



Healthcare Systems: Germany

Based on the 2001 Civitas Report by David Green and Benedict Irvine

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Introduction

The German health care system has undergone a series of recent and controversial changes,¹ implemented in an attempt to improve competition within the health sector and reduce its spiralling cost to the government. It remains to be seen whether the reforms will achieve those goals, but even if finance continues to be a problem for German health care, as it will for all countries suffering from economic difficulties and an ageing population, there are many aspects of the German health care system which work well. This report will therefore set out the key characteristics of German health care, exploring its recent improvements and highlighting areas that may be of interest to the NHS.

As of 2009 it is compulsory for all German citizens and long-term residents to have health insurance.² For those earning less than €49,500, insurance is provided by the public statutory health insurance scheme (SHI),³ known in Germany as *Gesetzliche Krankenversicherung* (GKV).⁴ SHI is operated by approximately 150 competing sickness funds (SFs) and citizens are insured on a per family basis, meaning that the dependents of the insured are also covered.⁵

Anyone earning more than €49,500 per annum has the option of purchasing a private health insurance plan, although upwards of 85 per cent opt to remain with SHI.⁶ Individuals are insured on a per person basis and once they have chosen to enter the private health insurance sector they can no longer return to SHI.⁷ As health insurance is now compulsory, both statutory health insurance funds and private health insurance companies must accept any applicant. Furthermore, because private health insurance enrolees can generally no longer return to SHI, private insurance companies are legally obliged to offer a basic package of services for a similar price to the GKV scheme.⁸ 10 per cent of the population is covered by private health insurance, with civil servants and the self-employed making up the majority of this group. The remaining 5 per cent of the population is covered by special regimes, such as the scheme for soldiers.⁹

GKV: Statutory Health Insurance

Principles of the Health Care System

The German system of social insurance was first established on the national level in 1883 by Otto von Bismarck. The founding principles of his scheme are commonly identified as solidarity, subsidiarity, and corporatism.¹⁰

When Germans speak of **solidarity**, they mean that the government takes responsibility for ensuring universal access by helping those unable to participate in the private health insurance sector. Thus, everybody contributes according to their means but public sector monopoly is not implied as it is in the UK. The idea of social partnership is also upheld, reflected by the similar contributions made by employers and employees.

Subsidiarity suggests a decentralised system under which policy is implemented by the smallest feasible political and administrative units in society. This doctrine is endorsed by political parties of all persuasions and is embedded in the German constitution—the Basic Law of 1949. In health care, subsidiarity means that the government is only responsible for setting the legislative framework and establishing the corporatist bargaining process.

Corporatism is seen in the democratically elected representation of employees and employers on the governing boards of sickness funds and in the importance of national and regional decision-making bodies. These bodies negotiate the terms of medical care and reflect the interests of groups such as doctors, dentists, pharmacists, the pharmaceutical industry and insurers.¹¹ The result is that it is difficult for any one group to change the rules, or to raise fees or contribution rates without the consent of the other parties.¹² This does however lead to its own problems, as required changes can come up against vested interests. Moreover, German health care, like the UK, suffers on occasion as a result of the ruling parties' differing ideologies.¹³ Health care policies are therefore often fragile, watered-down in order to protect the cohesion of the central government coalition and in danger of being reversed once the balance of political power changes.

Organisation

Responsibility for the health care system in Germany is shared between the Länder (states), the federal government and civil society organisations, thus combining vertical implementation of policies with strong horizontal decision-making.

