Obermann, Müller, Zilch, Winter, Glazinski (Eds.)

The German Health Care System

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Understanding and Accessing Health Care in Germany

Including: **Responding to an new infectious disease: The case of the COVID-19 epidemic**

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Preface

The German Health Care System, established in the late 19th century, is historically the first universal health care system. After World War II, in line with the "Universal Declaration of Human Rights" of 1948, other universal health care systems emerged all over Europe, some following the German example, some coming up with new ways to administer and finance health care for their people.

The development of individual health care systems in Europe created a wide variety of variations, e.g. concerning the way systems are financed, the organization of the public health care system, the extent to which different stakeholders are involved (e.g. the state, insurance providers, professionals etc.), the main contributors and other interesting distinctions. In trying to understand the complex health care systems that have evolved, a large number of aspects need to be taken into account. On a governmental level, one of the most important aspects is cost-effectiveness. Although the German health care system is among the systems providing a very high quality of health care, it is also one of the most expensive and keeps undergoing reforms to reduce costs and maintain or improve quality.

This book aims to provide an interested international audience with insight into the "German way" of providing universal health care with all its advantages and disadvantages. We hope it will contribute to facilitating a better understanding of the German health care system by providing information on a multitude of aspects for scientific and practical discussions and exchange.

Professor Joachim Fischer M. D.
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Foreword to the Third Edition

We are very pleased to announce the third edition of our book on the German Health Care system. Over the years we have found that a wide range of people from abroad but also from Germany not working in the health sector have found this short but comprehensive introduction useful to gain an understanding about key principles and structure before venturing into more detailed accounts.

The volume of services has steadily grown in the last years with current (2019) spending standing at around 410 billion €, which translates into more than 1.1 billion € per day. This economic aspects is balanced by a strong historical tradition which aims an equitable provision of services and a balanced contribution to financing. Local structures and agreements and consensus-seeking are defining characteristics of the system.

The German Health Care System manages multiple care processes aiming at the best health provision for every patient. This leads to huge amounts of data and at this point a healthcare system depends on digital support. Digital tools may help in multiple ways, e. g. enabling health care professionals to comply with evermore complex regulation ranging from documentation to adherence to medical guidelines.

Despite digital tools being everywhere in a modern life, they are scarcely available for patients who need to navigate the system or follow-up with their care provider. Only recently digital momentum has been developed in the German health care system. Extensive legislative reform aims to increase the quality as well as the convenience of care by digital means. This includes structural changes to the governance structure of the system by merging institutions or making the ministry the decision-maker instead of the self-administration bodies.

Furthermore, strong financial incentives have been created to integrate personal electronic health records and electronic prescriptions in the system and setting up a digital health infrastructure. In addition to this, Germany is the first country in the world where approved health apps can be prescribed and will then be reimbursed by social health insurance.

Several studies have ranked Germany at the lower end of digital competence and progress in terms of health care. Re-

cent reforms aim at changing this dramatically. Already, digital tools are essential for providing health care. The future of health care provision will be shaped by digital tools and the prudent use of big data. After years of political procrastination, Europe's largest single health care market is receiving an update towards a data driven health care system. We have completely revised chapter 3.2 to reflect these fundamental changes.

The Corona crisis has revealed the strengths and weaknesses of a local and yet encompassing system. As described in chapter 2.4 the German system could cope rather well due to its local, flexible structure, the high care capacities, and the willingness of the self-administration partners to react quickly in financing specific services.

In the last 4 years, a number of changes have taken place, the most important ones are described in this book. We hope to have again been able to come up with a balanced introduction to a complex health care system, which has shown its capabilities and resilience during a serious crisis. We invite reader to comment, criticise, and suggest changes.

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1

How the System Evolved: History, Principles and Reforms

1.1 History

1.2 Principles and Corporatism

1.3 Recent Reforms

1.1 History

The Need to Provide Social Security

The earliest forms of (health) insurance developed during medieval times in the form of guilds and miners' associations. This was due to a combination of facing substantial risks, being relatively well off, and for trying to instill some form of solidarity.

Major reforms were undertaken in the 1880s amidst a turbulent industrial development.

