

Germany: Health Care System Overview and SWOT Analysis

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Abstract

This is the second article of the International Health Care Systems series. The first part of the article provides an overview of the German health care system, including its historical evolution, insurance coverage, service delivery, and aspects like equity, cost-control, and health technology. The second part analyses the strengths, weaknesses, opportunities, and threats for the German health care system.

Keywords: German health care system, statutory health insurance, sickness fund, universal health coverage

An Overview of the German Health Care System

The German health care system is an extension of its principle of social solidarity and welfare, embodied in its constitution viz. The 'Basic Law'. It has a social insurance system based on individual contributions, and its primordial features can be traced back to the middle ages.^[1] Mutual aid societies arose in the 19th century, and a national level legislation, the Sickness Insurance Act, was passed in 1883 under Otto Von Bismarck's reign to cover employees earning less than \$500 per annum.^[2,3] Voluntary sickness funds existed before Bismarck, and the move came in an attempt to consolidate power and working class support.^[2] Coverage was extended in later years. Post reunification of East- and West Germany, the dominant Western system of social insurance prevailed.^[2]

The Social Code Book V details minimum health-care provisions.^[1] The system is highly decentralized. The Federal government decides on legislation and policy; states are entrusted with hospital planning, public health, and supervision of physician and health

insurers associations; and local governments focus on disease prevention and public health programs.^[2] About 11.7% of GDP is spent on health. In 2012, public and private funding constituted 72.9% and 27.1% of total expenditure.^[4]

Health insurance is mandatory by law since 2009.^[4] Those earning below 4050 Euros a month are obligated to join the German Statutory Health Insurance (SHI). Employees above the income threshold for 3 consecutive calendar years have an option for private health insurance (PHI). PHI is also available for certain other categories (e.g. private school teachers, self-employed, clergy etc.), and is compulsory for certain groups like civil servants.^[1,4] As of 2012, about 85% population was covered under SHI on either compulsory or voluntary basis; PHI's share was around 11%, and remaining 4% was comprised of government schemes for certain groups (armed forces, military etc.).^[4] A long-term care insurance was introduced in 1995.

Sickness funds/Statutory health insurers, their associations, and SHI physician associations are statutory bodies having considerable autonomy and power of self-regulation, under the aegis of the Federal Joint Committee (G-BA).^[1,4] SHI insurers are under obligation to cover any and all applicants and offer uni-

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form provisions irrespective of their health risks, and are non-profit. People have choice of insurers. About 15.5% of wages is incurred as premium contributions with matched employee-employer share, and insurers facing a shortfall charge a supplementary premium.^[1,4] Sickness funds could be organized based on geography, occupation, or industry,^[3] and cover a wide range of preventive, promotive, and curative services, including dental care. Prescription drugs attract co-payments of 5-10 Euros for ambulatory care.^[4] SHI pays the association of SHI physicians a global sum adjusted for risk, which then pays individual physicians on a fee for service basis, whose rates are negotiated between physician and SHI insurers associations.^[2,3,4] Fees are sensitive to volume of services provided, and excess service provision attracts fee reductions in subsequent quarters.^[2,3] Patients have choice of physician. Hospitals are paid on a Diagnosis-related groups (DRG) basis, whose rates are negotiated between insurers associations and hospitals.^[2,3,4]

PHI includes supplementary insurance, which only covers services not available under SHI.^[1] PHI can charge premiums based on individual risk profile, has little compulsions in terms of enrolling applicants and benefit packages, and often pays substantially higher rates for physician/hospital services, although they are required to offer certain minimum services at not more than maximum SHI rates.^[1]

The healthcare providers landscape is a dispersed one,^[3] lacking a gatekeeper and strong coordination of care. Ambulatory physicians are largely for-profit. The share of hospital beds in public, non-profit, and for-profit sectors were 48%, 34%, and 18% respectively in 2012. Operating expenses of hospitals are met largely through insurance payments, and capital investments are through the state.^[4] While there has been a traditional dichotomy between ambulatory and hospital physicians, with ambulatory physicians being barred from treating patients in hospitals, more integrated models have arisen lately.^[3,4] As regards pharmaceuticals, while drug prices and profits are not directly regulated, reference prices for pharmaceutical reimbursement under SHI are decided nationally.^[4]

To avoid inequities, SHI contributions flow to a central reallocation pool managed by the Federal Social Insurance Office, which reallocates funds to SHI insurers based on a morbidity-based risk adjustment scheme (Morbi-RSA).^[1,4] The association of SHI physicians regulates the number of physician practices within a planning district. When their number exceeds a certain

threshold, approvals are denied for new practices; in case of shortage of practices, incentives are provided for setting up new ones.^[1] Further, although insurance is based largely on employment, the unemployed and disabled continue to remain under SHI, with their contributions subsidized by the government.^[3] Certain groups including students and apprentices receive premium subsidies.^[1]

The German cost containment act, 1977, was a response to rapid rise of sickness fund expenditures in the 1960s and 1970s. It sought to limit budgets of physician associations paid by sickness funds. The German re-unification presented formidable challenges at cost control, leading to the Health Care Reform Act, 1993, which introduced competition among sickness funds and DRG payments for hospitals.^[2] Another 2004 reform stopped over-the-counter drug coverage and increased co-payments.^[3] Some other recent reform proposals included individual insurance with wage subsidy, basing contributions on non-wage earnings/assets etc.^[2]

