

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

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Germany and health 1



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Bismarck's Health Insurance Act of 1883 established the first social health insurance system in the world. The German statutory health insurance system was built on the defining principles of solidarity and self-governance, and these principles have remained at the core of its continuous development for 135 years. A gradual expansion of population and benefits coverage has led to what is, in 2017, universal health coverage with a generous benefits package. Self-governance was initially applied mainly to the payers (the sickness funds) but was extended in 1913 to cover relations between sickness funds and doctors, which in turn led to the right for insured individuals to freely choose their health-care providers. In 1993, the freedom to choose one's sickness fund was formally introduced, and reforms that encourage competition and a strengthened market orientation have gradually gained importance in the past 25 years; these reforms were designed and implemented to protect the principles of solidarity and self-governance. In 2004, self-governance was strengthened through the establishment of the Federal Joint Committee, a major payer-provider structure given the task of defining uniform rules for access to and distribution of health care, benefits coverage, coordination of care across sectors, quality, and efficiency. Under the oversight of the Federal Joint Committee, payer and provider associations have ensured good access to high-quality health care without substantial shortages or waiting times. Self-governance has, however, led to an oversupply of pharmaceutical products, an excess in the number of inpatient cases and hospital stays, and problems with delivering continuity of care across sectoral boundaries. The German health insurance system is not as cost-effective as in some of Germany's neighbouring countries, which, given present expenditure levels, indicates a need to improve efficiency and value for patients.

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This is the first in a **Series** of two papers about Germany and health

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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.

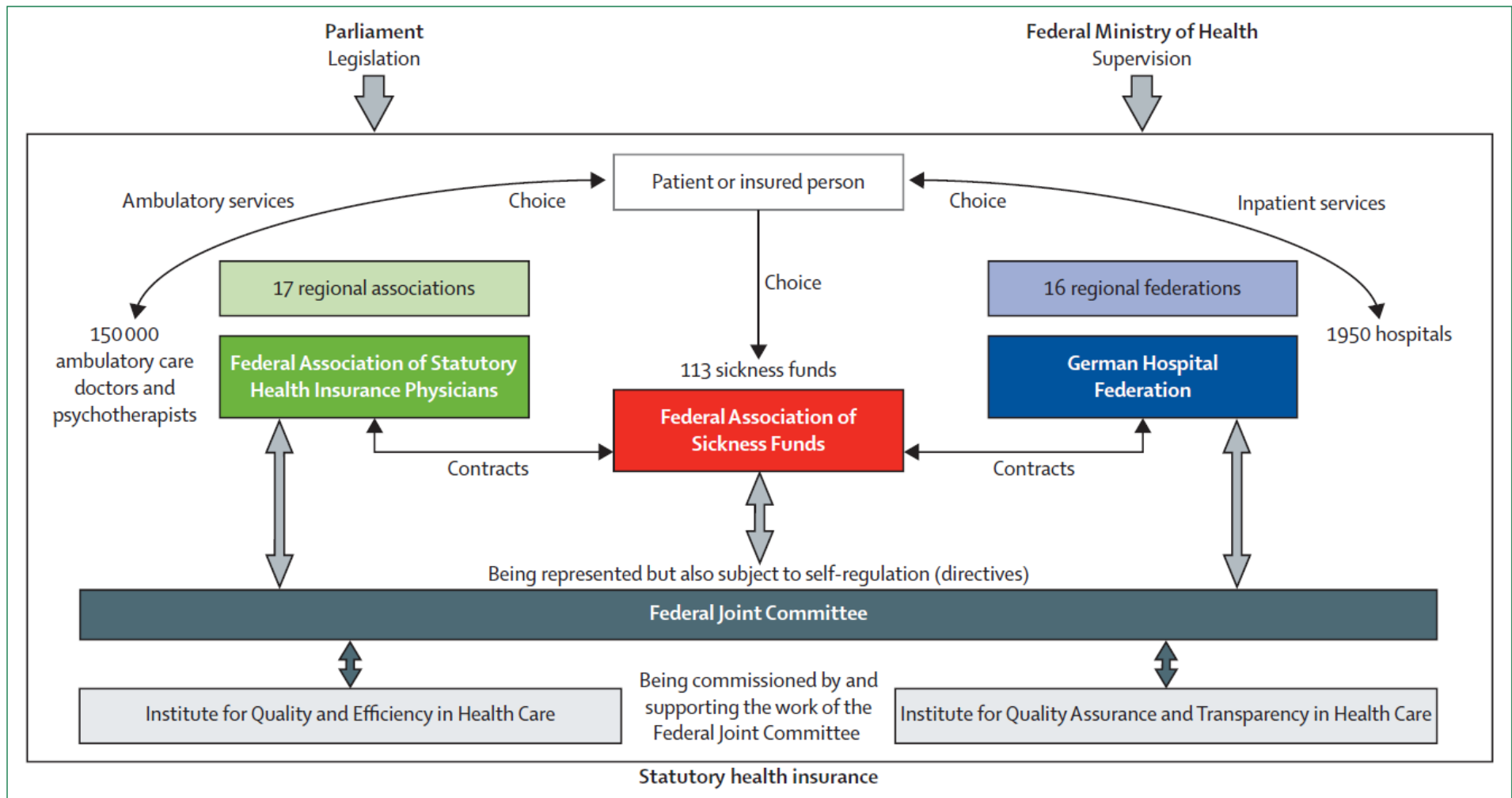
<p>1871-1918 German Empire and World War I</p>	<p>Extension of population and benefit coverage 1881: Kaiser Wilhelm I's „Royal Proclamation on Social Policy“ 1883: Establishment of SHI by Bismarck's „Health Insurance Act“, covering initially 10% of population 1911: Health, pension and accident insurance became integrated into the „Imperial Insurance Code“ (in force from 1914) 1913: Berlin Convention on Ambulatory Care, the first step towards joint self-governance in SHI system 1913: 35% of population are covered by SHI</p>	
<p>1919-1933 Weimar Republic</p>	<p>Strengthening of medical profession 1923: Imperial Committee of Physicians and Sickness Funds 1925: Majority of population (51%) is covered in SHI 1931-1933: Special presidential directives on ambulatory care; create regional associations of SHI physicians and a “total payment” for ambulatory care</p>	
<p>1933-1945 Nazi regime and World War II</p>	<p>Fundamental structures of SHI remained, but 1933: Withdrawal of self-administration and exclusion of socialist and Jewish workers from the committees of the sickness funds 1933-1938: Work prohibition for Jewish physicians; denied access to health care for Jews and other minorities 1934: regional associations of SHI are merged into one National Association of SHI Physicians 1934-1935: Redefining organizational framework along the rules of Nazi-dictatorship: centralization of sickness funds, welfare organizations, and community health services by the Nazi Party 1941: SHI coverage for retired persons</p>	
<p>1945-1989 German Separation</p>	<p>West: Continuation of SHI system in the Federal Republic of Germany (FRG) 1955: Restoration of self-administration of sickness funds (after a long and fierce debate) 1960-1964: Failed reform acts 1972: Hospital Care Financing Act 1972/1975/1981: SHI coverage for farmers, students, disabled and artists 1977: First Cost Containment Act 1988: Health Care Reform Act</p>	<p>East: Strong focus on public health in the German Democratic Republic (cf. panel 5) 1945: Establishment of the Central administration for the East German health care system 1950: “Central Planning Act” - introduction of universal health coverage, managed by two national social insurance agencies 1974: Introduction of disease management programs 1989: Only few weeks before the fall of the Berlin wall, a „National Health Conference“ decided to implement substantial health care reforms with increased investment</p>
<p>1989-today German Re-unification</p>	<p>Transfer of the FRG health care system to the eastern part of Germany 1989: Transformation of the „Imperial Insurance Code“ of 1914 into the „Code of Social Law“ (Sozialgesetzbuch – SGB), divided into books; the fifth book (SGB V) covers SHI 1990: Re-unification Acts 1993-2017: cf. table 1</p>	

