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Overview of the German Healthcare System

The new Federal Minister of Health, Philipp Rösler (Free Democrats), is a doctor. This is a good precondition for understanding the complexities of the healthcare system and for appropriate decision making. It is, however, not only the Federal Minister who influences the development of the health system, but multiple interest groups and important demographic, medical and economic changes.

The German health system is divided into an insurance sector with public and private insurance funds, and a healthcare sector. The healthcare sector covers a range of services and departments, including ambulatory outpatient care (provided mainly by individual doctors at their offices), pharmaceutical care distributed by pharmacists, inpatient care in hospitals and rehabilitation clinics, and a nursing care sector (caring for the increasing elderly population).

It is the complex network of interest groups that form the connection between this structure and the political arena. The 2000 hospitals, for instance, are represented by the German Hospital Federation, Deutsche Krankenhausgesellschaft. These interest groups act as legitimate partners of the political and democratic process in opinion and decision-making.

Insurance Sector and the Central Health Fund

There are 82 million people living in Germany; 85 percent are insured by statutory insurance funds, 11 percent by private insurance funds, and four percent are supported by different institutions or pay out of pocket. In Germany 250 billion euro is spent each year on healthcare, 10 percent of the gross domestic product. In international comparison, Germany ranked third in healthcare spending compared to GDP, following France with 11 percent and USA with 16 percent. The United Kingdom ranked fourteenth with eight percent.

Since January 2009 a central health fund collects and distributes the money for statutory insured people, in total 50 million members and 20 million relatives. The fund gets its financial volume of about 174 billion euro (2010) largely from member payments. Currently, the employer of a member pays seven percent of the gross income of his employees. The employee pays 7.9 percent. Before 2009 insurance rates differed according to the fund, but today all rates are standard. Since 2004, funding also comes from the federal budget, supplementing 12 billion euro per year, and an expected increase to 14 billion euro in 2012.

At an income level of 4,162.50 euro per month (2010) an employee can switch to a private insurance fund. If one chooses to use a private fund, only under certain conditions such as job loss can he or she return to be covered by a statutory fund. Relatives, partners and children need an additional private insurance. If employees exceed this level they are under no obligation to leave the statutory fund. Such members pay 14.9 percent, including the employers' fee only up to 3,750 euro per month (2010). Relatives, partners and children, are insured for free.

There were 170 insurance funds in Germany at the end of 2009. Their income from member payments goes directly to the central fund to be redistributed to the insurance funds according to specific morbidity criteria. These compensational payments reflect the population that each fund serves. Some funds for instance have a higher portion of elderly people or of people with expensive diseases. The evaluation and distribution procedure works on a daily basis with administrative expenses exceeding 10 billion euro per year.

Additional Fees

If an individual fund is unable to balance income and expenses – despite the criteria and the additional money – it is allowed to claim an additional fee by its members. Without checking the income of its members, the fund may require up to eight euro per month (with a check, up to one percent of the gross income). Currently, several funds have announced to do this in 2010. The members are then allowed to quit their membership and shift to a fund without additional cost. It is predominantly young people with low health risks and people with higher income who tend to leave their fund. Rösler, Federal Minister of Health, plans to expand this possibility with the next health reform, expected in the second half of 2010.

By introducing the right to claim additional fees, the legislator wanted more competition among funds at the advantage of the insured. In total, the funds can increase their income up to five billion euro per year (eight euro per insured member per month), but at high administrative expenses of about one billion euro. Moreover, the funds have a small additional income by the doctor's office fee. This is 10 euro per quarter per patient, in total about two billion euro per year.

A fund can get into serious financial difficulties by claiming an additional fee. Therefore, the main balancing strategy of the insurance funds is to reduce healthcare costs, not only by themselves in negotiations with the providers but also by influencing legislation, to make laws curtailing healthcare providers.

Ambulatory Outpatient Care

Traditionally, doctors have provided ambulatory outpatient care from their offices. Legally defined, there are instances where specialised care can also be provided in hospitals, for instance ambulatory surgery, therapy for cancer patients and social paediatric therapy.

