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**Access, Choice, and Guidance in
German Health Care**

An account of health policy reforms since 2004

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Access, Choice, and Guidance in German Health Care

An account of health policy reforms since 2004

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Abstract

This paper discusses the influence of recent health care reform acts in Germany on choice, guidance and access from the perspective of patients, insured, insurers, and health care providers. Particular emphasis is put on health policy reforms since 2004, i.e. the Social Health Insurance Modernization Act 2004 and the most recent Social Health Insurance Competition Strengthening Act 2007. Various aspects of the reforms are included as long as they have an influence on access, choice, and choice to health care in Germany.

Kurzfassung

Dieser Beitrag diskutiert den Einfluss vergangener gesundheitspolitischer Reformgesetze in Deutschland auf Wahl- und Wechselmöglichkeiten, Steuerung und Zugang aus der Sicht von Patienten, Versicherten, Versicherungen und Leistungsanbietern. Dabei werden insbesondere das Gesetz zur Modernisierung der Gesetzlichen Krankenversicherung 2004 (GMG) sowie das Gesetz zur Stärkung des Wettbewerbs in der Gesetzlichen Krankenversicherung 2007 (GKV-WSG) betrachtet.

JEL classification: I18

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List of Abbreviations

DMP	Disease Management Program
GKV-WSG	Statutory Health Insurance Competition Strengthening Act
GMG	Statutory Health Insurance Modernization Act
GP	General Practitioner
HMO	Health Maintenance Organization
KV	Regional Association of SHI Physicians
POS	Point of Service Organizations
PPO	Preferred Provider Organizations
SHI	Statutory Health Insurance

1. Introduction

This paper discusses the influence of recent health care reform acts on access, choice and guidance in German health care. Traditionally, Germans enjoy a very high degree of free access and choice of both providers and health care insurance. Health care services are available, reachable and affordable. Instead of underuse, the German system rather suffers from overuse of health care services. Therefore policy makers have recently introduced measures that are to restrict utilization of services and provide stronger guidance for patients. The *Statutory Health Insurance (SHI) Modernization Act (GMG)* of 2004 and the *Statutory Health Insurance Competition Strengthening Act (GKV-WSG)* of 2007 constitute turning points in this regard. For the first time in the history of German health care, the *GMG* introduced user fees for outpatient health services. Both acts promote new forms of care that are to improve care coordination and patient guidance but also to increase competition among health care providers. This paper will take a closer look at these measures and accompanying changes at the institutional and organisational level and describe their impact on access to and utilization of health services as far as research results are available. Other aspects of the reforms are included as long as they have an influence on access and choice to health care in Germany.

The paper is organized as follows. In section 2 we shortly discuss concepts of access, choice and guidance. In section 3 we describe the status quo of access to and choice of health care in Germany prior to 2004. We look at past health care reforms (1988-2003) and their impact on access and choice from the perspective of the insured, patients, insurers, and health care providers. Section 4 discusses the impact of the *SHI Modernization Act 2004* and the *SHI Competition Strengthening Act*¹ on access, choice and guidance. Section 5 concludes.

2. Concepts of access, choice and guidance in health care

Definitions of access

The World Health Organization defines access in health care as the proportion of the population that reaches appropriate health services (WHO 1998). Other definitions interpret access as a basic minimum of benefits that ensures that no citizen falls beneath a particular level of subsistence, or see access guaranteed when the same level or quality of health care is equally accessible to all, regardless of social status, residence and income (Wörz et al. 2006a). Moreover, it can be differentiated between access to care for individuals with different types of diseases such as emergency and acute care patients, elective surgery patients and the chronically ill.

Whereas internationally, access is discussed in the order of availability (infrastructure, human resources), reachability (within easy geographical reach), and affordability (financing, ability-to-pay, reimbursability of defined benefits) (Wörz et al. 2006a), the debate in Germany focusses on the latter. However, from an economic point of view, one has to keep in mind that increasing resource allocation to health care involves trade-offs on four different levels: On the first level, health care is just one field of public activity among others (such as education, defense, public transport, etc.). Secondly, it has to be decided how much resources are spent on each of the stages of medical care (e.g. prevention, acute care, rehabilitation, long-term care, etc.). Third, within acute care, resources are traded off between diagnoses and treatment. And fourth, resources can be allocated according to diseases, for example according to the International Classification of Diseases (ICD-10). In general, there are few infrastructural or

¹ Most aspects of the reform will come into force in April 2007. However certain elements are going to take effect at a later date. See section 4 for details.

geographic barriers to access health care in Germany. The two main barriers to free access and choice in the German health care system are cost-sharing arrangements and the introduction of gate keeping and integrated care schemes.

*Choice versus guidance*²

Managed Care Organizations are an important subject of study when examining the role of choice and guidance in health care. For instance, they are the result of selective contracting which requires freedom of contract for providers and insurers. On the other hand, especially Health Maintenance Organizations (HMOs) limit free choice of providers for individuals by requiring all care to be delivered through the plan's network and only after being authorized by the primary care physician. Preferred Provider Organizations (PPOs), and Point of Service Organizations (POS) include less strict restrictions of choice. They are characterized by a two-tier coverage and aim to steer patients to network providers via financial incentives or a combination of financial incentives and a primary physician acting as a gatekeeper.³ In the US-health care system, the "public backlash" (Docteur et al. 2003) caused by consumers and providers led to a high popularity of PPOs relative to HMOs, increasing the role of choice for individuals.⁴

In contrast to these developments in the U.S., the U.K. and other countries, German health policy makers are promoting forms of care that reduce choice for patients. Lack of coordination between outpatient and inpatient care in Germany has caused problems in funding and purchasing of health care. Experts argue that reducing choice and guiding patients via integrated care (2000, 2004) and disease management programs (2002) could at least partially contribute to improving horizontal and vertical coordination and also increase competition among providers and sickness funds.