Year	Notes
1883	Health Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> First of all, address books for most members of the sickness funds system, supported by the introduction of a state-allocated registration system to coordinate contributions payable among sickness funds (SFB) Members based health work force planning for ambulatory care doctors and accreditation requirements for statutory health insurance doctors Introduction of full cost coverage for hospitals Introduction of health fund physician specialties for the major sectors of health care Increased requirements for pharmaceutical products and distribution according to price (SGB II) and price list (SGB III) Introduction of a parallel list of pharmaceutical products
1934	Sickness Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Introduction of statutory long-term care insurance as of 1936 managed by sickness funds or private health insurance companies
1935	Health Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Reduction of all contribution rates by 4.5 percentage points
1972	Hospital Care Financing Act (Gesetz über die Krankenhausfinanzierung) <ul style="list-style-type: none"> Increased requirements for hospital care, pharmaceutical products, medical aids, ambulance transportation, and dentures Introduction of hospital care benefits Increased possibilities for non-collective contracts between sickness funds and providers
1988	Health Care Reform Act (Gesetz über die Gesundheitsreform) <ul style="list-style-type: none"> Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures
1990	Transfer of the FRG health care system to the eastern part of Germany (Gesetz über die Gesundheitsreform) <ul style="list-style-type: none"> Transfer of health care system from the GDR to the FRG Lowering requirement rates for pharmaceuticals and dentures Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures
1993	Health Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures
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2003	Health Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures
2007	Health Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures
2017	Health Insurance Law (Gesetz über die Krankenversicherung) <ul style="list-style-type: none"> Introduction of a new system for the 1988 introduction of statutory health insurance Lowering requirement rates for pharmaceuticals and dentures

Empire – Republic – dictatorships – German separation and unification: SHI resilience with expansion of population & benefits coverage