At the national level, the Federal Assembly, the Federal Council (the upper house, representing the states) and the Federal Ministry of Health and Social Security are the key actors.¹⁴ Further down the ladder, the ministries in each Land (state) are responsible for passing their own laws, supervising subordinate authorities, and financing investment in the hospital sector. The Länder are subdivided into administrative districts and local authorities (towns, municipalities, counties), all of which have numerous competencies in the healthcare system, from health promotion to hospital planning.¹⁵ The role of the central government in relation to localities in Germany has been compared to the less unitary 'tripartite' structure in the UK NHS prior to 1974, under which hospitals were run by Regional Hospital Boards, community health services were controlled by local councils and primary care GPs were contracted.¹⁶

Ambulatory general practice medicine and specialist care is delivered by physicians who are, by law, mandatory members of regional Associations. These Associations negotiate contracts with sickness funds, are responsible for organising care and act as financial intermediaries.¹⁷

Alongside regional Physician Associations, there are also professional 'chambers' for physicians and dentists. Although coordinated centrally, these chambers operate predominantly at the level of the Länder and are responsible for secondary training, continuing education and setting professional, ethical and community relations standards. They are also under increasing pressure to address quality assurance more vigorously than they have in the past.¹⁸

Other key bodies in health services provision include the national associations of insurance providers (statutory and private health insurance), hospital associations and the charity associations.¹⁹

GKV Sickness Funds

Since the 1990s, Germans eligible for statutory health insurance have been free to choose their insurer and can switch provider once every 12 months.²⁰ Eligibility for coverage is portable within the country²¹ and the system has been made more efficient by the introduction in 1995

of *Chip-karten* (smart cards), which replaced the 100 year old system of an insurance certificate (*Krankenschein*).

The sickness funds fall into six major groups:²²

- General regional funds, *Allgemeine Ortskrankenkassen* (AOK) which fall under the umbrella organisation, the Federal Association of AOK. These funds cover approximately a third of the German population.xxii²³
- Company-based funds known as *Betriebskrankenkassen* (BKK). These covered approximately a fifth of the population in 2004.
- Trade guild funds, *Innungskrankenkassen* (IKK).
- Agricultural funds, *Landwirtschaftliche Krankenkassen* (LKK).
- Miners-Railway-Sea funds, *Knappschaft-Bahn-See*
- Substitute funds known as *Ersatzkassen*. Their predecessors were the early mutual aid societies and, like the AOK, *Ersatzkassen* cover approximately a third of the population (2004 figures).

What is covered by SHI?

The broad contents of the SHI benefits package (examples of which are given below) are legally defined but the specifics are decided upon by a Federal Joint Committee.²⁴

- Preventive services, particularly during pregnancy and for the early detection of cancer or other major illness such as heart and circulatory disorders.
- Physician services
- Inpatient and outpatient hospital care
- Rehabilitation
- Mental health care
- Dental care
- Prescription drugs
- Sick leave compensation.
- Domestic nursing care where it is not possible to hospitalise patients. Patients with children under the age of 12, or who are handicapped, and who cannot be looked after by another person at home, may also receive domestic help.

Since 1995, long-term care is covered by a separate insurance scheme, which is mandatory for the whole population and usually supplied by the same carrier that provides an individual's regular health insurance. As with GKV contributions, contributions to long-term care insurance are split between employers and employees at a combined rate of 1.95 per cent of gross salary, although citizens without children are required to pay an additional 0.25 per cent.²⁵ The benefits supplied by long-term care insurance are dependent on an evaluation of individual care needs by the SHI Medical Review Board and are also limited to certain maximum amounts, depending on the level of care required.²⁶ This is not the case with ordinary health insurance, which cannot take into account prior health conditions and does not set maximum benefit allowances. Given the limits on public long-term care insurance benefits, citizens are advised to buy supplementary private, long-term care insurance.

Long-term care insurance benefits are received either in-kind, (often through a home care agency), or in cash, which gives patients the freedom to choose their own provision, such as

care by relatives. Most providers of long-term care are private, non-profit organisations, frequently based on religious or charitable groups.²⁷

Finance

Statutory sickness funds are financed predominantly through payroll taxes which have been legally fixed at 15.5 per cent of gross wages (an increase from 14.9 per cent in 2010).²⁸ The insured are expected to pay 8.2 per cent of their income, whilst the remaining 7.3 per cent is paid by employers.²⁹ The unemployed may also access sickness funds and they contribute in proportion to their unemployment entitlements or, if they have never worked, are catered for through a social fund (*Sozialamt*). This fund arranges cover directly with doctors, or through one of the AOKs. The health care costs of children are increasingly covered by tax revenues, which supplement payroll contributions.³⁰ Means-tested subsidies would be provided to those whose insurance costs rise an additional 2 per cent above the 15.5 per cent rate.

