) • Founding of the Institute for Quality and Efficiency in Health Care

Self-governance and competition (among providers and payers): the central role of the Federal Joint Committee



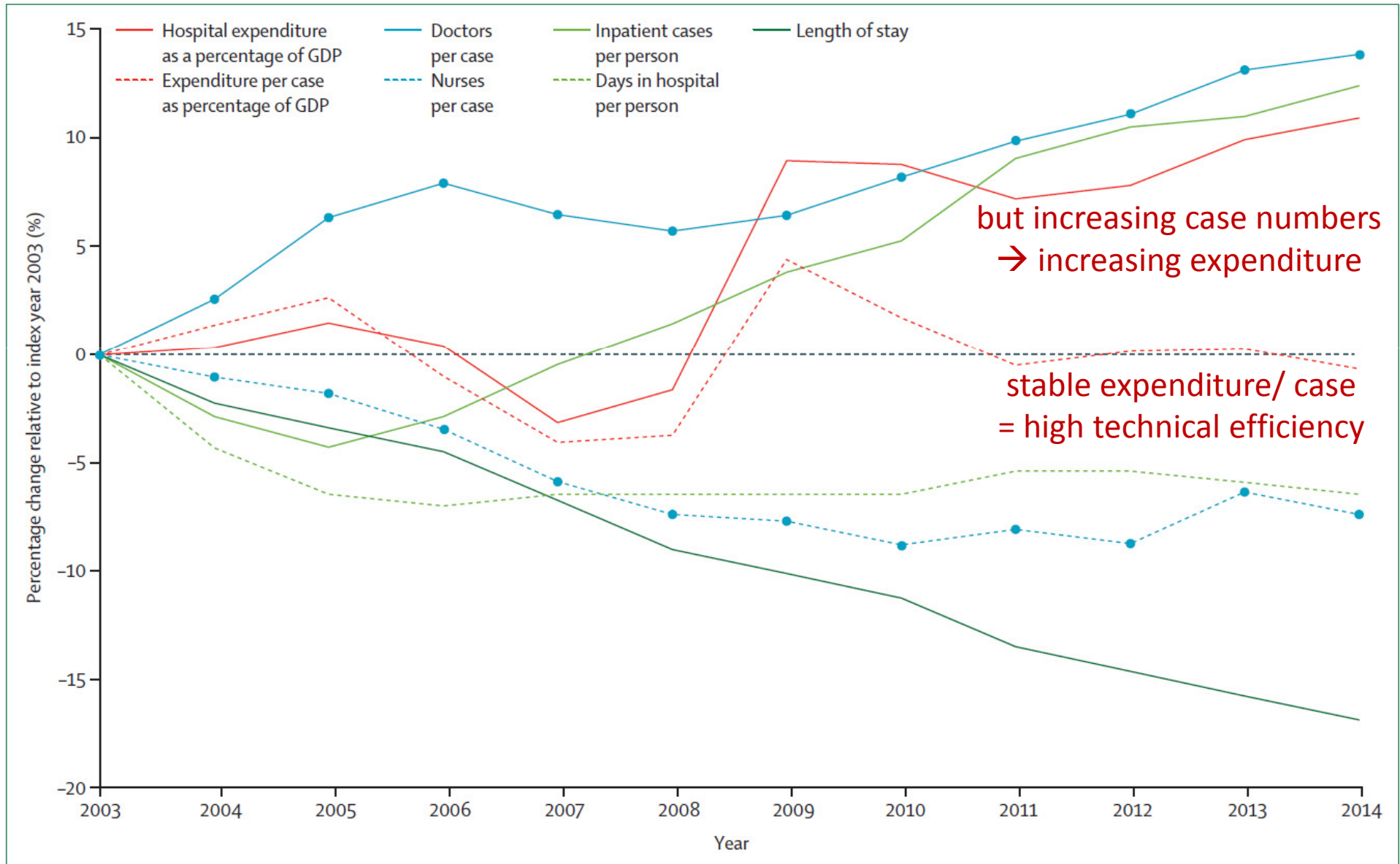
Key messages (II)

- Joint self-governance has developed alongside competition and has contributed to a system with good access to health care; however, joint self-governance has also jeopardized continuity of care and has led to an oversupply of pharmaceuticals and inpatient care.