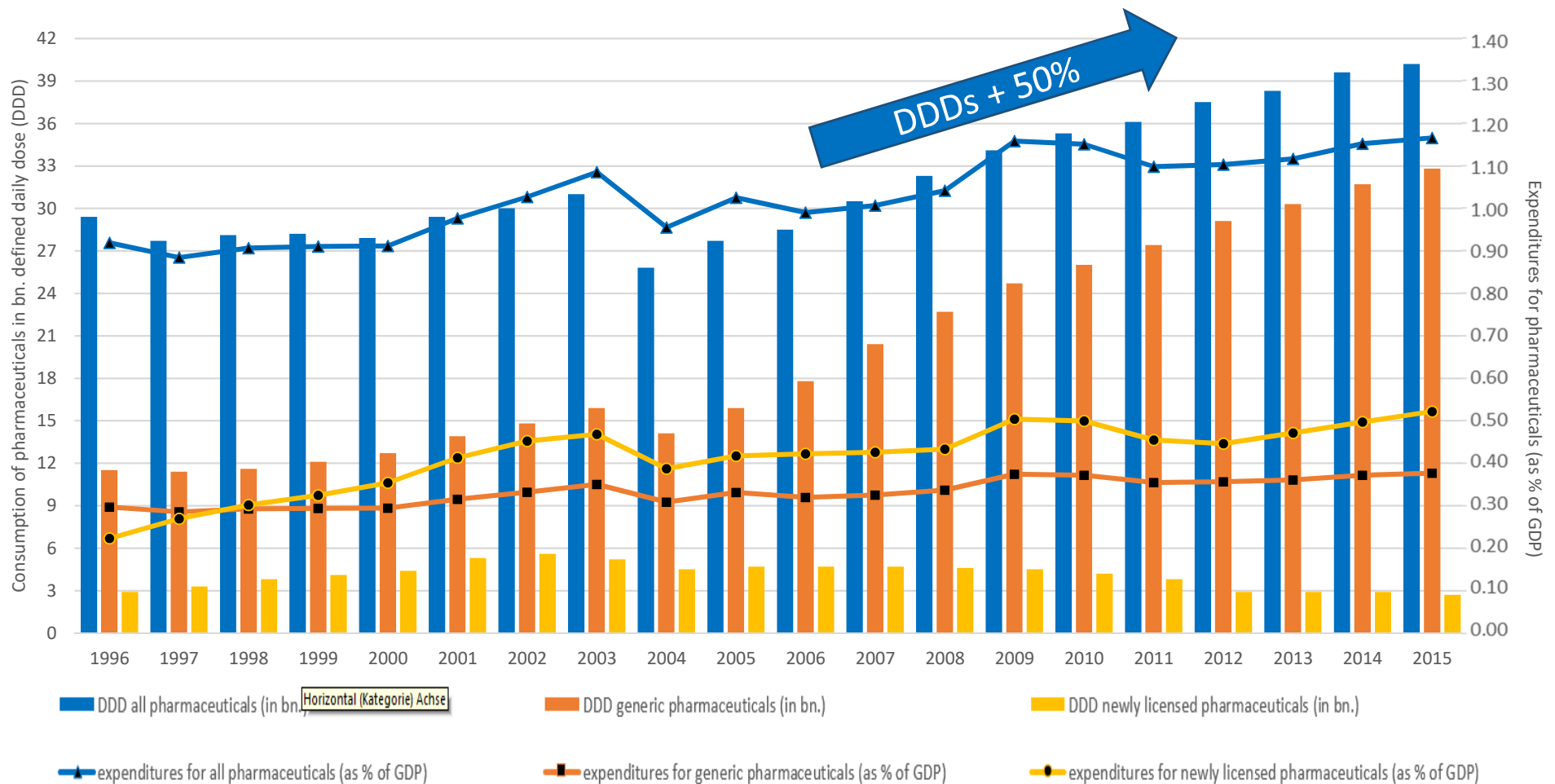
Year	Reform	Contents and selected measures
Christian Democratic–Liberal coalition (Chancellor: Helmut Kohl, CDU); Health Minister: Horst Seehofer (CSU)		
1993	Health Care Structure Act	<ul style="list-style-type: none"> • Free choice of sickness funds for most members of the statutory health insurance, 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 unnoticed increase in pharmaceutical consumption by 50% (while costs increased “only” 20%)