Industrialization had led to a massive labor migration from the countryside to the cities. Large parts of the population suffered from insufficient health care, which led to pauperisation due to the inability to work.

The traditional systems of social support, e. g. family, village communities or feudal systems, could not handle the "industrialized population", and improved health care became a focus of the labor movement.

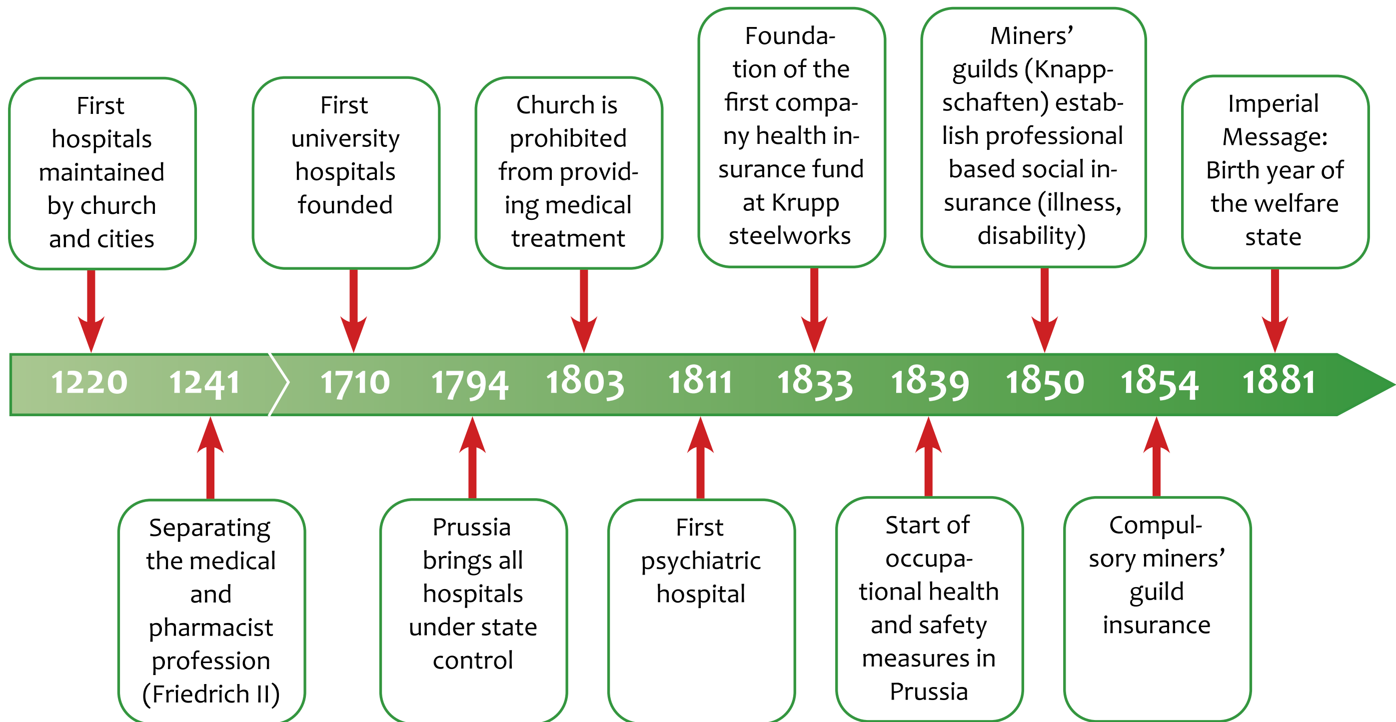
The "social question" also was raised by an encyclical of Pope Leo XIII in 1891. In addition there was a strong movement from academics, mostly economists, ("Kathedersozialisten" e. g. Gustav von Schmoller, Werner Sombart) to develop a coherent social policy in order to curtail the influence of revolutionary social democrats.

Chancellor Bismarck, under political pressure from workers' associations, initiated legislation for social security systems. A tax-financed system was not viewed favorably by the influencial East-Elbian nobility as they feared increased responsibility and correspondingly, higher taxes.