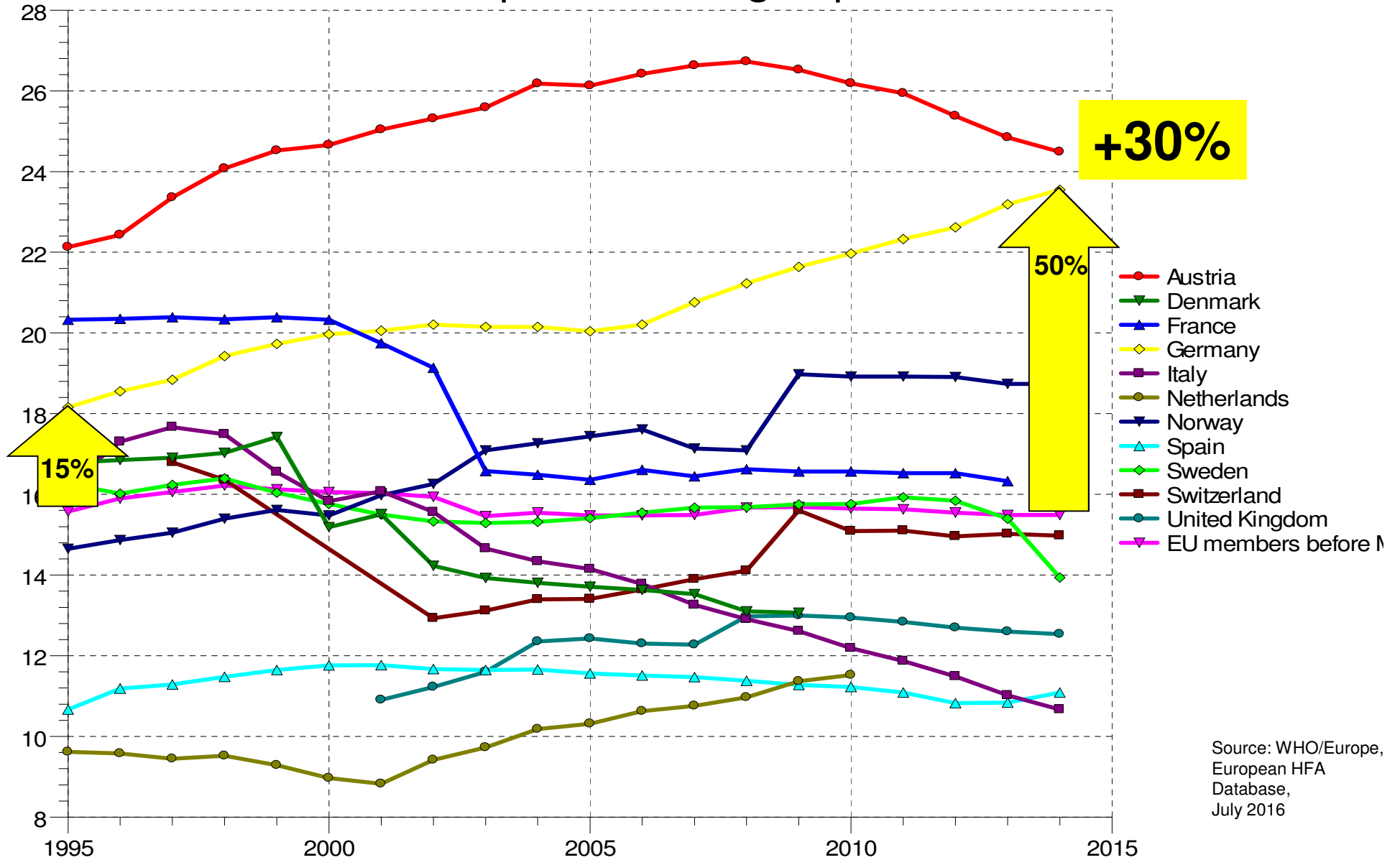
Unfortunately hidden in the appendix: the increase in pharmaceutical consumption by 50% (while costs increased “only” 20%)

Important hospital utilization and cost figures, 2003 (DRG introduction) - 2014



... which differentiates Germany ...