... while much attention was put on patented drugs

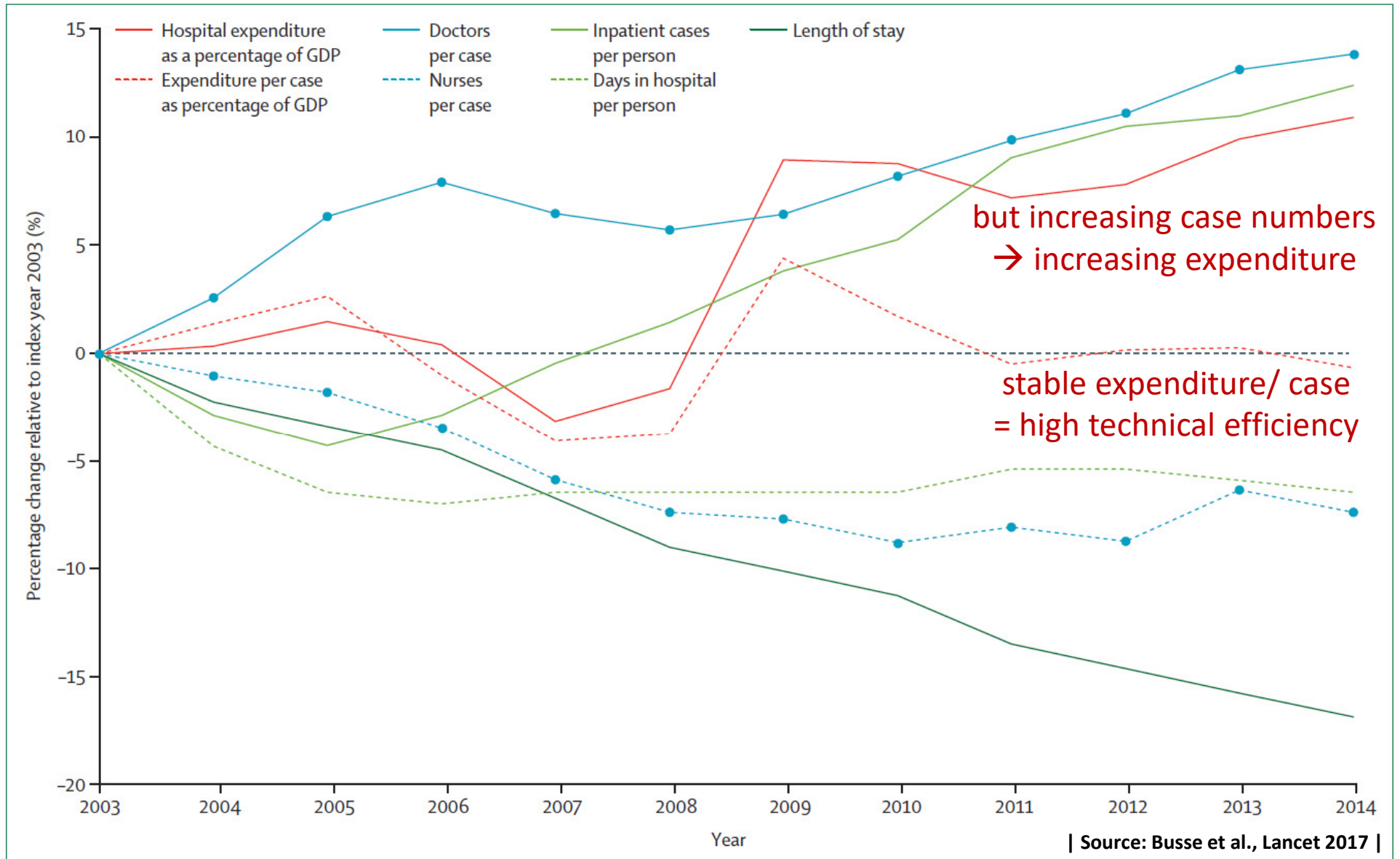
Important policies regarding patented drugs in Germany since 1996.

	1996-2003	2004-2006	2007-2010	Since 2011
Evaluation of additional/comparative benefit	No	Upon application of Ministry of Health or parties in G-BA		Mandatory for all new drugs/ indications except orphan drugs ^{a, b}
Price-setting	Free by manufacturer			Officially free by manufacturer, but de facto only for 12 months after launch
Reimbursability (benefit basket)	All patented drugs included in benefit basket	Drugs without proof of effectiveness or with proven inferior effectiveness or with more efficient alternatives may be restricted or excluded (such as insulin analogues) [11]		Only drugs with proven inferior effectiveness or with more efficient alternatives may be restricted or excluded
Reimbursement price in case of no additional benefit		Drugs are grouped and a reference price is determined per group; patient pays difference between price and reference price (example: atorvastatin [Sortis])		New drugs are grouped as well and are liable to reference price; if grouping is impossible, price may not exceed that of existing alternative
Reimbursement in case of additional benefit	Reimbursement = price (possibly temporarily lowered by a certain %)	Reimbursement = price (possibly temporarily lowered by a certain %)	Maximum reimbursement ceiling may be set following cost-effectiveness analysis (not done in a single case); in other cases reimbursement = price	Country-wide rebate on manufacturer price is negotiated between Federal Association of Statutory Health Insurance Funds and manufacturer (→ fixed reimbursement price from month 13 after launch)
Unevaluated drugs			Reimbursement = price (possibly temporarily lowered by a certain %)	
Cost-effectiveness analysis	No	No	May be commissioned by G-BA for drugs with additional benefit (two analyses commissioned)	If negotiations fail and if one side challenges the result of the arbitration, a cost-effectiveness analysis is commissioned by the G-BA

^a Although the additional benefit is deemed to be proven for orphan drugs, a dossier has to be submitted, and price negotiations will follow. The dossier does not have to present proof of the medical benefit and additional benefit. However, the dossier must include information on the groups of patients for whom there is significant medical additional benefit and on the extent of this additional benefit [10]. If the business volume of an orphan drug reached the amount of 50 million EUR during the last 12 months, a second (and full) dossier demonstrating additional benefits will have to be submitted within 3 months of its request by the G-BA.