The fixed contribution marks a change from the previous system, where sickness funds had a degree of autonomy in setting their own premiums (displayed as a percentage of income) and would compete on that basis.³¹ Another innovation, formally established in 2009, is the Central Health Fund, which pools all sickness fund contributions together with federal government revenue. This money is then reallocated to each SF based on a prospective risk equalisation formula (morbidity oriented risk structure compensation or Morbi-RSA)³² that takes age, sex and the morbidity rates of 80 chronic and/or serious illnesses into account. This means that SFs will receive considerably more from the central fund for patients with cancer, AIDS or cystic fibrosis than for enrollees with no such long-term or serious condition. SFs may charge an additional flat rate nominal premium if the received resources are insufficient, although few currently do for fear of losing their enrollees to another provider.³³ Therefore, rather than having to charge additional rates, SFs are more likely to try and generate savings elsewhere, for example in contracts with providers or by improving efficiency in administration. This is a good example of the benefits of a competitive insurance market. The reforms also contained cost-saving measures, such as restrictions on how much SFs could spend on administration.³⁴

The establishment of the Central Health Fund also represented a relatively good compromise between two conflicting approaches on how to fund the SFs in light of rising contributions under the previous system. Left-wing parties in Germany had come to favour *Bürgerversicherung* (civic insurance), meaning a broadening of the revenue base of the SHI system so that exempted groups with private insurance would be included or other taxes would fund the system, while the centre-right had proposed ending the payroll tax in favour of flat-rate premiums, known as *Gesundheitsprämie* (healthcare premium). The Central Fund has elements of both approaches, broadening the revenue base by including some central government tax revenues to supplement the sickness fund contributions, while employer contributions are frozen and future spending increases will lead to rising premiums, in effect leading to a conversion to flat-rate premiums.^{35 36}

Remarkably, at a time when some other health services are still battling deficits, these reforms also resulted in a debate arising in Germany in 2012 over how to spend an estimated €26 billion surplus in the SF system. This was due to the decisive actions the government took in 2011 to deal with deficits and instability among the sickness funds, including the aforementioned payroll tax increase, the imposition of spending cuts and the allocation of an additional €2 billion in federal subsidies. Not all of this €26 billion is freed for any use, however, as the Central Health

Fund is required to hold €3 billion in reserve and had a deficit left over from 2009 of €2.5 billion, while the SFs must hold reserves of €4 billion. Different interests wanted to spend the remaining portion of the surplus in different ways, with physicians demanding fee increases, SF representatives wanting it to be kept in the system as a 'rainy day fund' and some politicians advocating reductions in contribution rates or refunds for sickness fund members. The federal minister of health, Daniel Bahr, has advocated using some of the money to abolish the €10 per quarter user-fee charged for physician visits (see Reforms-Cost below), while the federal Ministry of Finance has preferred to reduce the federal subsidies to the Central Fund coming out of general taxation, in order to return some of this money to the control of the ministry.³⁷

Cost-sharing

Sickness funds function as third-party payers, with patients obtaining benefits in-kind from providers, who are then paid by the insurer via one of the local associations of doctors (see below). However, SHI will not always cover all the costs associated with medical services. Often there is a small co-payment that patients must pay on top of their payroll contributions. Traditionally these co-payments only applied to a small number of services - mainly pharmaceuticals and dental care. However in 2004, as part of the on-going attempts to improve health care finances, additional co-payments were introduced for visits to a physician (under-18s exempt).³⁸ This led to an increase in out-of-pocket payments, which accounted for 13.2 per cent of total health expenditure in 2010, up from 10 per cent in 1992. However, measures were put in place to prevent any individual from getting into financial difficulty as a result of these co-payments. For example, recipients of unemployment allowances and those on low incomes are exempt, as are individuals injured at work and pregnant women.³⁹ Furthermore, cost-sharing is generally limited to 2 per cent of household income per annum or 1 per cent for the chronically ill, who are also exempt from making contributions towards the cost of prescription drugs.⁴⁰

Private Health Insurance

The Bismarckian system of social security was based on the principle that the state should provide only for those unable to provide for themselves; consequently there was a continuing role for private enterprise alongside the state scheme.

