Healthcare in Germany: Great Leeway for Major Players

by Jürgen Wasem, Alfred Krupp von Bohlen und Halbach Foundation Endowed Chair for Medicine Management, University of Duisburg-Essen, Germany

"Reform is dead. Long live reform." It is a sentiment heard time and again throughout the German healthcare sector. After all, the past 35 years have seen the country enact six sweeping reform packages and an array of smaller ones. The new government majority under Chancellor Angela Merkel that emerged in the last parliamentary elections in September 2009 announced in its coalition agreement that it planned to enact another healthcare reform, this one scheduled to take effect in 2011.

Financial Development as a Driver of Healthcare Reform

In my opinion, a reform of the financing structure of Germany's statutory health insurance system is urgently needed. The new federal government intends on adding contributions that are independent of income levels (flat per-capita contributions) to the existing system of income-dependent contributions. A model that combines these two kinds of contributions is in place in some other countries, such as the Netherlands. I consider this a sensible step. It will help ensure that the healthcare system is financed more sustainably. If enacted, however, a form of social compensation would be needed, financed through taxes, for insured parties with low incomes. Because the government is also determined to cut its income from taxes via a major tax overhaul, it is entirely possible that we will lack the tax revenue needed to pay for this social compensation. I therefore believe our policymakers will need to choose between tax reform and reforming the financing of our healthcare sector.

There is a contentious debate regarding whether our high healthcare expenditures yield proportionate benefits. According to various international studies (such as the OECD Health Care Quality Indicators Project or the measurements taken under the European Union's Open Method of Coordination), the German healthcare sector's outcome is only moderate. The council of healthcare experts convened by the federal government has found that overtreatment, undertreatment, and provision of wrong or inappropriate healthcare services are widespread. Patient satisfaction, on the other hand, is generally high, and waiting times are mostly short.

Do the Benefits Outweigh the Costs?

I am convinced that the sharp dividing line between outpatient and inpatient care is one of the reasons for the comparatively unfavorable cost-benefit curve. Hospitals are permitted to provide outpatient treatment only within very narrow limits. Instead, this is reserved for physicians in private practice, even when specialist care is needed. Since 2004, medical care centers have also been permitted to participate in outpatient care. Such centers are being built by hospitals, for example. I believe we need to reconsider the division of labor between hospitals and physicians in private practice. Looking at the international landscape, the role taken by the German government in controlling and directing the course of the healthcare sector is rather modest. That means that the major players in the healthcare sector traditionally enjoy tremendous latitude. The central body in this regard is the Federal Joint Committee, whose membership is made up of representatives from health insurance companies, physicians, dentists, and hospitals. Patients' representatives have the right to attend and speak at its meetings, but have no voting rights.

The central task of the Federal Joint Committee is to specify the catalog of services approved and paid for under the statutory health insurance system. Physicians can therefore use new methods of outpatient diagnosis or new treatment methods only on the condition that they are approved by the Federal Joint Committee as medical services provided under statutory health insurance. As a result, it is possible to assess the benefits and cost-benefit ratio of specific therapies. Physicians also receive information on how to prescribe medications for maximum economic efficiency. The decisions made by the Federal Joint Committee are central in terms of quality assurance as well. For example, it sets the minimum quantity standards for operations.

A Stronger Role for Health Insurers

Since the beginning of 2009, insured parties and employers have been paying their contributions to a newly established central health fund (see Fig. 3). The health fund distributes moneys to the