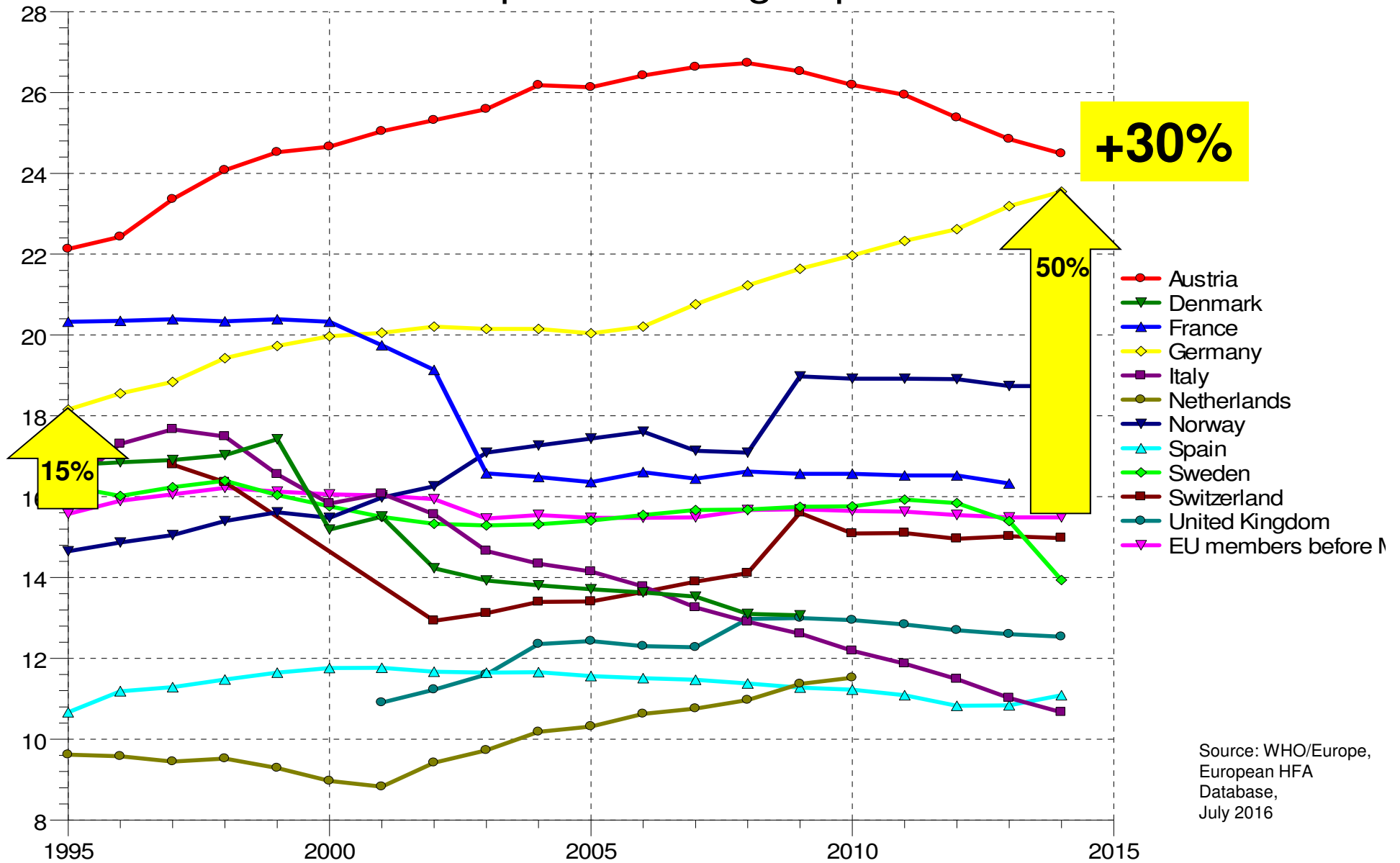
^b Patented pharmaceuticals that were approved before 2011 are also assessed in the AMNOG process, if it is initiated by the G-BA.

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



... which differentiates Germany ...