Private health insurance (PHI) plays both a substitutive and a supplementary role. The supplementary role means that PHI can be used to cover certain SHI co-payments, especially for dental care and add minor benefits to the SHI basket, such as access to single hospital rooms.⁴¹ The substitutive role means that all Germans not covered by SHI, including civil servants and high earners who choose to opt out of SHI, must access the entirety of their health care through private insurance plans.

Unlike SHI, PHI premiums are risk-related,⁴² assessed before enrolment. Those insured with a PHI company must also pay separate premiums for their dependents. However, there is still some central government regulation in order to prevent inequity and uphold universality. For example:

- All contracts are for life and insurers may not refuse applicants with pre-existing conditions.⁴³ As of 2009, private insurers offering substitutive cover will be required to take part in a risk adjustment scheme (separate from SHI) in order to be able to offer insurance for persons with ill-health at a reasonable price.⁴⁴

- Private health insurance companies must have a 'basic package,' which can be offered to those with chronic conditions, or those over 55 years old who are in financial distress. This basic package mimics the conditions offered by SHI.⁴⁵
- PHI companies may not increase premiums for any other reason than general expenditure increases caused by the entirety of their enrollees.⁴⁶

Health Care Provision

Most ambulatory general practice and specialist care is delivered by primary care physicians who work in solo practices. Hospitals play a limited role in this sector, providing few out-patient services. Treatment under GKV is provided by doctors or dentists recognised by the sickness funds—more than 90 per cent of established medical practitioners – and all physicians practising under GKV must join an Association, which controls the physician payment system and monitors physician performance.⁴⁷ Besides this limitation, patients are free to choose their physician or hospital and can refer themselves directly to a specialist. GPs have few formal gatekeeping responsibilities, but a gatekeeping system is increasingly encouraged in order to cut costs.

There are many specialist practices to be found in medium-sized towns and waiting lists are short.⁴⁸ There are only a few specialties (psychiatry for example) that are poorly represented in some regions. This equal coverage of specialisms has been achieved largely through the Health Care Reform Act of 1992, which allowed the Regional Physicians' Associations to geographically restrict the settlement of new doctors according to their speciality.⁴⁹ In order to restrict physician migration into the private sector, any doctor wishing to practice in the private sector must do at least six years of hospital-based service prior to setting up practice on their own.⁵⁰

Sickness funds do not pay providers directly. Instead, since 2003 they have negotiated capita grants based on the population of insured in that region and paid these directly to Regional Physician Associations. The Associations in turn distribute these funds amongst the providers in their area on a fee-for-service basis regulated by the Uniform Value Scale.⁵¹

Private physicians are either paid directly by the patient, or their private insurance company. Services provided for either in the public or private sector are subject to predetermined government price schedules, although the private provision fee scale allows physicians to earn up to twice as much for services paid for privately, compared to services paid for through GKV.⁵²

Whether public or private, a majority of medical facilities are still not-for-profit and staffed by salaried doctors, although senior doctors may also treat privately insured patients on a fee-for-service basis.⁵³ Non-profit or community hospitals are usually run by religious orders affiliated with the Catholic or Protestant churches and are partially funded by the German church tax, though some are run by other organisations, such as miner's associations. In 2010, there were 2,064 acute care hospitals in Germany.⁵⁴ Hospitals in Germany are classified by the Statistical Offices of the Länder by three types of ownership: publicly owned, non-profit private and for-profit private.⁵⁵ In 2010, 30.5 per cent of hospitals were publically owned, 36.6 per cent were non-profit and 32.9 per cent were for-profit private. This balance represents a shift towards privatisation, as in 1992 the public sector had owned 45 per cent of hospitals and the private sector only 15 per cent. This trend has been attributed to fiscal difficulties in the municipalities, leading to privatisations and a slowdown in public construction. However, the share represented by the non-profit sector remained stable, so while the hospital sector is majority