Continued on page 79

Facts & Figures

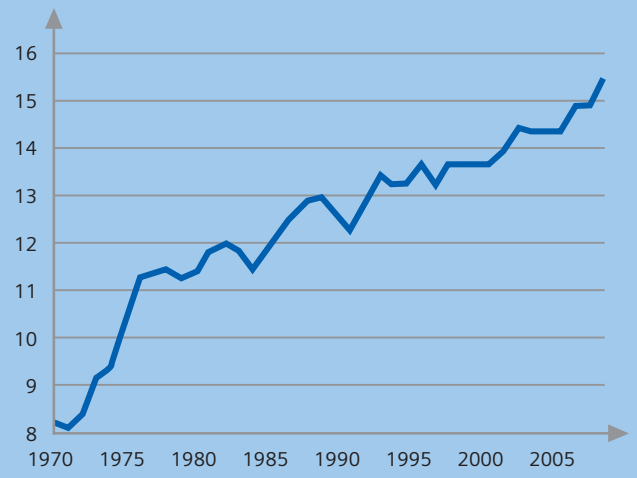
Healthcare Expenditures

Germany is one of the countries with the highest level of health expenditures expressed as a portion of GDP, after the United States, Switzerland, and France. In terms of per-capita spending, Germany ranked near the top among OECD countries in 2006 at US$3,371 (measured at purchasing power parity).

Contribution Rates

As Fig. 2 (see opposite page) shows, the percentage of GDP consisting of healthcare spending has also risen sharply, from 5.7 percent in 1970 to 10.4 percent in 2007. The rising contribution rates charged by health insurers are also attributable to the fact that incomes subject to mandatory contributions (particularly employee wages) have grown slower than GDP.

Fig. 1: Average contribution rate charged by health insurers (as % of income)[1]



Statutory Health Insurers

The development of contribution rates under the statutory health insurance system regularly drives healthcare reform cycles in Germany. Nearly 90 percent of the population is covered by approximately 170 statutory health insurers. The statutory health insurance system collects income-based contributions to finance the costs of care. As Fig. 1 shows, the average contribution rate for health insurers has risen from eight percent in 1970 to more than 15 percent in 2009, in spite of the many healthcare reforms enacted during that period.

Private Subscribers

The German Health Insurance Act permits employees with a high income (the threshold for 2010 is €49,950), the self-employed, and civil servants to decide whether they wish to belong to a statutory health insurance plan or would rather obtain insurance from a private health insurer. As a result, about ten percent of the population has private coverage.

Healthcare Policy in Recent Decades

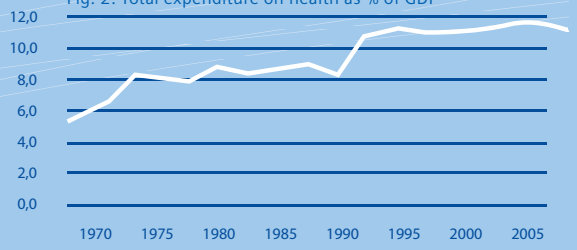
To curb spending in the healthcare sector, healthcare policy over the past three decades has tended to favor health insurers over the providers of healthcare services. One of the very first steps was to call on health insurers to act more consistently and uniformly, and there was a substantial push to centralize decision-making authority. At the federal level, an industry association of health insurance companies was established. Its responsibilities include establishing fixed prices for pharmaceuticals and medical aids, with its decisions binding for all health insurers. This association works together with the group that represents the interests of physicians in private practice, the National Association of Statutory Health Insurance Physicians, to establish the required fee schedule and the rules capping physician compensation. The association also works with the German Hospital Federation to decide on the lump-sum payment system (German Diagnosis-Related Groups), which is also binding for all health insurers.

Competition Among Health Insurers

The German legislative branch has consistently and deliberately encouraged competition among health insurers. Since 1997, all insured parties generally have the right to change health insurers. About five percent of insured parties do so each year – a significant enough figure to put pressure on insurance company managers to compete. The major competitive parameter for health insurance companies in the past was the contribution rate: Insured parties and their employers paid contributions directly to the health insurers, which had to calculate contribution rates to be sufficient to cover their own costs.

[1] Source: German Federal Ministry of Health

Fig. 2: Total expenditure on health as % of GDP[2]



General Government Expenditure on Health as % of Total Expenditure on Health: 76.6 (2006)

Population in Thousands: 82,641 (2006)

Per Capita Total Expenditure on Health: US$3,669 (2006)

[2] Source: German Federal Statistical Office. All other data: WHO Statistical Information System (WHOSIS), http://www.who.int/whosis/en; last accessed February 5th, 2010.