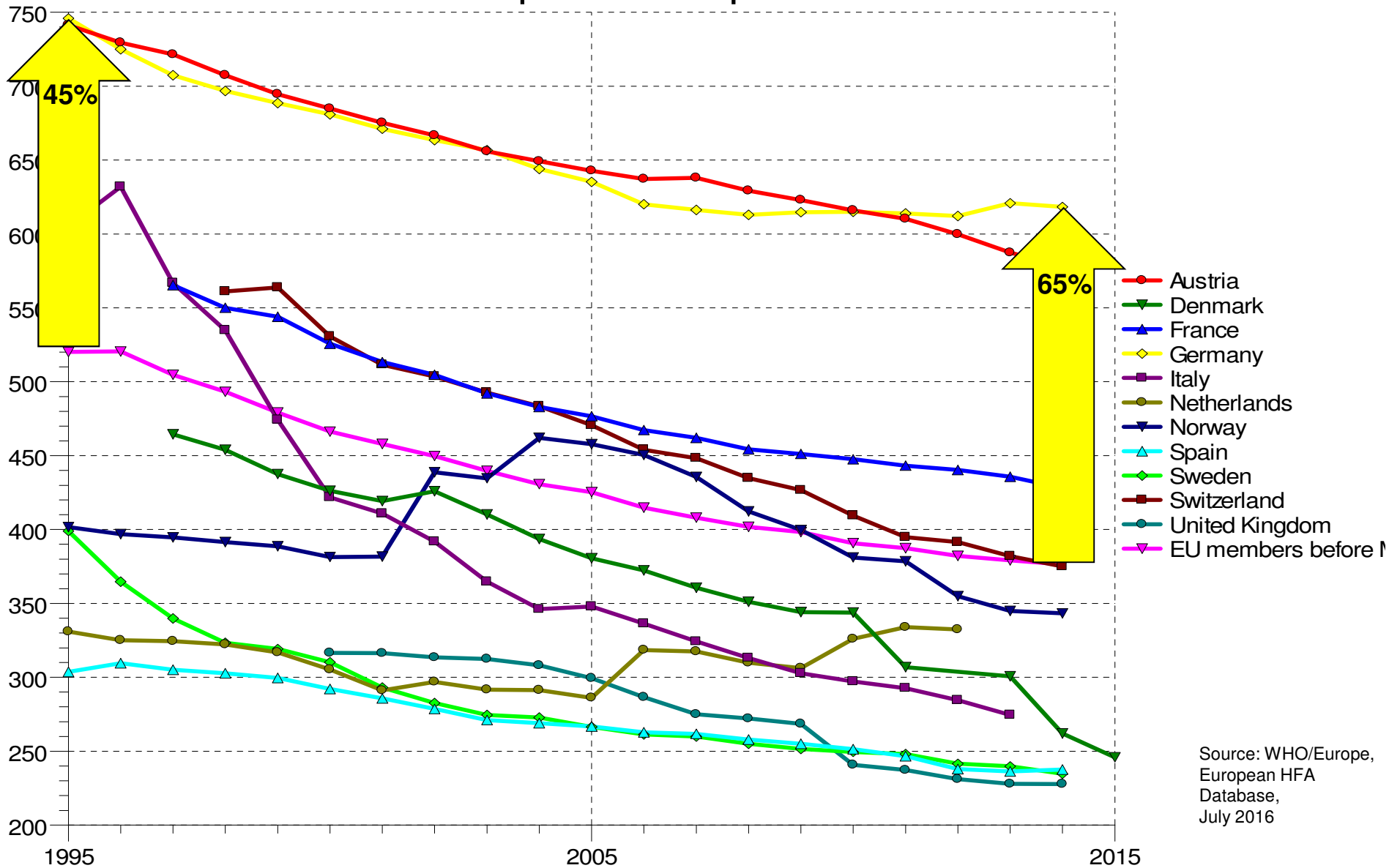
Acute care hospital discharges per 100