3. Access, choice and guidance in Germany – Status Quo

In this chapter we look at past health care reforms up to the year 2004 and their impact on access, choice and guidance in German health care. The main objective of reforms prior to 2004⁵ was cost containment in the SHI system. In order to decrease expenditure and increase efficiency, these reforms, most notably the *Health Care Structure (HCS) Act* of 1993, introduced competition among sickness funds and shifted part of public expenditures to patients (Busse and Riesberg 2004). Cost containment measures with the strongest impact on access and choice of health care were the introduction of new and the increase of existing co-payments, the exclusion of certain services from the SHI benefit catalogue and the opening of sickness funds to (almost) all SHI insurees. Prior to 2004, new forms of care like gatekeeping programs, integrated care and disease management programs have only played a minor role in German health care.

² In this context we define patient guidance as counselling and support for patients in determining the most suitable care arrangements and methods. Guidance can be given by physicians and/or a physician's practice team. Stronger patient guidance is expected to lead to more effective and efficient care.

³ For the different types of Managed Care see for example Wagner (1996) and Hauser (1988).

⁴ In 2005, 61% of all covered employees in the USA were covered through a PPO-plan, 21% through an HMO-plan, 15% through a POS-plan and 3% through a traditional indemnity plan (Gabel et al. 2005).

⁵ For a detailed list of health care reforms passed from 1988 until today please refer to Annex 1 to this paper.

3.1 The perspective of insured

Insurance coverage

So far, Germany and Ireland are the only two European countries that do not have a universal health insurance system (to be changed in Germany with the *SHI Competition Strengthening Act 2007*, see section 3.2). However, only 0.2% of the entire population or 200.000 people have no health insurance at all, although the number of uninsured has been rising over the last years (Laschet 2005).

Introduction of sickness fund choice

The *Health Care Structure Act* of 1993 introduced for the first time free choice of sickness funds for the majority of their members (approximately 97%, see Wörz and Busse 2005). Exempt are miners, sailors and farmers that are insured in closed sickness funds with a relatively low number of members. Insurees can choose among 252 different sickness funds and can change funds once every 18 months or when contribution rates are increased. Sickness funds are to compete for insurees over contribution rates and certain special programs such as “no claim” bonus schemes.

Since 1996 about one in four persons has changed their sickness fund at least once (Braun et al. 2006). Table 1 shows the proportion of insured who changed their SHI fund in a given year. Studies show that the main reason for changing is the contribution rate⁶. Individuals that changed funds are in better health than those who did not change (Wörz and Busse 2005) and younger persons are more willing to change than the elderly (Braun et al. 2006). Sickness funds that gained in membership were above all company-based funds whose contribution rates tend to be lower than those of for example regional sickness funds. Regional funds were those that lost most members (ibid).

Table 1 – Proportion of insureds who changed their statutory sickness fund (in %).

	1997	1998	1999	2000	2001	2002	2003	2004
West Germany	3.8	4.3	4.3	5.5	5.7	4.4	5.0	5.7
East Germany	4.8	4.8	5.2	6.0	6.2	3.9	5.5	6.6
Total	4.0	4.4	4.5	5.7	5.8	4.3	5.1	5.9

Numbers are based on a sample from the Socio-Economic Panel (SOEP); Source: Andersen, H. and Grabka, M. (2006), p. 150.

SHI benefit basket

Both the coalition of Christian Democrats and the Liberal Party (1982-1998) and the coalition of Social Democrats and The Greens (1998-2005) were faced with increasing health expenditures and felt pressure to apply stricter cost containment measures. They excluded services from the benefit basket and introduced stricter rules for health technology assessment. The Social Code Book V, the legal framework for the German SHI system, stipulates that the SHI has to provide “[...] medically necessary services according to the principle of appropriateness in a sufficient and efficient way.” (Wörz and Busse 2005, p. 134). Measured by this definition and given that the benefit basket of the German SHI is quite comprehensive covering outpatient and hospital treatment, medication, dental treatment as well as rehabilitation services, exclusion of services from the benefit catalogue have so far not caused

⁶ Contribution rates of sickness funds range from about 12% to 15.5% of gross earned income up to the contribution ceiling of €3562,5 (2006). Therefore, individuals can save about 62 Euros per month at the most if they change their sickness fund.

any access shortages. Insurees continue to have access to an appropriate number of services at a high level of quality. The content of the SHI benefit basket is predetermined up to about 95%. Reimbursable services are determined jointly by sickness funds and in- and outpatient health care providers in the Federal Joint Committee, a decision making body of the joint self-governing body in the German health system⁷.

Next to the benefits that are reimbursed by sickness funds, insurees have access to individual health care services (so-called IGeL services) that need to be paid for privately. The Federal Joint Committee has classified these services as medically not necessary and therefore they are not included in the SHI benefit basket.

Since the emphasis in German health care lies on acute care, availability of preventive services is still limited. The SHI benefit basket comprises certain preventive measures such as breast cancer screening for women older than 30, colon cancer screening for persons older than 50, and two dental health check-ups per year. However, outpatient physicians are not incentivized to offer continuous preventive services to their patients because remuneration is based on a fee-for-service system for treating sick patients. For individuals with chronic and complex conditions who need ongoing support during non-acute phases of their diseases, adequate care is not yet available to the extent necessary (Advisory Council on the Assessment of Developments in the Health Care System 2005; Advisory Council for the Concerted Action in Health Care 2001).

3.2. The perspective of patients

Availability and infrastructure

Although there is only few data on waiting times in Germany, recent patient surveys indicate differences in waiting times based on type of insurance (see table 2), age and place of residency (Zok 2007; KBV/FGW 2006; Wörz et al. 2006b; Ulmann et al. 2005). SHI insurees, older patients, and patients living in less-populated, rural areas tend to wait longer for physician appointments. All in all, privately insured seem to be privileged in access to office-based physicians.

Table 2: Waiting times for outpatient physician visits

	SHI insurees	Privately insured
Not at all	23.4	31.6
1 day	8.5	13.5
2-7 days	27.7	34.1
8-14 days	15.0	13.0
2-4 weeks	11.7	4.9
more than 4 weeks	13.6	2.9

Source: Zok 2007.