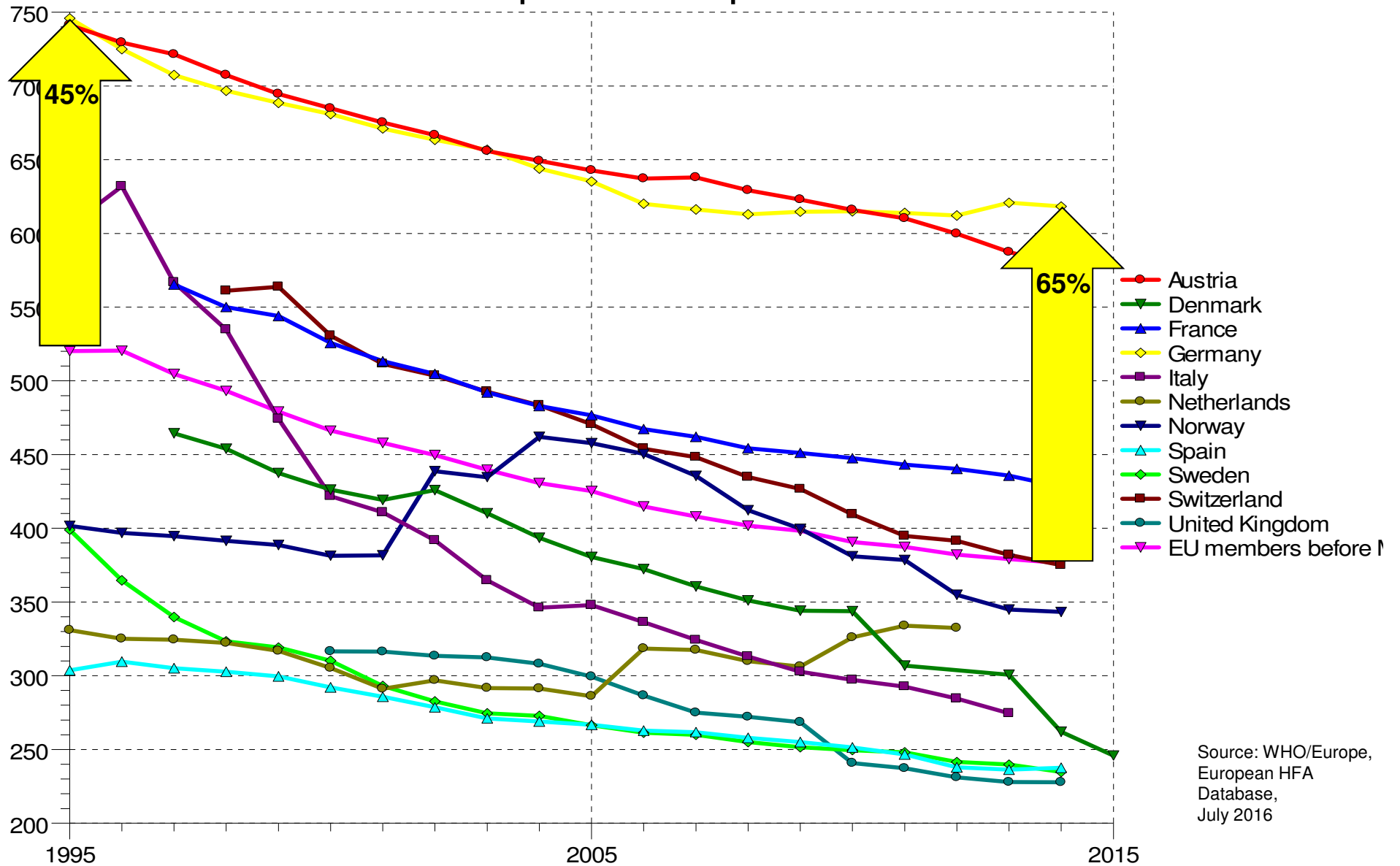
Acute care hospital discharges per 100



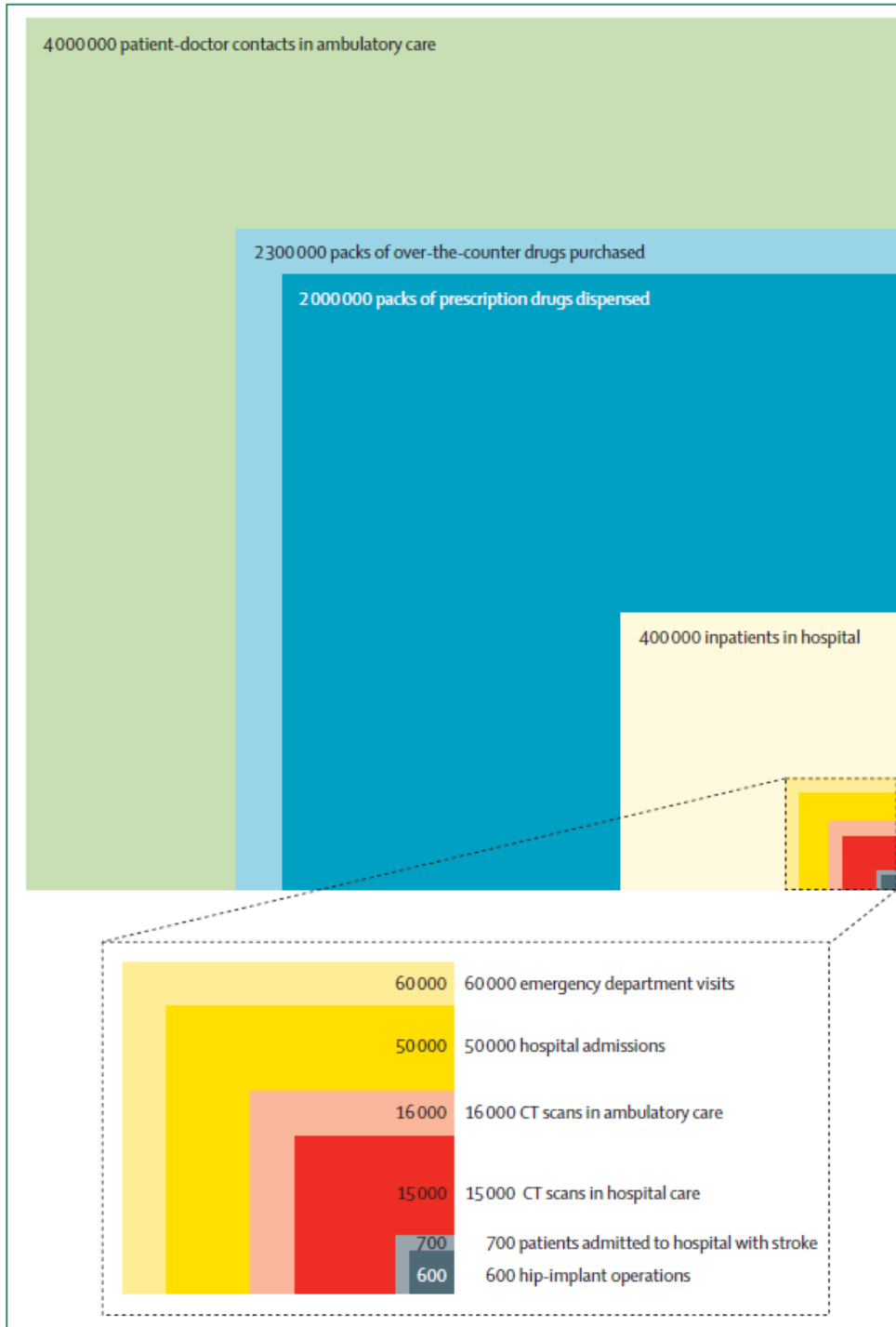
Source: WHO/Europe, European HFA Database, July 2016