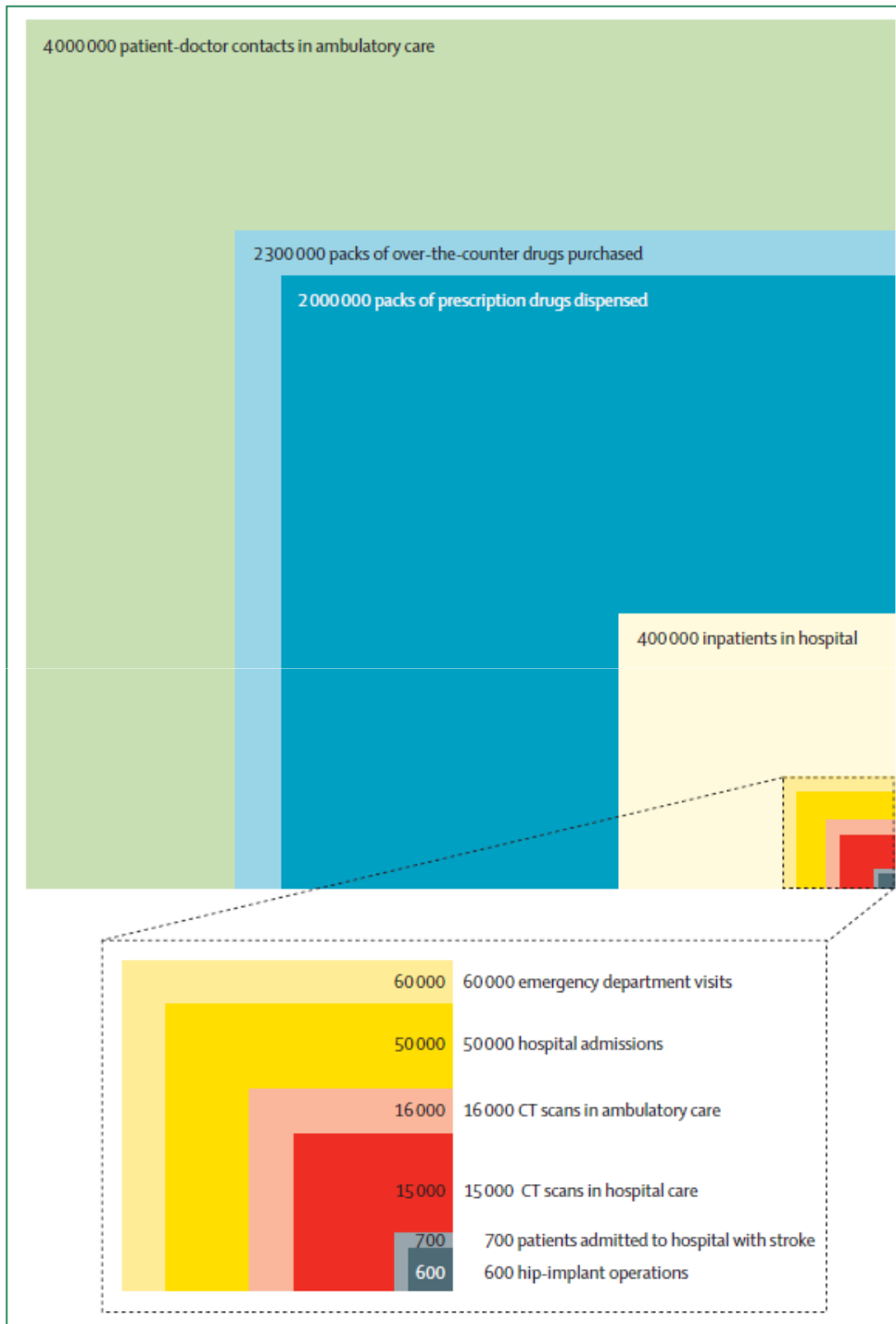
Source: WHO/Europe, European HFA Database, July 2016