Number of Hospital Beds per 10,000 Resident Population: 83 (2006)

Number of Dentists per 10,000 Resident Population: 8 (2006)

Number of Physicians per 10,000 Resident Population: 34 (2006)

Number of Nurses per 10,000 Resident Population: 80 (2005)

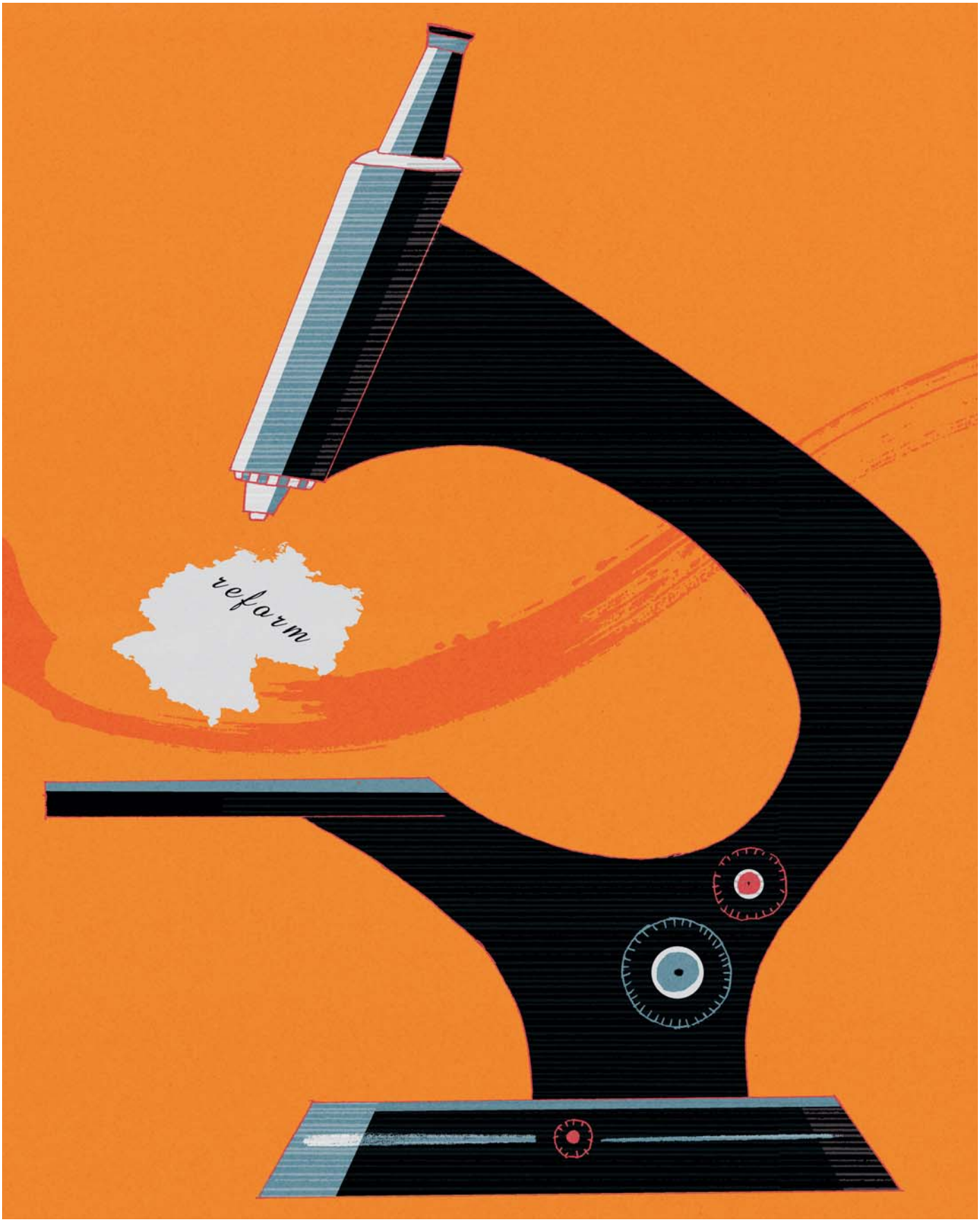
80

Male Life Expectancy at Birth in Years: 77

77

82

Female Life Expectancy at Birth in Years: 82


reform

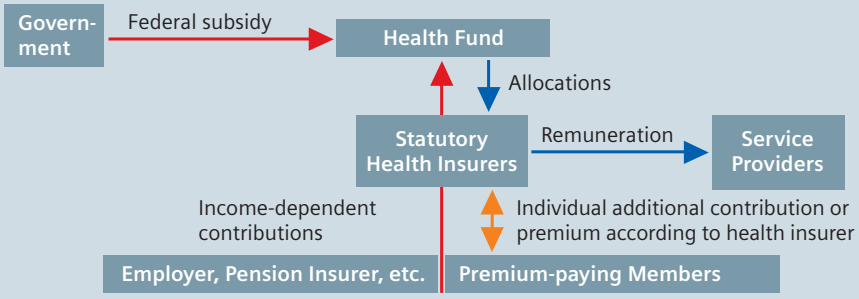
health insurance companies according to the risk structure of their insured parties. If the health insurers cannot cover their expenses with these allocations, they have to charge the insured an additional contribution. On the other hand, they can provide the insured with a reimbursement if the amount they are allocated by the fund turns out to be greater than their needs. The amount of this additional contribution is developing into a major competitive factor. While the basic contribution to the health fund is paid in about equal portions by the employer and the insured, the insured party alone pays the additional contribution.

The additional contribution to the health insurance company, like the basic contribution rate, depends largely on the health insurer's expenditures. The individual health insurance companies have recently been given an increasing number of tools for managing their expenses. For example, individual health insurers can sign discount agreements with pharmaceutical companies, giving the drug company preferential supplier status with their insured parties in return. The insurance companies can also sign selective contracts with physicians' networks or integrated care providers. The effort to curb expenses is at the heart of these actions.

Increasingly, however, the health insurers are coming to see these selective agreements as an opportunity to make their own particular mark on the healthcare sector and thereby position themselves compared to competitors.

I believe it is necessary to encourage competition among health insurers with regard to the quality and economic efficiency of care. This way, insured parties can obtain health insurance coverage that is in line with their preferences.

Fig. 3: Flows of payment in the statutory health insurance system



A Two-class System of Medicine?