Health Technology Assessment (HTA) arose after the 90s with quality and efficiency in sight. In 1997, the German Scientific Working Group Technology Assessment for Health Care was founded to develop an HTA database and improve HTA methodology. A 2010 reform formalized HTA, leading to the establishment of the German Agency on HTA under the German Institute for Medical Documentation and Information (DIMDI). The G-BA, DIMDI, and the Institute for Quality and Efficiency in Health Care are the main bodies involved in HTA.^[5]

Digital patient health records are provided by different companies, and patients have full control over information sharing. However, to facilitate data integration, interoperability, safety, and also to improve care quality, the Appointment Service and Supply Act was passed in March 2019 - which requires SHI insurers to provide Electronic Health Records (EHR) to insureds from 1st January 2021.^[6]

SWOT Analysis

Strengths

Germany has universal coverage without significant access problems, and the SHI benefit package is also comprehensive, including such services as dental and prescription drug coverage which are excluded in many countries. There are no deductibles before insurance coverage sets in, and patient cost-sharing is minimal. This is while it has been able to avoid excessive

waiting lines and rationing of needed care, unlike the UK and Canada. Germans have shorter waiting times for surgery than Americans,^[7] while avoiding the numerous drawbacks of the US health system. Patients, providers, and insurers have considerable autonomy despite effective government oversight.

It also fares well in terms of infant mortality and life expectancy at birth among OECD nations, both of which stood at the European Union (EU) average in 2018, as per World Bank data. As of 2017, Germany had the highest number of hospital beds per capita among European member states.^[8] The number of physicians per capita is also greater than the EU average, and among the highest among OECD nations.^[4,9] It also has one of the highest doctor consultations per capita among OECD nations.^[10] The average length of hospital stay came down from 12.8 to 7.7 days between 1991 and 2012,^[4] falling further to 7.5 days in 2017. Use of expensive technology, though on the higher side, is lesser than the US.^[2] Germany is one of the largest pharmaceutical producers in the world,^[4] despite having a modest spending on pharmaceuticals itself (14.2% of health spending in 2018).

Cost control measures after the 2000s have been reasonably successful, and despite covering an increasing number of services, growth of health spending has been relatively modest. This has been held to be indicative of good technical efficiency.^[4]

Weaknesses

A dispersed healthcare organization and fewer avenues for cost control can be held as the major disadvantages. Negotiations between sickness funds and healthcare providers are the prime instrument of cost control.^[2] Germany lacks a gatekeeper system, thereby providing fewer incentives for using primary care services and continuity/coordination of care. Fewer incentives for patients to limit service use, and for providers to limit service supply, predisposes to moral hazard and inefficient service use. Public health and mental health services have been considered a weak link.^[2]

Child vaccination and influenza vaccination rates are modest, and below many OECD nations.^[11,12] Germany in 2017 had the highest number of MRI examinations per 1000 persons in the OECD.^[13] Overall, Germany is one of the highest overall and per capita spenders on health. Despite a number of recent reforms, quality of care remains below that of top OECD nations.^[4]

There are also East-West disparities. Rates of hospi-

tal admission and hospital deaths due to heart failure are higher in East Germany, which has been attributed to greater prevalence of hypertension, obesity, and diabetes in East-Germany.^[14] Also, there are disparities in public hospital investment, 83% of which went to West Germany hospitals in 2012.^[4]

Opportunities

The German health system exhibits remarkable institutional stability and hasn't tottered from its basic principles since at least over thirteen decades, which is an essential prerequisite for sustaining universal coverage in the future. Proposals to revoke and replace social health insurance with individual compulsory insurance have failed to garner support, and amendments in the decentralized structure permitting greater federal control in public health have also been foiled.^[2,4]

There has been renewed emphasis on improving quality of care. One such measure has been to adopt legislation on EHRs in the form of the Appointment Service and Supply Act. Through integration, interoperability, and better management of patient information, this can provide an impetus to quality improvement.

The proportion of health spending financed through taxes has also declined in the last few decades,^[4] with an increasing share coming from contributions - without significant hardships for the population. This could signify some reserve capacity to spend on health in case of soaring future health demands and stagnant wages. Further, favorable track-record in terms of balancing cost-control vs. equity and access, and continued increases in health spending despite the 2009 economic slowdown,^[4] offer promise as regards dealing with potential challenges like stagnant economic growth and aging.

Threats

Rapid aging presents the foremost threat. Germany had 21.5% of its population above the age of 65 years in 2019, and is already among the countries with the highest elderly population in Europe.^[15] This projects significant future challenges in the form increasing burdens and demands due to chronic ailments, and also due to diminishing working age population. In the face of stagnant economic growth and wage increases (thus reduced contributing ability), this could seriously threaten sustainability of universal, affordable health care.^[2]

Out-migration of physicians from the country and

resulting shortage has also been identified as a threat. In a cross-sectional study in 2018, about 30% of physician participants wished to emigrate. High workload and low job satisfaction are held as important causes for the desire to emigrate to Switzerland and Scandinavian countries.^[16]

While the German health system exhibits remarkable institutional stability, the same could pose a threat due to a lack of enough flexibility to adjust with changing demands. Generating widespread consensus among various quarters will be essential to push major changes in the system architecture when required.

Finally, the SHI-PHI dichotomy has been identified as a challenge due to differential access, financing, and provisioning.^[4] In the face of challenges like population aging and slow economic growth, it could lead to amplification of inequities between the groups.

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