private and has a significantly greater for-profit element than it once did, it can overall still be characterised as majority (67.1 per cent) non-profit. Moreover, it is important to take into account hospital size and bed numbers, as 223,385 beds (48.3 per cent) are found in public hospitals, compared to 164,337 in non-profits (35.6 per cent) and only 74,735 (16.1 per cent) in for-profit facilities.⁵⁶

There is contentious debate as to which of the three types perform best, with different studies producing varying results. Some data has suggested that public hospitals are the most cost-efficient and have more staff, in addition to containing far more beds. However, other evidence suggests private for-profit hospitals have lower waiting times, have better access to new equipment and may offer better patient experiences in terms of quality indicators that aren't typically taken into account in efficiency studies (e.g. the availability of single rooms).⁵⁷ Investment per patient is 64% higher in private for-profit hospitals than in their public counterparts and for-profit facilities tend to contract out maintenance and service functions. The availability of quality data online (mandated by the German government) and the premium German consumers seem to place on provider choice are thought to be powerful motivators for the for-profit sector, as to compete these hospitals must maintain strong reputations for quality. Studies evaluating cost-efficiency and quality in the non-profit hospitals, sometimes seen as a 'best of both worlds' source of provision free of both state standardisation and some of the negative factors associated with profit motive, have yielded mixed results.⁵⁸

Traditionally, payment to hospitals was based on per-diem rates that were independent of diagnosis, amount of care, or length of stay.⁵⁹ However, eventually it was agreed in 2000 to try the Australian AR-DRG system (Australian refined diagnosis related groups). This system was made obligatory in 2004 and is revised annually to account for new technology changes in treatment patterns and associated costs. This system, whereby hospitals are paid the same for the same 'type' of patient, puts pressure on inefficient hospitals to perform procedures quickly and at minimal cost, without compromising quality (quality assurance is discussed further below). In 2004, hospitals were also allowed to provide certain highly specialised procedures on an out-patient basis, although at least 50 per cent of specialists still work outside of hospitals.⁶⁰

Reforms

Competition

Since the 1990s German governments have been trying to increase competition between insurance and medical care providers. Although price and service competition between sickness funds is muted thanks to the legally defined basic package and uniform contribution rate, individuals can choose freely between the sickness funds and switch once a year if they desire.⁶¹ This has led to improved information on the internet and in journals about the services offered by each fund and how they might be compared. The result has been a large-scale shift away from the traditionally dominant funds and a significant reduction in the number of funds.⁶² Since 2007, sickness funds have also been given more freedom in negotiating the price and quality of services offered, for example through selective contracting. It is hoped that this will raise efficiency and improve quality of care across the board. It is also hoped that freedom in contracting will encourage sickness funds to offer health service packages that better suit the respective risk and income structure of their insured population.

Competition in the private health sector is much greater than for SHI and in 2007 it became more so when the variety of tariff options and insurance plans was widened. Insurance companies may now offer lower rates to those customers that choose, for example, an integrated care scheme, which may include a gatekeeping GP element, or a contract with a high deductible (minimum insurance excess).⁶³ The laws on ageing reserves have also been changed. Ageing reserves are the savings collected by insurance companies from insurance premiums paid whilst the insured individual is young and healthy. These are then set aside and used to minimise the increase in premiums as the insured get older and require greater levels of health care. Previously, these reserves remained with the insurer when an individual cancelled a policy, or changed to another insurer. Since January 2009 however, an individual's ageing reserves have been transferable, which means that customers will be much less reluctant to switch policy if they become unhappy with their current one.⁶⁴