Bismarck himself, although deeply rooted in Christian tradition, looked at social policy primarily from a state perspective: "What is favorable for the Prussian State and the German Empire?" was his guiding principle and overarching goal.

Also, he felt that it would be prudent to allow for participation and self-administration in order to reconcile workers to the established political and economic order.

Health Care Before Bismarck



The 1881 Imperial Message (“Kaiserliche Botschaft”)

“Already in February of this year We voiced our conviction that the healing of the social damage cannot only be sought through the repression of social riots, but equally on the positive promotion of the welfare of the workers. We consider it our Imperial obligation to again recommend warmly this task to the Reichstag, and We would look back with much greater satisfaction to all the success with which God has obviously blessed Our government, if We were to raise awareness on this issue and bring the fatherland new and permanent guarantees of its internal peace and to help those in need with greater security and efficiency of the assistance to which they are entitled.

[...]

For such assistance it is a difficult task to find the right ways and means, but also one of the highest responsibilities of any community, based on the moral foundations of Christianity. The close connection to real life forces of this nation and the merging of the latter in the form of corporate co-operatives under state protection and state support will, as We hope, make the solution of tasks possible that the state alone to the same extent could not provide.”

[...]

A Clear-Cut Conceptional and Ethical Basis to Establish Social Protection

Wilhelm I, German Emperor

Wir Wilhelm,
von Gottes Gnaden
Deutscher Kaiser, König von Preußen,
etc. etc. etc.

Imperial Message ("Kaiserliche Botschaft"), 1881

Otto von Bismarck, Chancellor

Social Security Develops

- 1881: "Imperial Message" as foundation of social security system
- 1883: Establishment of statutory health funds by Bismarck.
- Establishment of the "Accident Fund" in 1885 and the "Pension Fund" in 1891.
- In 1885, about 11% of the total population is covered by more than 18 000 sickness funds – the average number of contributing members per fund was below 300.
- At the beginning, payments primarily covered loss of income during sickness – the ratio between monetary payments and medical service costs was 1.7 to 1.
- In 1892, first comprehensive regulations between health funds and health care providers were established. Health funds could decide whom to contract as a statutory health insurance physician (SHI-physician).
- 1896: The Prussian medical fee schedule came into effect.
- From then on, coverage was continuously expanded with major parts of the population, e.g. students and farmers, included up until the 1960s and 1970s.

Health, pension and accident insurance became integrated into the "Imperial Insurance Code" ("Reichsversicherungsordnung", RVO) of 1914. As of 1989, the RVO was transformed into the Code of Social Law ("Sozialgesetzbuch", SGB), divided into 12 sections. The fifth section (SGB V) covers social health insurance.

German Social Security Viewed as Strong and Encompassing

Die deutsche Sozialversicherung
steht in der ganzen Welt vorbildlich und unerreicht da.

Die Krankenversicherung

1885 1900 1913

Altersversicherung

Jnvaliden-Fürsorge

Hinterbliebenen-Fürsorge

von 1885 bis 1913

Tägliche Leistung 1913
mehr als
2¼ Millionen M.

11 Milliarden Mark
wurden in der deutschen Arbeiterversicherung-Sozialfürsorge- in der Zeit von 1885 bis 1913 aufgewendet.

Krankenversicherung 1912 in	Deutschland	England	Frankreich
Beiträge in Millionen Mark	464	besitzt ähnliche	41
Leistungen " " "	426	Einrichtungen	24
Verhältnis von Leistung zu Beitrag	92%	erst seit Mitte	59%
Leistung pro Fall in Mark	65	1912	40

Strengthening Physicians (1900–1930)

Hermann Hartmann founded the “Hartmannbund” in 1900 as a medical self-help organization. In 2020, its membership stood at over 70 000.

The “Berlin Treaty” of 1913 regulated for the first time the number of insured per statutory health insurance (hereafter also “SHI physician”) with one doctor per 1 350 insured persons and thus limited the influence of the funds.

Creed: “The patient is the one to choose the doctor, not the insurance company.”

In 1932, the “Berlin Treaty” expired, and doctors were asked to provide the most economic medical care. A major “strike” broke out – doctors asked patients to pay directly for services received. The health plans set up their own medical practices.