With regard to the ratio of health professionals to the population, Germany lies above the OECD average: In 2002 there were 3.4 practising physicians per 1000 inhabitants in Germany, the OECD average is 3 physicians per 1000 inhabitants (OECD Health Data 2006). However, demographic developments (aging population, migration toward urban centers, increasing

⁷ For more information on how the benefit basket in Germany is determined refer to Busse et al. 2005a and Schreyögg et al. 2005.

number of physicians about to reach retirement age) are expected to lead to a shortage of health professionals in some rural regions in (East) Germany within the next five years (Federal Association of SHI Physicians 2003; see also Wörz et al. 2006b). Between December 2005 and December 2006 alone, the number of general practitioners in the Eastern states decreased by 3.1% (Federal Association of SHI Physicians 2007). These developments may deteriorate access to health care, especially for the older population with restricted mobility. Some Eastern federal states try to offset the impact of the looming shortfall of physicians. One strategy is the employment of community nurses who visit patients in their homes and carry out tasks that normally would have to be performed in physician practices (see Blum 2006).

Affordability of health care

Reforms during the last 20 years have steadily increased both the level of co-payments and the number of drugs and health care services on which co-payments were imposed. This trend can be observed for dental care, medical devices and aids, emergency transportation as well as for in- and outpatient services. The share of private expenditure in total health care expenditure has consequently grown during the last years: from 19.5% in 1995 to 21.8% in 2003 (see table 3).

Table 3: Expenditure on health by sources of funds as % of total expenditure on health

	1995	1997	1999	2001	2003
Private expenditure on health	19.5	20.9	21.5	21.6	21.8
Out-of-pocket payments	10.0	10.8	10.9	10.7	10.4
Private health insurance	7.6	7.9	8.2	8.3	8.8
All other private funds⁸	1.9	2.1	2.4	2.5	2.6
Public expenditure on health	80.5	79.1	78.5	78.4	78.2
General government expenditure, excl. social security schemes	14.3	10.8	10.1	10.2	9.8
Social security schemes	66.2	68.3	68.4	68.2	68.4

Sources: OECD HEALTH DATA 2006

In order to ensure equal access to care based on need, financial hardship regulations and exemptions for certain groups of insured based on age, income, and health status were introduced. Children up to the age of 18 were exempt from co-payments. For low-income individuals and the chronically ill yearly limits for co-payments exist (2% and 1% of gross annual household income, respectively).

Research on the impact of co-payments and user charges on access or utilization of health care in Germany is scarce. In general, co-payments and user charges tend to be regressive and can constitute a heavy burden on low-income earners (see e.g. De Graeve and Van Ourti 2003;

⁸ This includes health expenditure incurred by corporations and private employers providing occupational health services and other unfunded medical benefits to employees plus expenditure by non-profit institutions serving households such as the Red Cross, etc.; benefits provided for free by medical care providers plus health expenditure incurred by the rest of the world (OECD 2006).

Murray et al. n.d.). Preliminary results from a study among insurees of Germany’s biggest regional sickness fund indicate that co-payments might have a negative impact on utilization of health care because patients are not familiar with the rules for exemption and therefore do not make use of them⁹ (Eller et al. 2002).

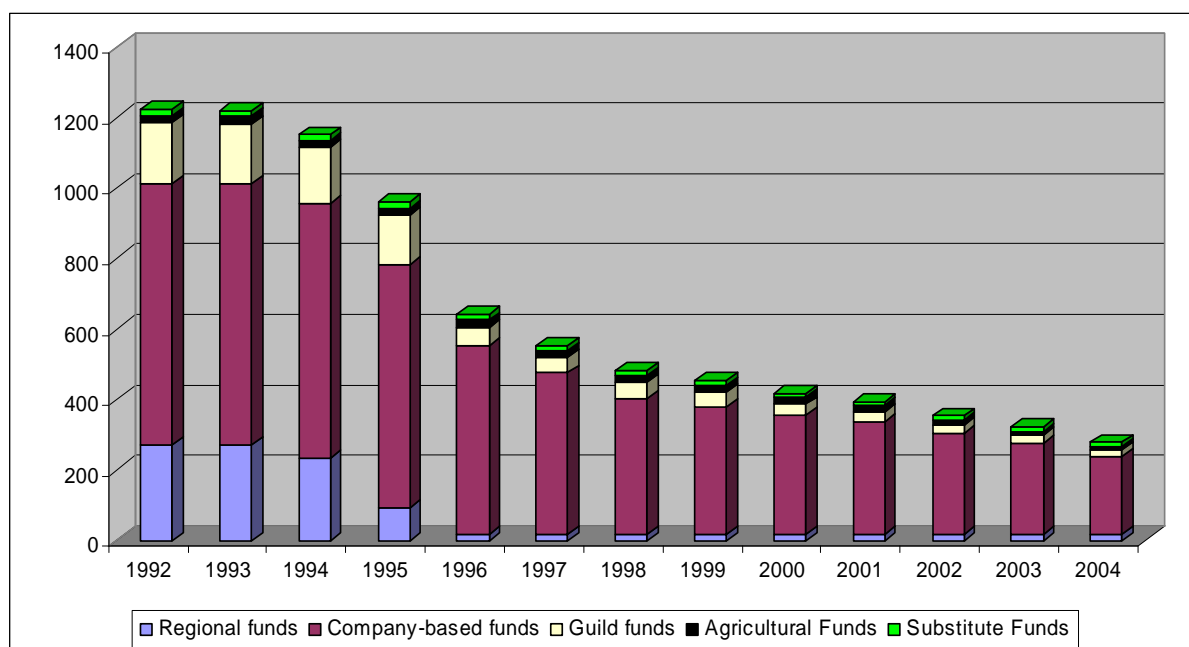
Altogether there seem to be no marked differences in utilization of health care services based on income though. Studies showed that low-income earners make higher use of health care services than high-income earners (Winkelhage et al. 1992, in Wörz and Busse 2005). A study by van Doorslaer et al. (2004) indicates that there is a pro-poor inequity with regard to general practitioner visits and a slight pro-rich inequity for specialist visits.

3.3. The perspective of insurers

Statutory Health Insurance

The Statutory Health Insurance (SHI) System in Germany is ruled by public law (the Social Code Book V), comprises some 252 fiscally autonomous and self-sufficient sickness funds (January 2007), and insures about 85.5% of the German population.¹⁰ As figure 1 shows, the total number of sickness funds has been steadily decreasing, especially since the regional and substitute funds were legally opened to everyone in the SHI system through the *Health Care Structure Act* in 1993. There are seven different types of sickness funds in the SHI-system: Regional funds (AOK), company-based sickness funds (BKK), guild funds (IKK), substitute funds, agricultural funds (LKK), the maritime health insurance fund, and the Federal Miner’s Insurance Institution (Bundesknappschaft).