Cost

Germany's high health care expenditure is often subject to criticism. This is exacerbated by the perceived threat of an ageing population, increased public demand for all the best the medical world has to offer, rising costs of advancing medical treatments and supply-side inefficiency.⁶⁵ A number of reforms were therefore implemented to try and curb costs such as increased co-payments (since January 2004 members of the statutory insurance plan have had to pay €10 per quarter to see a GP), charges for non-prescription drugs and an end to free services such as health farm visits and taxi rides to hospital. Budget caps were also used for a number of years, which were effective but crude and over the years have generally been phased out. For example, after 2009 ambulatory care budget caps were replaced with more flexible guidelines that took population morbidity into account. Meanwhile, hospitals have moved away from fixed budgets towards a DRG based system and in the pharmaceutical sector, negotiated rebates between SFs and pharmaceutical manufacturers, along with incentives to lower prices below the reference prices, are now the major instruments of cost restraint.

The 2000 Reform Act of Statutory Health Insurance strengthened the family doctor system by allowing sickness funds to offer financial bonuses to those who use GPs as gatekeepers to specialist services. Since then a number of other elective insurance schemes have been introduced to allow sickness funds some parameters for competition and to encourage cost-consciousness amongst enrolees. Elective insurance schemes include, for example, Disease Management Plans (see below), the aforementioned family physician model, sick-pay for the self-employed or optional deductibles.

Quality

Quality of care and procedure has been improved in a number of ways. In 2004 the Institute for Quality and Efficiency in Health Care (IQWiG) was created, which provides health technology assessment for drugs and procedures: all diagnostic and therapeutic procedures applied in ambulatory care must be positively evaluated in terms of benefits and efficiency before they can be reimbursed by sickness funds. There is also a mandatory quality reporting system for all acute care hospitals. Hospitals receive individual feedback based on quality indicators and since 2007 all hospitals have been required to publish results on 27 selected indicators of the Federal Office for Quality Assurance, thus allowing for targeted comparisons between hospitals.

Integrated care

In 2000 integrated care contracts were introduced to improve cooperation between ambulatory physicians and hospitals on the basis of contracts between sickness funds and individual providers or groups of providers belonging to different sectors. Because of legal and financial barriers only a few initiatives were established, but since 2004 integrated care has been strengthened and rules of accountability have been clarified.

Improved integrated care was heralded under the 2007 Statutory Health Insurance Competition Strengthening Act, which extended the availability of start-up financing for population-oriented, integrated care contracts. The Act also allowed for the possibility of including both long-term care and non-medical healthcare professions in the same contract.

The Act to Reform the Risk Structure Compensation Scheme (2003) introduced Disease Management Programmes (DMPs) as a new form of SHI-organized, managed care instrument designed to improve coordination of care for chronically ill patients. As well as providing better quality of service for patients, it was hoped that DMPs would also reduce risk selection among funds because patients enrolled in a DMP are treated as a separate category in the risk structure compensation scheme. Both GPs and sickness funds also receive financial compensation for each patient enrolled in a DMP. Sickness funds are free to offer incentives to enrol in a DMP (which are voluntary), such as exemption from co-payments on pharmaceuticals. DMPs currently exist for diabetes types 1 and 2, breast cancer, asthma and a few others and as of 2007, there were 3.8 million patients enrolled in a DMP.

Electronic Records

Since 2006 there have been plans to replace the old system of electronic *Chip-karten* health cards introduced in 1995 with a newer set of cards (*Elektronische Gesundheitskarte, eGK*), perhaps comparable to those already in widespread use in the similarly social insurance-based French health system (see the 'Healthcare Systems: France' briefing)⁶⁶. In October 2011, the new eGK cards were introduced for public usage, with about 7 million cards issued in the first two months of the roll-out alone. Initially the cards will carry the same basic data as the old ones (name, date of birth, address, insurance status, sex and additional benefits details), but in future the data range will be expanded to contain detailed patient histories (hospital records, information on allergies and chronic diseases, test results and past correspondence). To protect their privacy, cardholders will be able to choose which information they make available and a new microprocessor chip is intended to keep the information secure and accessible only to them via a special PIN code. Unlike the old cards, the new ones feature a personal photograph to prevent fraud and also have each German's European Health Insurance Card (EHIC) on the back, allowing them to use the same card to obtain care when travelling in the European Economic Area. Hospitals are gradually being equipped with new card-reading machines as part of the scheme.⁶⁷