... mainly due to a massive bed supply

Acute care hospital beds per 100 000



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



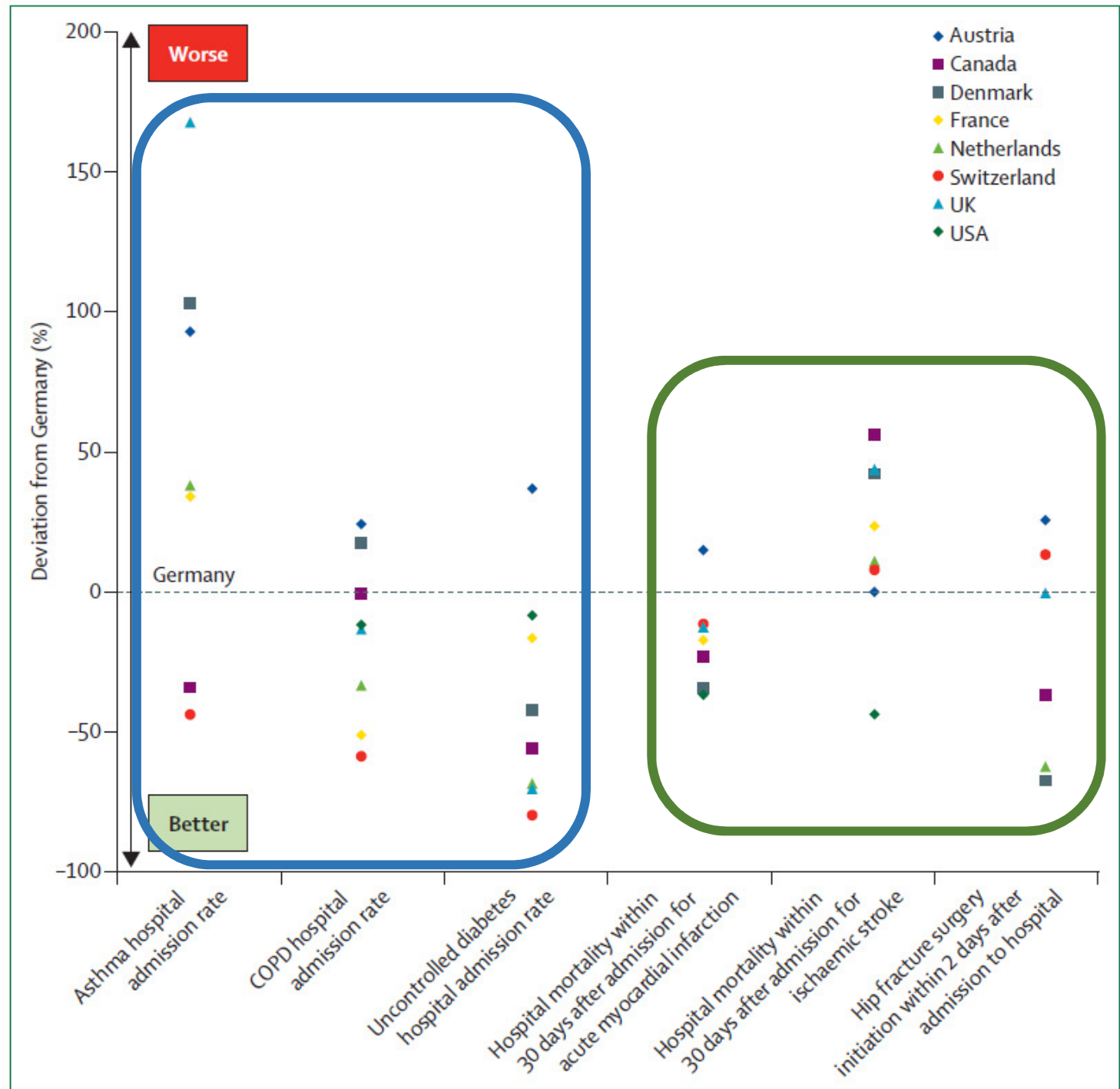
1 in 200 Germans spent the day as inpatients (vs 1 in 500 Danes)* and 1 in 20 see an ambulatory care doctor every day