Figure 1 - Development of the total number of Statutory Health Insurance funds.



Source: German Ministry of Health (2005); Not in graph: Maritime health insurance fund and Federal Miner’s Insurance Institution.

⁹ In Germany, it is the patients’ responsibility to prove that private expenses for health care exceed the yearly co-payment limit.

¹⁰ Sources: German Ministry of Health, Federal Statistical Office.

The SHI system is based on the pay-as-you-go-system and is organized as a compulsory insurance for those earning less than € 3,975.00 a month and for unemployed, pensioners, students, disabled persons, poor and homeless people. Individuals with an income above the income threshold for compulsory insurance or those who are self-employed can either stay in the social system on a voluntary basis or opt out and purchase private health insurance. On the other hand, sickness funds are obliged to contract. Dependents (children and non-employed spouses) are co-insured without extra costs. Statutory sickness funds are financed through social security contributions related to ability to pay. In January 2006, the average contribution rate of all sickness funds was 13.25% of earned income or its replacements (e.g. pensions or unemployment benefits). Generally, contributions are equally shared among employers and employees, (thus each of them paying 6.625%), however, since July 2005, employees have to pay a special contribution of 0.9% covering expenditures for dentures. Due to the way financing is organized, a number of redistributive effects occur: Expenditures are redistributed from healthy to sick individuals, from young to old individuals, from singles to families, from individuals with high income to individuals with low income (as long as the high income individuals earn less than the contribution ceiling of €3,562.50 a month) and from men to women. A refund of contributions in case an individual did not make use of health care services throughout a year is only possible for voluntarily insured individuals and is limited to a monthly contribution.

Independent of the amount of contributions paid or the duration of the insurance, every insured (members of a particular sickness fund and their dependants) are entitled to the same benefits (provision of and access to care). Except of sick and maternity benefits, benefits are generally granted through the principle of benefits in kind meaning health providers are reimbursed directly from sickness funds without the patient having to pay for services first.

Private Health Insurance

In contrast to the SHI system, private health insurances are based on a private contract between the insured and the insurance company and build upon the funded principle in order to guarantee lower premiums at a higher age. Currently, about 10.2% of the population are inscribed to one of the 52 private health insurance companies.¹¹ Until the present reform, old-age provisions were tied to a specific insurance company thus the longer an individual stayed in a particular insurance company, the more unattractive it became to switch to another insurance company. Table 4 shows the amount of saving accounts built by German private insurers.

¹¹ Sources: Federal Statistical Office, Association of private health insurers.

Table 4 – Old-age provisions of private health insurers in Germany.

Year	in Billion €	%- Change
1992	19,21	
1993	21,66	11.3
1994	24,60	12.0
1995	28,38	13.3
1996	33,28	14.7
1997	38,69	14.0
1998	44,62	13.3
1999	52,14	14.4
2000	59,55	12.4
2001	68,22	12.7
2002	76,30	10.6
2003	85,14	10.4
2004	93,81	9.2
2005	103,37	10.2

Source: Association of private health insurers, Annual reports (provisions include health care and long-term care provisions)

Only employees with a monthly income higher than €3,975.00 a month, public servants, and self-employed individuals have access to private health insurances. Dependants each have their own individual contract with individually risk-rated premiums. Insurance companies can choose whether to close a contract or not. Premiums are based on the benefits principle and risk-oriented according to the state of health, age, sex, coverage, etc. They are partly paid for by the employer (the highest average employer's contribution in the SHI serves as a maximum). Besides the redistribution from healthy to sick individuals, there is no distribution based on solidarity grounds. The extent of the benefit package depends on the individual contract and benefits are granted according to the cost reimbursement principle. Hence, when health services are used, the privately insured individual will pay the provider before being reimbursed by his or her insurance company. Finally, refund of contribution is generally part of private health insurance contracts. Table 5 summarizes the main differences between the Statutory and the private health insurances in Germany.

Table 5 - Comparison of SHI funds and private health insurances in Germany.

	Statutory Health Insurance System	Private Health Insurances
Type of Insurance	Compulsory insurance by law (pay-as-you-go-system)	Private Contract (funded system)
Insured	<ul style="list-style-type: none"> • Compulsory insured • Voluntarily insured 	<ul style="list-style-type: none"> • Employees with a monthly income > 3.975 € • Public Servants, self-employed, etc.
Obligation to contract	Yes	No
Financing	<ul style="list-style-type: none"> • Social security contributions (related to ability to pay) • Employer's and employee's contribution • Risk structure equalisation (RSA) 	<ul style="list-style-type: none"> • Risk-oriented premiums (benefits principle) (state of health, age, sex, coverage, etc) • Partially paid by employer
Redistribution	<ul style="list-style-type: none"> • From healthy to sick individuals • From young to old individuals • From singles to families • From high to low income • From men to women 	<ul style="list-style-type: none"> • From healthy to sick individuals • No other redistributive effects (saving accounts)
Co-insurance of dependents	Dependents are co-insured without extra- costs.	Dependents have their own individual contract with respective premiums.
Benefits	<ul style="list-style-type: none"> • Principle of benefits in kind (except of sick benefit, maternity benefit) • Identical benefit package 	Cost reimbursement principle
Contribution refund	Only for voluntarily insured individuals	Yes

Source: Based on Simon 2005, p. 128.

3.4. The perspective of health care providers

Generally, there has been a clear sectoral division between outpatient and inpatient care and patients can freely choose providers in both sectors.¹² The separation largely results from different reimbursement schemes within the two sectors and from the way the negotiating process between health care providers and insurances is currently organized.¹³

In the outpatient sector, health care services are reimbursed according to a fee-for-service system with a fixed budget and floating (point) values. The traditional bargaining process within the SHI is based on a system of collective contracting. Outpatient providers such as general practitioners and specialists belong to one of the 17 so-called Regional Associations of Statutory Health Insurance Physicians (“Kassenärztliche Vereinigung”, KV) that contract with the regional head associations of SHI sickness funds. In return for being reimbursed by the sickness funds, the association of physicians takes over a service guarantee¹⁴.