Private health insurers do not assess income-dependent contributions. Instead, they calculate premiums according to the individual risk levels for each subscriber. By taking out health insurance, young subscribers are saving toward the increasing costs they will face as they age ("provisions for aging expenses").

By law, those with private health insurance pay higher prices to obtain services from physicians, hospitals, and pharmacies than those insured under the statutory health insurance system. This has triggered some debate regarding whether these patients are given preferential medical treatment, with others receiving "second-class" medicine. Empirical evidence shows that privately insured patients receive appointments for medical care more quickly and are more frequently given expensive new drugs. That leaves us with the question of whether we are moving increasingly toward this kind of "two-class" medical system. Thus, I am firmly convinced that we urgently need to reform the financing of the statutory health insurance system.

The opinions reflected in this article do not necessarily reflect those of Siemens Healthcare.

Jürgen Wasem studied Economics and Political Science at Pennsylvania State University, USA, the University of Sussex, UK, and the University of Cologne, Germany. After earning his doctorate, he became a consultant with the German Federal Ministry of Health. After holding professorships at the University of Munich and the University of Greifswald, he moved to the University of Duisburg-Essen, where he has held the Alfred Krupp von Bohlen und Halbach Foundation Endowed Chair for Medicine Management since 2003.

Professor Wasem was the chairman of a commission of experts assembled by the German Federal Government on the reform of premium calculations in the private health insurance sector; the legislature acted on the majority of the commission's findings. He is also the chairman of the federal board in charge of mediating disputes on fees between health insurers and physicians who provide outpatient care, and the Chairman of the Academic Advisory Council of the Federal Social Insurance Office, which is responsible for comparing risk structures between the health insurers. Professor Wasem also played a major role in developing a network of health technology assessment (HTA) task forces in Germany; his institute regularly performs HTAs and systematic reviews for the appropriate federal agencies. In his work, he also focuses on evaluations of the health and economic efficiency of medical products and pharmaceuticals.