In Germany, the doctors' associations contribute their income. They are public corporations and negotiate the overall budgets for their doctors in a defined region with the insurance funds. According to the medical services and other criteria, the corporations distribute the budget to individual doctors quarterly. Before the last health reform in 2008, the services were weighted by points, or appointments per doctor. The weakness in this system was a decline of euro per point when services and points increased while the global budget remained nearly constant. Now the doctors have defined fees in euro and it seems easier for them to calculate their income. If a patient visits a doctor, the doctor on the average gets 50 euro per quarter. If the patient has more visits, the fee, however remains constant. The physician can help himself only by controlling the number of visits. In the former system there was not such an incentive.

In 2008 the doctors had 7.5 cases per quarter per insured per year. In total, this is about 500 million ambulatory cases. Each case has 2.5 appointments on average per insured (total 1.2 billion appointments). The number of patient contacts with about 18 per insured per year is the highest in international comparison. It is nearly twice as high as in comparable OECD countries. People in Sweden for instance have about three appointments per insured per year (OECD data 2006).

GP Contracts

After the last health reform the insurance funds were obliged to offer their members a General Practitioner (GP) contract. The GP should act as a gatekeeper as it is the case in many other European health systems. The members are free to subscribe to this offer, but give up their free choice of doctors and hospitals. In return they get financial advantages, such as no doctors' office fee. The negotiation of the contracts led to great differences within the doctors' corporations. The GP-Group is attempting to establish a main GP corporation for withdraws, but the development is not settled yet.

About 135,000 physicians work in the ambulatory sector; while 120,000 work in an office of their own, 40,000 as GPs and 80,000 as specialists. Additionally, about 10,000 doctors, mainly chief physicians at hospitals, have the right to provide services in a small and specific range of ambulatory services. In the last few years the number of medical care centres (MCC) has increased dramatically. Ambulatory care evolved into stronger organisational structures. In total, about 6,000 doctors work in MCCs, with 500 out of 1,300 MCCs in the ownership of hospitals (2009).

Care in Hospitals

The hospital sector is a powerful economic factor. One million people in 2,000 hospitals care for 17 million inpatient cases and 18 million outpatient cases. The turnover is close to 65 billion euro, nearly three percent of the GDP.

Inpatient cases are remunerated by German Diagnosis Related Groups (G-DRG), a system which is adapted on a yearly basis. It comprises about 1,200 categories. The main idea is that money follows service. Before the introduction of the budget effect of the G-DRG in 2005 additional patients were cost factors for a hospital. The budget was negotiated annually with a calculated number of days plus a change rate, mostly below 1 percent. If a hospital had a plus in admissions – for instance about 10 percent – it had to pay back about 75 percent of the additional income in next years' budget negotiations. The costs of the additional treatments remained the responsibility of the hospital. These internal costs increased to a higher extent than the income of the hospital causing many efficient hospitals serious financial difficulties during that time period.

With the budget effect of the G-DRG since 2005 the remaining pay of additional inpatient cases increases. Moreover, the hospital has the right to consent additional inpatient cases with the insurance funds – if there is a higher need for hospital care respectively. If the funds reject an agreement the hospital can go to the court. The remaining pay for contracted additional inpatient cases increases from 35 percent in 2005 to 100 percent in 2010.

Investment in Hospitals

Whereas the patient treatments are paid mainly by the insurance funds via G-DRG and via further remunerating fees (95 percent of the hospital budget), investments are paid by the Bundesländer (five percent). This divided responsibility has been introduced 1972 and is called the dualistic financing system. The Bundesländer are responsible for the development, planning and investment financing of hospitals. Over many years, however, the investment rate has declined from 25 to five percent. This is due to shortages of public budgets and changing priorities. The idea of hospitals as institutions with over-capacity and over-utilisation led to a political neglect of the hospital sector.

Currently, the DRG-Institute develops a comprehensive approach to hospital financing by integrating the investment components into the DRG-system. At the end of 2010 the self-government – German Hospital Federation and the Federation of Insurance Funds – shall discuss proposals of the DRG-Institute in cooperation with the Bundesländer.

Looking Ahead

The political discussion about the hospital sector in the past mainly concentrated on the "cost factor"; hospital admissions, hospital beds and how to contain costs. In recent years however, the focus has changed. The political realm is quickly realising the future challenges within German healthcare due to changing demands of society. The need for highly qualified medical and nursing care will continue to increase, our society is

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aging as the portion of elderly people increases, and medical innovations shall accelerate. The amount of wealth and health production by the hospital sector shall become a decisive factor in the development of modern society.

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