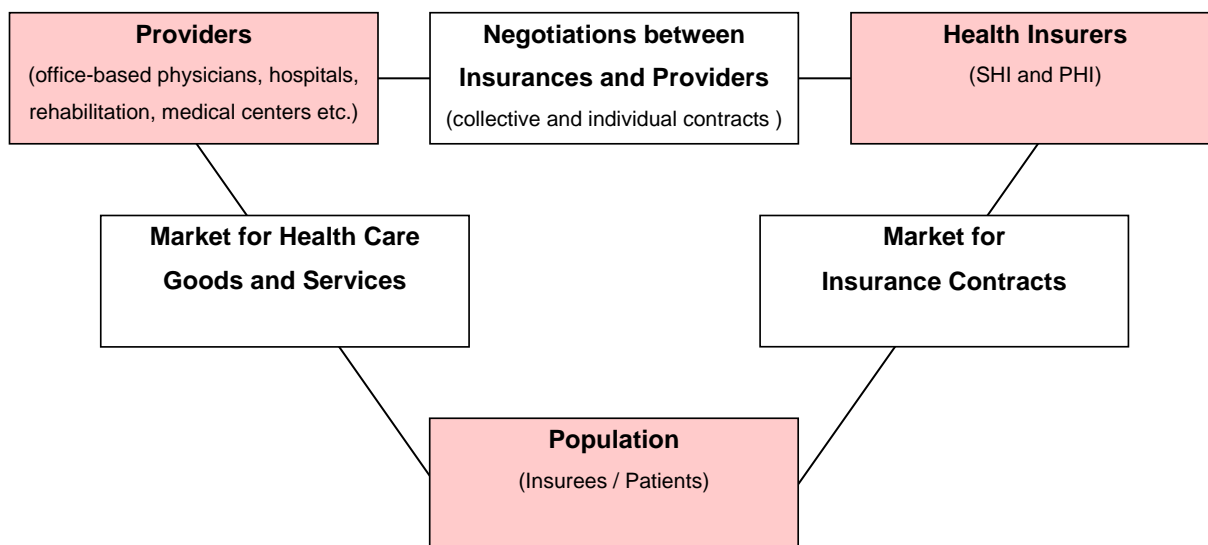
In contrast to that, the inpatient sector is characterized by a dualistic hospital funding system where operating costs are reimbursed by sickness funds based on the G-DRG system introduced in 2004 and by tax-financed state funds covering capital investments. The service guarantee is provided by the states. For inpatient care, the individual hospital contracts directly with sickness funds. Figure 2 summarizes the negotiating process.

¹² The fragmentation also extends to rehabilitation, long-term care and prevention.

¹³ As a consequence of fragmentation, there is a parallel structure for specialist care: Specialists can be found providing inpatient care in hospitals as employees and outpatient care as office-based, self-employed solo practitioners.

¹⁴ According to § 75 of the Social Code Book V, the KV has to guarantee adequate medical services in terms of quality, geographical reachability, time, needs, and economic efficiency.

Figure 2 - The Negotiating Process in the German Health Care System



Source: Own graph.

Up to 2004, departures from this standard way of providing care, e.g. through guiding patients via managed care were very rare in German health care. On a regional level experimental settings prior to integrated care legislation and structural contracts existed that aimed at improving coordination and cooperation in health care. However, on a large scale new types of service delivery remained unpopular even though integrated care had been introduced with the 2000 health reform. This can be partly attributed to missing financial incentives, experience and expertise. Moreover, many legal, tax and organizational obstacles had to be overcome. A major challenge was that until 2004 the Regional Associations of Statutory Health Insurance Physicians had to be obligatory partners in integrated care contracts. With more integrated care contracts based on selective contracting, KVs would lose influence as their current responsibility is to collectively contract with sickness funds (see above p. 13f.). This caused conflicts of interest and impeded further development of integrated care (Hesse 2005). Other than experimental integrated care settings some sickness funds started offering GP-centered schemes to their insured on a voluntary basis. Bonus schemes and the reimbursement of co-payments work as incentives for the insured to enrol in those plans.

4. New provisions under the *Statutory Health Insurance Modernization Act 2004 (GMG)* and the recent reform legislation (*Statutory Health Insurance – Competition Strengthening Act (GKV-WSG)*)

4.1. The perspective of insured

Universal coverage

The *SHI Competition Strengthening Act*, to come into force in April 2007, will make universal health insurance mandatory. Every resident will be required to take out health insurance either through social health insurance or privately. Although the number of uninsured individuals in Germany is small compared to countries such as the United States, it has been rising over the last years. Both public and private insurers have so far not been obliged to sell insurance. In the past they could reject individuals who had no coverage or who had lost their insurance due to unemployment, divorce, or low-income jobs. Under the new provision, individuals who have lost coverage are to return to the type of insurance where they had last been covered. Private insurers will have to offer at least a basic benefit package. Individuals falling under the

SHI scheme are required to take out insurance from April 1, 2007, those that fall under the private insurance scheme from January 1, 2009, on.

More choice for insured individuals

Choice for insurees and patients has been widened by encouraging sickness funds to offer different tariffs and types of plans such as GP-centered care schemes, deductible health plans, integrate care schemes, etc. (see section 3.3). On the other hand, choice will be restricted to a certain degree when insurees choose gatekeeping plans or integrated care plans (see section 3.4). Finally, sickness funds with closed membership will be opened to all insurees in the SHI system¹⁵. The only sickness funds that remain closed are some company-based sickness funds and farmer sickness funds.

Extension of the benefit basket

The SHI benefit basket will be extended to include new services, especially in the area of prevention and rehabilitation. From April 2007 on, sickness funds will be required to pay for rehabilitative care services for the elderly. This is to improve health status of elderly persons after accidents or illnesses, assisting them to stay in their own home and to lead an active, self-determined life. So far, elderly persons would frequently end up in a nursing home after an accident or severe illness. The widening of the SHI benefit basket in this area certainly improves access to care for the elderly. Moreover, sickness funds are obliged to reimburse vaccinations that are recommended by the federal institute responsible for disease control and prevention (Robert Koch Institute). Further, treatment for families with children at rehabilitative resorts will also be added to the SHI catalogue. Additionally the *GKV-WSG* will improve access to care for the terminally ill by including palliative care into the benefit basket of sickness funds. Palliative care teams consisting of medical and nursing professionals will be approved and take over care for this part of the population.