... mainly due to a massive bed supply

Acute care hospital beds per 100 000



Source: WHO/Europe, European HFA Database, July 2016



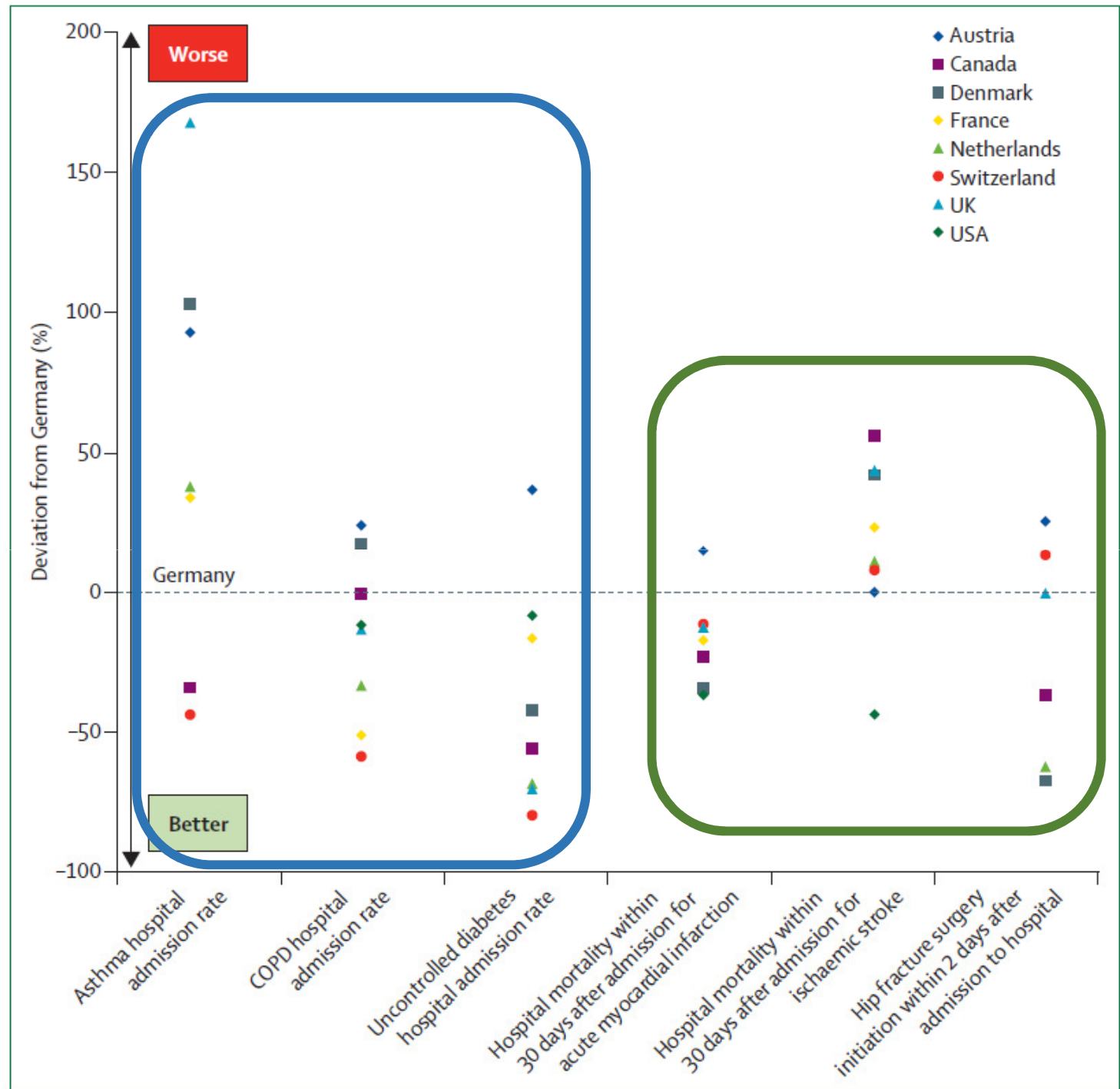
1 in 200 Germans spent the day as inpatients (vs 1 in 500 Danes)* and 1 in 20 see an ambulatory care doctor every day