However, the scheme will cost the government and insurance companies the equivalent of £1.5bn and has faced years of delays and objections. These problems have included concerns about safety, security and personal privacy due to the sensitive nature of some of the data potentially stored, despite the promised safeguards. The initial limitation only to the previous basic data and patient choice over what data can be accessed were further necessary concessions. Hospitals have been frustrated with the cost of having to equip themselves with the new reading machines.⁶⁸ Further, more than a year into the roll-out concerns are still being

expressed about how successful it has been, in terms of costs, implementation and whether it will in fact have any visible impact on patient outcomes.⁶⁹ The idea of a similar smart card containing personal health records has sometimes been suggested by advocates of a social insurance model of healthcare in the UK, such as David Laws⁷⁰, and so while France certainly shows the potential of these schemes, Germany may offer some lessons as to what difficulties would need to be overcome in order for them to be successfully implemented in the UK.

Conclusions

The German health care system is recognised worldwide as providing good quality care, short waiting lists and attentive service. Much of this is based on the significant amount of money spent on health care in Germany: over 11 per cent of their GDP, with out-of-pocket payments making up over 13 per cent of total health care expenditure. This shows that Germany's health care system is not cheap and is undeniably putting financial strain on the government. It has also had to undergo a reasonably significant amount of change in the past 20 years, occasionally removing policies that had been implemented just a few years before, which is a waste of time, energy and money. However, despite these problems, it is undeniable that the Germans do at least get value for money and if the recent changes to contribution rates and cost restraints work, then the world will find little fault with Germany's system.

Coverage of dependents and mandatory long-term care insurance are based on excellent principles and, when combined with ageing reserves, show suitable concern and preparation for the problems of an ageing population. Although there may be limitations in care for those on Sozialamt,⁷¹ it would appear for the main-part, therefore, that Germany does well in protecting the most vulnerable in society, evidenced further by DMPs. Contributing exactly in proportion to one's means through payroll contributions is a system that further adds to the image of a health care system that is fair and logical. Arguably, the payroll contribution system is fairer even than national insurance contributions, which are flawed because contribution levels fluctuate and individuals cannot see exactly how much of their income is going into the NHS.

Some may suggest that a two-tier system of private and public health insurance can be divisive and lead to a much higher quality of care for the wealthy. However, the fact that so many citizens earning above the SHI threshold decide to stay with SHI suggests that this is predominantly not the case. After all, the SHI benefit package must provide more than adequate quality of care and waiting times for those wealthy enough to afford PHI to decide to remain with the statutory system. Indeed, it might be in the German government's interests to alter the fee schedules for health care provision in order to prevent doctors from charging so much more for privately provided treatment. This might persuade more people to take up private health insurance and therefore take the burden off the governmental scheme. This would improve the balance between public and private and would do little to damage the high quality of care that seems to characterise both sectors. Meanwhile, within the SHI system the risk-equalisation basis of the new Central Health Fund has also been noted to prevent the sort of unequal 'postcode lotteries' that are at times a problem in the NHS, as Sickness Funds representing regions (or sections of society) that are wealthier are unable to hoard funds.⁷²

The even spread of specialisms across the country is an impressive achievement and a characteristic that marks Germany apart from France, although this has come at the cost of restricting freedom of settlement. The disparity that Germany still needs to work on, however, is one that the NHS also suffers from: ease of access to pharmaceuticals. One study indicated

that only 12 per cent of patients in the GKV system receive the newest innovative drugs, whilst 48 per cent of private patients receive them.⁷³ Although this is a difficult problem to solve, it might be an area where future reforms would benefit the population.