New elements in private health insurance: changes in access, basic tariff and portability of reserves for old age

The *GKV-WSG* introduces more restrictive rules for taking out private health insurance, thereby decreasing choice for part of the population. While so far insurees could opt out of SHI once their income exceeded the threshold (3,975 per month in 2006), this threshold now has to be exceeded for three years in a row. This provision is to increase solidarity and financial fairness in health insurance: High-income earners can no longer leave social health insurance as easily any more and their contributions will remain within the SHI system.

On the other hand, the *GKV-WSG* also makes access to private health insurance easier and less costly for certain groups of the population, e.g. for those that used to be privately insured and could not afford the premiums anymore or for insured at an high age with high premiums, since private health insurers will be required to offer a basic tariff from January 2009 on. New insurees can choose this tariff without risk assessment and without an additional risk premium. The basic tariff includes benefits similar to those offered in social health insurance and insurances cannot exclude any services. The premium is not to exceed the maximum SHI contribution rate (about 260 Euros per month) and can be lowered if the premium surpasses a certain percentage of the insured's income.

Moreover, choice for privately insured individuals is widened by establishing a portability provision. Privately insured can now change insurer and carry along part of their reserves for old age. This has not been possible so far and constituted a major obstacle to changing private

¹⁵ This applies for the maritime health insurance fund and for the Federal Miner's Insurance Institution.

insurers. Further, privately insured can switch insurers without renewed risk assessment if they choose the basic tariff.

4.2. The perspective of patients

As a novelty in the German health care system, the *GMG* introduced a co-payment for access to outpatient care. Patients have to pay 10€ per quarter for the first appointment at a physician's and dentist's office and for each physician visit without a referral from the first-visited physician. The aim of this measure is to decrease the utilization of unnecessary outpatient physician visits and to encourage self-medication of petty diseases (Gebhardt, 2005). Germans see their physician more often than their European neighbors: 7.8 times per year compared to an average of 6.2 times per year in the EU-15 states (Hesse and Schlette, 2005).

Empirical studies show mixed results with respect to the impact of the 10€ fee on utilization of out-patient health care services. Data from the Bertelsmann Stiftung Healthcare Monitor¹⁶ indicated that the number of physician visits initially declined (by about 8% between spring 2003 and spring 2005) but seems to remain relatively stable now (Gebhardt, 2005). Augurzky et al. (2006) found that the co-payment did not have a significant effect on the probability to visit a physician. Grabka et al. (2006) showed a negative impact of the fee on unnecessary consultations and did not find any social discrimination.

However, the user fee seems to have caused some unwanted social and health effects. Zok showed in a study conducted in 2004 that low-income earners tended to avoid physician visits after the introduction of the 10€ practice fee (see also Gebhardt 2005) but could not replicate these results in his 2005 study. Patients in bad health were more likely to reduce visits than patients in good health (Gebhardt 2005). Physicians brought up concerns that the number of medically needed physician visits went down as well (ibid). A study by Koch and Brenner (2005) showed that patients made less use of preventive health check-ups and that utilization of out-patient services among children and adolescents decreased. Both prevention check-ups and physician visits for children are exempt from the user fee though.

4.3. The perspective of insurers

Health Fund in the SHI-system

The so-called Health Fund is the core of the current reform and constitutes a major change on the financing side of the SHI system. It is supposed to start operating from January 1st 2009. The Fund will collect money from three different sources: Contributions from employers and employees and public funds. Currently, contribution rates differ quite extensively among sickness funds.¹⁷ In the future, social contribution rates will be unified and regulated by law. The sickness funds will continue to collect the contributions from employers, however, from 2011 on, they are allowed to charge regional authorities with the collection. Public funds from the federal government have already been an additional source of financing non-insurance services in the past: In 2006, €4.2 billion were transferred into the SHI system from the increase in the revenue of the tobacco tax. In 2007 and in 2008, this amount has been reduced to €1.5 billion per year. According to the new law, the tax pillar of the Health Fund is going to

¹⁶ The Bertelsmann Stiftung Healthcare Monitor is a representative survey instrument. Twice a year, 1500 SHI insurees and once a year about 500 physicians are being interviewed about issues relevant to healthcare policy. For further information on the Healthcare Monitor see www.bertelsmann-stiftung.de/cps/rde/xchg/SID-0A000F0A-A3AC0FA5/bst_en/hs.xml/prj_7097_7113.htm.

¹⁷ C.f. footnote 5.

be increased to €3 billion in 2009 and is supposed to be further augmented in the upcoming years. It shall be used to an increasing extent for the free co-insurance of children.¹⁸

Table 6 - Federal government funds to the SHI-system, 2004-2009 in billion €

Year	Billion Euro
2004	1.0
2005	2.5
2006	4.2
2007*	1.5
2008*	1.5
2009*	3.0

Sources: German Federal (Social) Insurance Authority, Federal Ministry of Health; *: estimated values.

The sickness funds are going to receive transferrals from the Health Fund which are made up of a lump sum payment and a risk adjusted payment. The risk adjusted payment will reflect age, sex, and a list of 50-80 diseases causing average per head health expenditures to be at least 50% above average SHI expenditures. Thus, this new system tries to take into consideration clinical characteristics and progression of diseases. The existing risk equalisation scheme came into place in 1994 with the aim of avoiding risk-selection. It equalises the financial consequences of factors such as age, sex, number of non-contributing dependents, number of insured pensioners with reduced earning capacity, type of sick benefits rights, and the different incomes of the members subject to contributions. In 2002, the risk equalisation scheme was supplemented by two additional factors: First, the registration of chronically ill in structured disease management programs (DMP) as an additional morbidity characteristic and second, a risk pool partially compensates for expensive benefit cases.¹⁹

If a particular sickness fund cannot cover its expenditures with the transferrals received by the Health Fund, it can charge an additional premium from its insured. This premium can be nominal or income-related and sickness funds can either collect them autonomously or charge the Health Fund to do so. On the other hand, sickness funds that are economically successful can pay out surpluses to their insured. Due to the unification of contribution rates, competition among sickness funds is likely to focus on the magnitude of the additional premium or pay out or on the quality and extent of health care provision.