In 1932, the first collective treaties shifted the monopoly for ambulant outpatient care to the physicians. In 1933, the National Socialists established a unified association of SHI physicians.

To the present day, the Association of SHI Physicians (“Kassenärztliche Vereinigungen”, KVs) is exclusively charged with the delivery of outpatient care, but this is slowly changing.

In Germany, physicians in hospitals are not allowed to provide outpatient care unless they have special clearance and are contracted by an SHI fund.

Huge successes of scientific medicine:

1882 Robert Koch identifies the cause of tubercolosis

1893 Emil von Behring develops a serum against diphteria

1895 Wilhelm Conrad Röntgen discovers X-rays

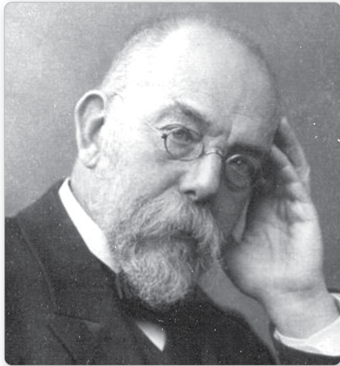
1899 “Aspirin” put on the market

1909 Paul Ehrlich develops “Salvarsan” against Syphilis

1923 Comprehensive regulation on the relationship between SHI and providers; An “Imperial Committee for Doctors and Health Funds” was founded

1935 Discovery of sulfonamides by Gerhard Domagk

Famous German Physicians



Robert Koch

Ferdinand Sauerbruch

Gottfried Benn

August Bier

Ludolf von Krehl

Rudolf Virchow

Social Engineering (1950–1970)

An underlying assumption of this era was that an idealistic society could be designed by technocratic means (e.g. behaviorism in psychology found human behavior to be shapeable).

The main idea was to create institutions that specialize in solving specific problems in certain areas.

For the health care system, this meant the re-establishment of self-administration (1951 Law on Self-administration and 1955 Law on Association of SHI Physicians) as well as a stabilization of the welfare state (e.g. preventing old-age poverty).

1956: The Laws on Statutory Health Insurance for Pensioners came into effect.

New laws also modernized the financing and management of hospitals (1972 Hospital Financing Law KHG).

1974: Self-employed farmers, artists, students and disabled living in sheltered facilities received coverage from SHI.

The development of the welfare state was based on the optimistic assumption of continuous economic growth as well as the extensive ability to control the system and its participants.

The 1973 Oil Crisis and subsequent economic stagnation led to changes: in 1977, the first of many cost containment / cost dampening laws came into effect.

Massive State Investments into Medical Care and Effects of the Oil Crisis

Expansion of services

Technology-driven health care – the new Göttingen University Hospital

Göttingen University Hospital

Oil crisis in Germany: empty motorway

Dealing with Limits (1970–1990)

Rising health care costs led to on-going discussions and reforms with the goal of cost containment including

- Income-oriented expenditure policy
- Reference price for pharmaceuticals
- Restrictions on high-cost equipment and treatments
- Limits on the total number of physicians
- Co-payments

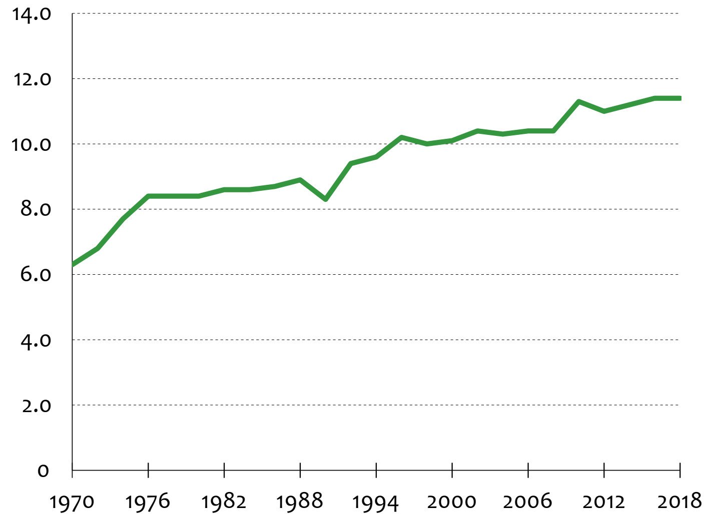
Between 1977 and 1983 several cost control laws were enacted.