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

Key messages (III)

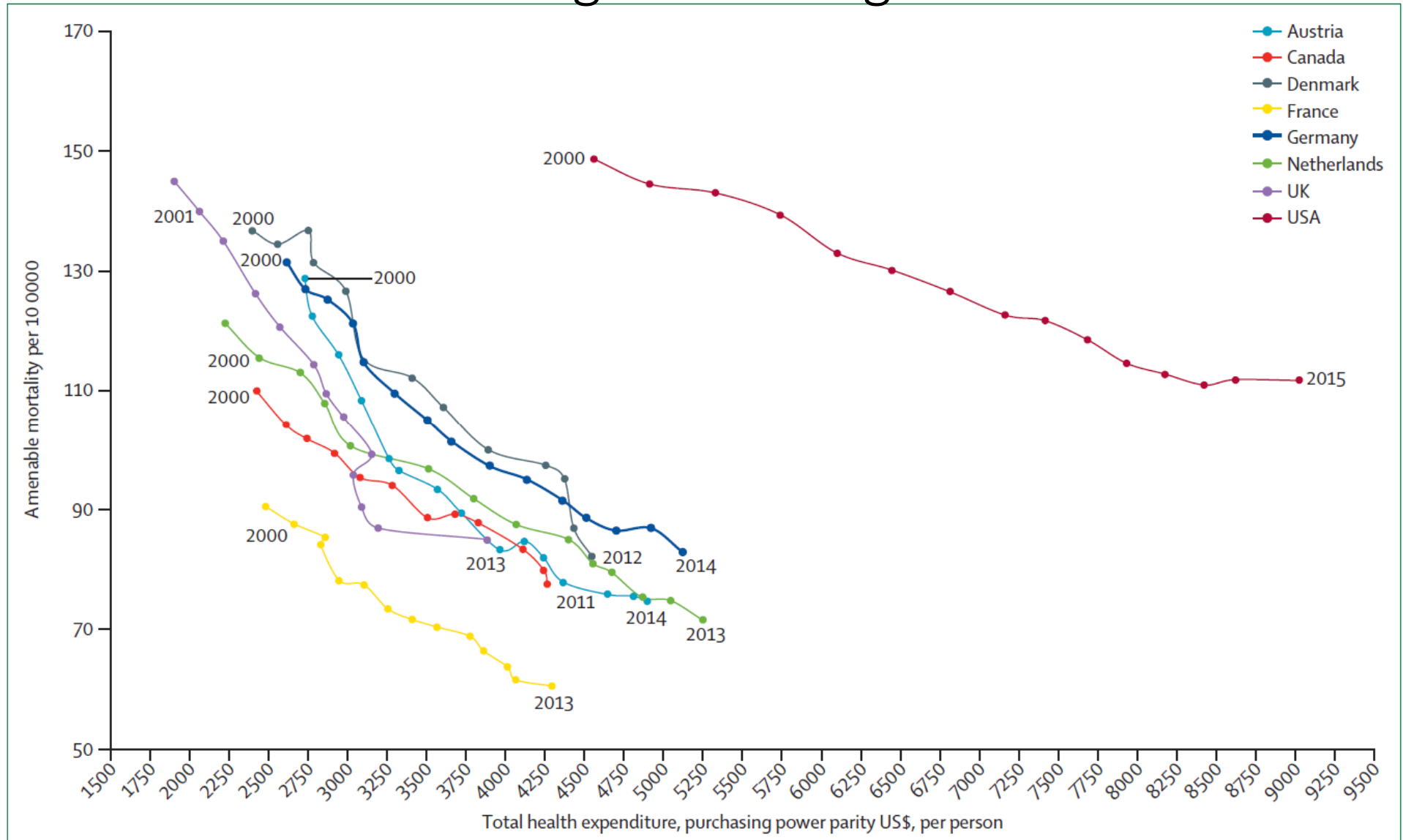
- Joint self-governance has developed alongside competition and has contributed to a system with good access to health care; however, joint self-governance has also jeopardized continuity of care and has led to an oversupply of pharmaceuticals and inpatient care.
- Since the late 1990s, the German health 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

| Source: Busse et al., Lancet 2017 |



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.