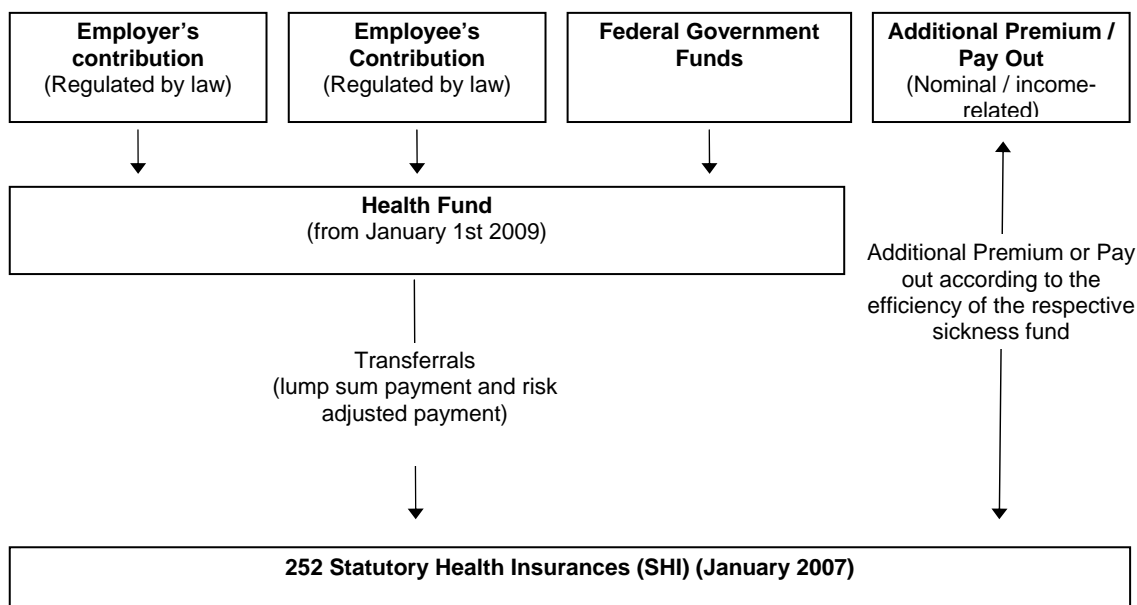
However, two restrictions do limit the competitive role of the additional premium or pay out: First the additional premium cannot exceed one % of a household's income.²⁰ Second, the Health Fund has to cover at least 95% of all expenses of the SHI system (at the beginning, the Fund's revenues will have to cover all of the SHI expenditures). Figure 3 summarizes the basic functioning of the Health Fund.

¹⁸ In 2004, health expenditures for children were estimated at €13.4 billion in the SHI and at €1.5 billion in the private health insurance system (German Federal Social Insurance Authority).

¹⁹ In 2005, the risk structure equalisation system resulted in a financial transfer of €16.35 billion (German Federal Social Insurance Authority).

²⁰ Up to an additional premium of €8 a month, the one %-clause does not apply. An additional pay out will also be limited (however, so far it is unclear where the limit will be).

Figure 3: Functioning of the “Health Fund Model“in the Statutory Health Insurance from January 1st 2009.



Source: Own graph.

Greater choice of tariffs in the SHI system

Other than the introduction of the Health Fund, sickness funds will have more freedom to offer different tariffs to their insured. According to the revised § 53 of the Social Security Code V, sickness funds have new options in four areas:

1. Franchises

The possibility of signing up for a franchise, i.e. a maximum amount that the insured has to pay out-of-pocket per year in exchange for a higher pay out will be opened to compulsory insured as well.

2. Refund of contributions

In contrast to the previous regulation, the option of contribution refunds, limited to a monthly contribution, will be extended to compulsory SHI insured.

3. New forms of medical provision

Higher pay-outs can be tied to the condition that the insured joins one of the new forms of health service delivery such as integrated care, GP-centered schemes (gatekeeper model), disease management programs, or projects with selective contracting with certain health care providers.

4. Cost reimbursement principle

The principle of benefits-in-kind can be more easily replaced by the cost reimbursement principle than previously. Also, the rate of cost reimbursement can be varied in exchange for a higher additional premium (e.g. an SHI insured individual can choose to reimburse his health care provider as if privately insured: paying a higher fee-for-service rate).

Currently, a large number of statutory sickness funds are developing new tariffs in these areas. Combinations of the new tariffs are also possible. However, the new tariffs require the insured to sign up for at least three years²¹, the tariffs have to be self-supporting and are not allowed to be cross-subsidized by other tariffs.

²¹ Except for tariffs with new forms of medical provision where insured only have to commit for one year.

From an economic point of view, the new tariffs will enable sickness funds to focus more on preferences of their insured thus raising efficiency. On the other hand, the effects of redistribution will be reduced, e.g. if young people with higher income choose contracts with higher franchises, there will be less cross-subsidization for the elderly or low income individuals than today. Also, choice carries a risk of more intransparency – it will be more difficult to compare the various insurance tariffs. Moreover, the sickness funds will have to start building actuarial departments in order to calculate pay-outs or additional premiums.

Centralization and mergers of sickness funds

Other than financing provisions, the 2007 reform also affects the organizational structures of sickness funds. The creation of a federal head association of sickness funds (“Spitzenverband Bund”) from July 1st 2008 probably constitutes the most far-reaching structural change. The new institution is to replace the existing seven head associations, each of which traditionally used to represent a different type of statutory sickness funds.

Furthermore, the recent reform facilitates mergers of sickness funds belonging to different SHI types (e.g. a regional fund could merge with a company-based fund). Interstate mergers (mergers of funds located in different federal states) do not require an agreement of the state governments involved anymore.