The goal was to conserve the basic structure of the health care system while stabilizing non-wage labor costs.

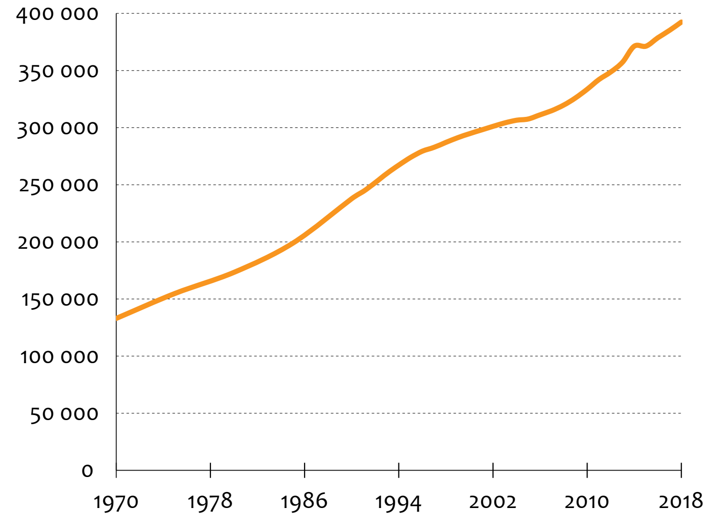
The Healthcare Reform Act (GRG) of 1989 led to the SHI being the Fifth of the 12 Books in the Code of Social Law.

Steady Growth in Health Care Expenditures

Total Health Care Expenditure, in % of GDP, 1970–2018



Total Number of Working Physicians, 1970–2018



A Different Approach: Health Care in the German Democratic Republic (GDR)

Centralized planning meant that the provision of care was organized through the state via hospitals, polyclinics and medical practice, with only few private practice physicians.

The central union and the government financed the health care system through a unified social insurance scheme.

After reunification, almost all ideas from the GDR health care system (e.g. polyclinics, public health initiatives) fell out of favor, but nowadays they are again part of the debate on improving patient-centered care in Germany.

Already in April 1945, a central committee was established for administrating health care in the Soviet occupation zone.

Health and health care was looked at in an encompassing way, and there was a close link between doctors providing population-based care and at the same time supporting the socialist state.

Focus on Public Health and Hospital-Based Care

Health and Unified Germany

Health in Germany continues to improve. Between 1990 and 2004, life expectancy at birth increased in Germany for both males and females as well as in all age groups.

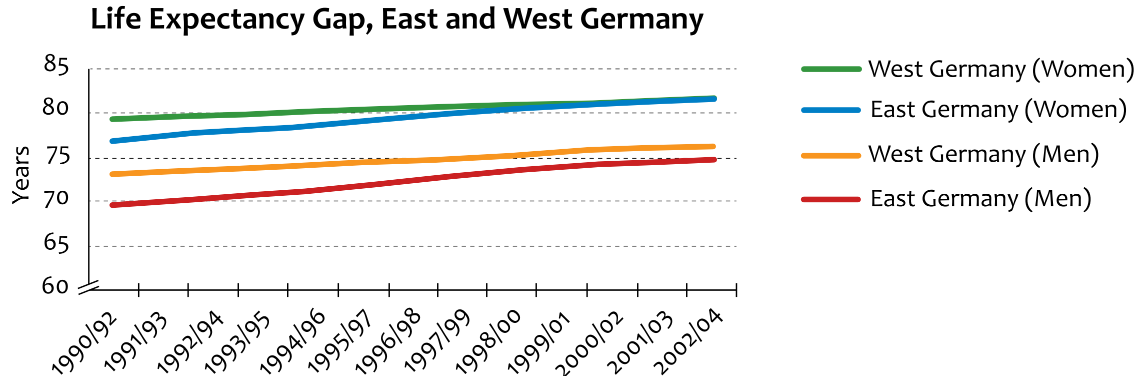
Since 1990, women's life expectancy has risen by 2.8 years to 81.6 years; men's life expectancy increased by 3.8 years reaching about 76 years. The difference between male and female life expectancy has decreased from 6.5 to 5.6 years.