Competition in various sectors of health care is something that Germany values. For this reason, it is possible that greater autonomy could and will in the future be given back to sickness funds in terms of setting payroll contribution rates, but this would have to be carefully monitored in order to avoid undue pressure on employers. However, even if competition in this area remains muted, there are other ways in which efficiency has been encouraged and the benefits of competition harnessed. Finally, we must remember that for a country to make their statutory public health care system as attractive, if not more so, than the private insurance sector for those that can afford the latter, is a significant achievement.

There is growing political interest in Britain in the social market economic consensus found in Germany. Notably, specific critiques have been made of the extent to which communities and civil society were left out and disempowered when social security mechanisms in the UK underwent wholesale nationalisation in 1948⁷⁴. In this sense, the German example is also relevant to healthcare and how we can potentially reform the NHS. The German system shows how corporatist and mutualist principles can lead to healthcare institutions being run in a manner that creates a concept of membership and stakeholder representation, while the acceptance of a contributory model means that both German citizens and their employers take some responsibility for their healthcare, rather than leaving power almost exclusively in the hands of the state. Further, the German model demonstrates that under the right conditions a degree of diversity in both health financing (diverse statutory insurance funds, operating alongside a smaller private sector) and provision (67% of hospitals are non-profit, but only 30% are state-run) is compatible with social solidarity and universal access to high-quality healthcare.

Statfile (most recent figures from the OECD unless otherwise stated, most recent UK figure and OECD average given for comparison)⁷⁵

Funding

Total Health expenditure: 11.6 % of GDP

\$4338.4 per person (US \$, adjusted for PPP) (UK: \$3433.2, OECD Average: \$3265)

Public expenditure: 76.8% of total health expenditure (UK: 83.2%, OECD Average: 72.7%)

Out of pocket expenditure: 13.2 % of total health expenditure (UK: 8.9%, OECD Average: 19.5%)

Resources

Practising physicians (per 1000 population): 3.7 (UK: 2.8, OECD Average: 3.1)

Practising nurses (per 1000 population): 11.3 (UK: 9.1, OECD Average: 8.6)

MRI scanners (per million population): 10.3* (UK: 5.9, OECD Average: 12.5)

CT scanners (per million population): 17.7 (UK: 8.9, OECD Average: 22.6)

Waiting Times⁷⁶

Percentage waiting four weeks or more for a specialist appointment (study of 11 OECD nations): 17%, lowest out of 11 (UK: 28%, Average: 37%)

Percentage waiting four months or more for elective surgery (study of 11 OECD nations): 0%, lowest out of 11 (UK: 21%, Average: 13.3%)

Outcomes

Average life expectancy (at birth): 80.5 (UK: 80.6, OECD Average: 79.8)

- Men: 78.0 (UK: 78.6, OECD Average: 77.0)
- Women: 83.0 (UK: 82.6, OECD Average: 82.5)

Infant mortality (per 1000 live births): 3.4 (UK: 4.2, OECD Average: 4.3)

Maternal mortality ratio: 8 (2005-2009) UNICEF

Mortality Amenable to Healthcare (OECD, Nolte & McKee Method^{77}):** 81 per 100,000 deaths (UK: 86, OECD Average: 95)

Mortality Amenable to Healthcare (OECD, Tobias & Yeh Method^{*}):** 88 per 100,000 deaths (UK: 102, OECD Average: 104)

Mortality Amenable to Healthcare (Commonwealth Fund⁷⁸): 74 per 100,000 deaths & 10th out of 16 countries (UK: 83 per 100,000 and 15th out of 16 countries)

* This only includes MRI scanners found in hospitals and therefore doesn't take into account MRIs that might be found in external specialist clinics

** Nolte & McKee method: mortality amenable to healthcare defined as “premature deaths that should not occur in the presence of timely and effective health care”

*** Tobias & Yeh method: mortality amenable to healthcare defined as “conditions for which effective clinical interventions exist [that should prevent premature deaths]”

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