* 1.74 bed days/ year/ capita in Germany vs 0.71 in Denmark

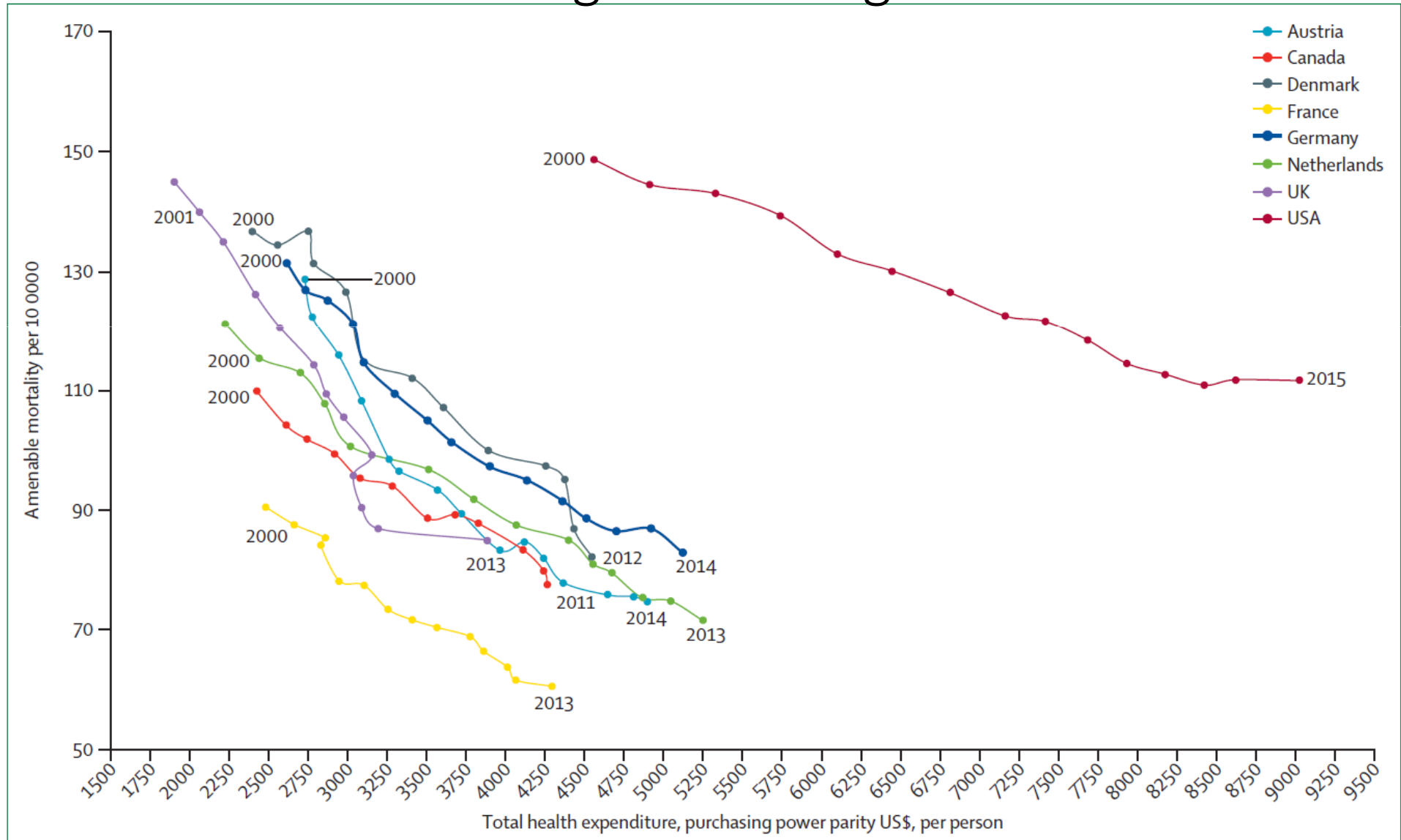
Key messages (III)

- Joint self-governance has developed alongside competition and has contributed to a system with good access to health care; however, joint self-governance has also jeopardized continuity of care and has led to an oversupply of pharmaceuticals and inpatient care.
- Since the late 1990s, the German health care system has moved towards integrated care and evidence-based health care, with new financial incentive schemes for both sickness funds and providers to improve quality and efficiency of care.

And what about the quality?
The large ambulatory care sector should people out of hospital – but doesn't ... and inpatient quality is also mixed



Amenable mortality has declined
(but is still higher than in many other countries) ...
and costs for achieving this are high



Key messages (IV)

- Joint self-governance has developed alongside competition and has contributed to a system with good access to health care; however, joint self-governance has also jeopardized continuity of care and has led to an oversupply of pharmaceuticals and inpatient care.
- Since the late 1990s, the German health care system has moved towards integrated care and evidence-based health care, with new financial incentive schemes for both sickness funds and providers to improve quality and efficiency of care.
- The German health care system has proven to be remarkably resilient and capable of extensive changes, while modernising gradually rather than through radical reforms; however, today it faces the same challenges as health systems in other developed countries, such as population ageing and increasing chronic disease burdens.

Recommendations (I)

“Germany’s pragmatic policymaking style with its limited state control of the health system means that the legislator is charging the same actors with solving the problems that they created in the first place ...

[T]he practice of setting policy objectives at the federal level but leaving it to self-governing actors to work out the specifics might need to be reassessed. ...

[Q]uality and efficiency targets might need to be spelled out specifically in the law and ... the definition of details and implementation need[s] more vigilance and enforcement in case the self-governing actors are too slow, too unambitious, or simply too divided.”

Recommendations (II)

In addition to quality improvement, we recommend the following key actions:

1. redefine the legal framework for statutory health insurance and private health insurance to address inequities in financial contributions;
2. close the gap between ambulatory and inpatient care, with particular attention to issues that fall between the two sectors (e.g. emergency care and care for highly specialised cases);
3. reduce total hospital capacity and centralise services in those hospitals that consistently provide high-quality care;
4. reform the payment system for doctors to further address imbalances between regions (e.g. rural vs. urban, areas with low vs. high shares of privately insured persons) and specialties;
5. strengthen primary care vis-à-vis specialists in ambulatory service provision, and
6. explore and test new roles for health professionals such as nurses.