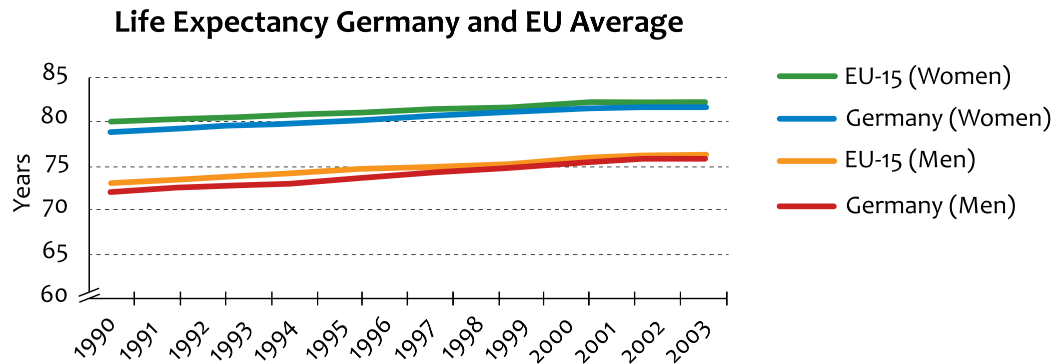
The gain in life expectancy was substantially higher in East Germany.

However, the difference between states with the highest and lowest life expectancy remains significant: 2.2 years for females and 3.6 years for males.

Life expectancy in Germany is slightly lower than the European (EU-15) average, but is converging towards it.

Life Expectancy: Closing the Gap





Source: Katharina Diehl

A Key Challenge: Demography

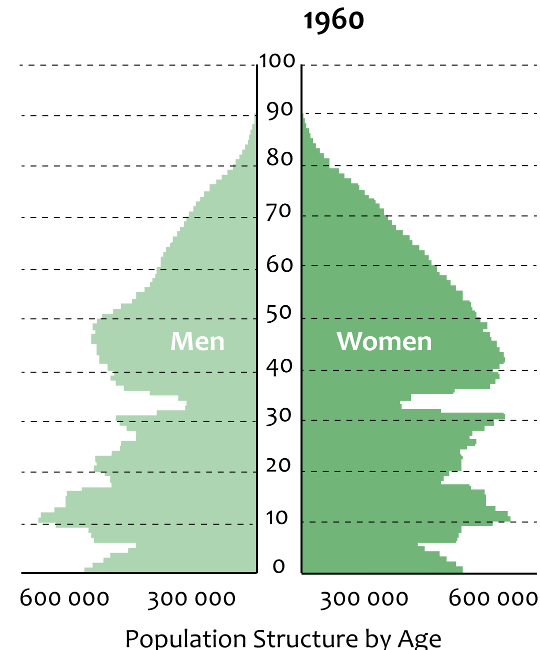
The demographic composition of the German population has changed markedly since the middle of the 20th century.

For more than three decades now, age cohorts have been shrinking due to lower birthrates. Since 1972, mortality rates have exceeded birth rates, which, at 1.57 births per woman, are among the lowest in the world.

During the last years, immigration has declined and does not even come close to compensating for the low birth rates and changing age structure. The population has been continuously shrinking since 2003. In 1970, there were 25 pensioners (age 65 and above) for every 100 members of the working population. Today, this number has reached 32 and is expected to exceed 50 by 2030. However, if one looks at the total number of dependents (i. e. the young and the old), this number was the highest in 1970 with 78 dependents per 100 workers. This ratio will not reach a similar level until around 2030.

These trends have led to an intense debate about the future of social security in Germany.

Not only will there be an ever smaller portion of the population working and thus paying into the SHI, but aging is also expected to increase the demand for health care services and related expenditures.



Population Structure by Age