Private health insurers

Private health insurers fear that the higher barrier to access for full contracts might result in a decreasing number of new contracts. Generally, the introduction of the basic tariff will move private insurances closer to the SHI system. Hence, the *GKV-WSG* might constitute a first step towards a uniform health insurance market. The new basic tariff will not be calculated according to actuarial risks but can only differ according to sex and age. In combination with the introduction of a maximum premium, PHI companies foresee a marked increase of regular risk-rated premiums, claiming that the latter is needed to cross-subsidize the basic tariff. They also fear that the obligation to offer the basic tariff without risk assessment might increase the risk of cream-skimming resulting in inefficiencies. Finally, competition among private health insurers and choice for privately insured could have been improved even more if the portability clause allowing individuals to change insurer and carry along accrued reserves for old age would not have been limited to the amount determined by the basic tariff (German Council of Economic Experts 2006).

4.4. The perspective of health care providers (initiatives for better coordination of care)

The German Advisory Council on the Assessment of Developments in the Health Care System has repeatedly shown that the German system suffers from over-, under- and misuse of health care services. Amongst other things, inefficiencies are attributed to the lack of coordination between health care sectors and providers (Advisory Council on the Assessment of Developments in the Health Care System 2005). The idea of managed care has therefore gained momentum in German discussions on health care reform over the past years. Managed care and stronger patient guidance are believed to improve quality of care and to control costs by increasing coordination and the efficient use of health care resources. Since 2004, the number of GP-centered schemes, Diseases Management Programs, medical care centers and integrated care projects has steadily increased.

GP-centered care

Since 2004 sickness funds are required offer their insured GP-centered schemes on a voluntary basis. The purpose is to increase quality and efficiency of care by giving the GP a stronger coordinating and guiding role. In February 2006, of 23 million sickness fund members, 2.6 million actually participated in GP schemes (Böcken 2006).

Data from the Bertelsmann Stiftung Healthcare Monitor shows that GP scheme enrollees are usually older and suffer more often from chronic diseases than non-participants. The number of specialist visits without referral is lower in the group of GP scheme participants than in the group of non-participants indicating that GPs have in fact assumed a stronger guiding and coordinating role (Böcken 2006).

The great majority of GP scheme insurees are satisfied with the coordinating role of their family doctor: 92% think that referrals were made at the right time and the GP explained the referral in an understandable way (Böcken 2006). Regarding the willingness to participate in GP models, for most (potential) participants it is important that they can stay with their GP. Moreover, participants want to freely choose a specialist if access to specialists is tied to a referral from their GP. If the choice of specialists (or in that line also of hospitals and pharmacies) is left to the GP, willingness to participate decreases drastically. Financial advantages are also a major incentive for insurees to enrol in GP models (ibid).

Disease Management Programs

The first Disease Management Programs were introduced in Germany in 2003. Physicians and patients can enrol in these programs on a voluntary basis. Sickness funds currently offer DMPs for six chronic conditions: Diabetes Type 1 and Type 2, CHD, breast cancer, asthma, and COPD. In October 2006, about 2.6 million individuals participated in DMPs (van Lente and Willenborg 2006).²² The Federal Insurance Office has issued the framework terms and approves of each single DMP. Plans to systematically evaluate experiences have not been carried out yet. Some DMPs have been self-evaluated by the sickness funds that run them, and results from patient and physician surveys indicate that satisfaction with quality and coordination of care has considerably increased. Individuals that participate in DMPs for diabetes showed for example improved blood sugar levels and blood pressure values (van Lente and Willenborg 2006).

Integrated care and medical care centers

The *Statutory Health Insurance Modernization Act* of 2004 paved the way for better coordination and continuity of care. The *GMG* introduced the possibility to establish medical care centers (policlinics) and the right for sickness funds and providers to enter into integrated care contracts. Integrated care is financed by redirecting 1% of the total budget available for ambulatory care and 1% of hospital budgets to integrated care contracts. Initially, this financing arrangement, so-called start-up financing, was to end in 2006. The *2007 SHI Competition Strengthening Act* takes integrated care contracts further in that it extends start-up financing until the end of 2008 and encourages intersectoral cooperations with non-medical providers (such as speech therapists, occupational therapists, etc.) and long-term care providers. In total, start-up financing amounts to approximately 700 million Euros.

²² There is a strong economic incentive for sickness funds to increase participation in DMPs since the number of registered chronically ill in DMPs is taken into consideration within the risk equalisation scheme (see section 4.3).

Table 7 - Integrated Care in Germany.

Quarter	Number of Contracts	Insurees (m.)	Volume (m. €)
1. Quarter 2005	613	2.07	237,38
2. Quarter 2005	841	2.18	278,18
3. Quarter 2005	1.346	2.51	347,44
4. Quarter 2005	1.913	3.16	446,20
1. Quarter 2006	2.109	3.26	478,36
2. Quarter 2006	2.469	3.38	498,78
3. Quarter 2006	2.901	3.54	521,64
4. Quarter 2006	3.309	3.59	570,71

Source: German National Agency for Performance Measurement in Health Care (BQS).

As Table 7 shows, the number of integrated care contracts has been rising significantly over the past two years, from 613 at the beginning of 2005 to more than 3300 contracts at the end of 2006. Most integrated care contracts are regional and cover only specific diseases or indications (e.g. artificial hips, knee prosthesis).

Medical care centers or polyclinics have been a common form of care in the former German Democratic Republic. After German reunification most of the polyclinics had been dissolved and outpatient care in the Eastern states had been organized as in the Western German states with practitioners working in solo practices and some in group practices. Today, only about 30 former polyclinics still exist and operate as medical care centers (Preusker 2007). However, the GMG led to a renaissance of medical care centers also in West Germany. In September 2006, 562 medical care centers existed in Germany compared to 270 in September 2005. On average, four physicians work together and most of these centers are managed by physicians or hospitals (ibid).

All in all, the *Statutory Health Insurance Modernization Act 2004* and the recent *Statutory Health Insurance Competition Strengthening Act* set out the legal and organization framework for better coordination and cooperation in health care. As the increasing number of DMPs, integrated care projects, and medical centers show, providers and payers slowly accept these new forms of care. The majority of patients enrolled in such programs are satisfied with the quality of care provided. However, one central factor for further successful implementation of new forms of care will be convincing patients that more guidance and less choice will not work to their disadvantage.

5. Conclusions

In general, Germans enjoy very good access to and choice of health care. Access will be further improved by extending coverage to the entire population under the *2007 SHI Competition Strengthening Act*. Private health insurance will be more affordable for lower income individuals by requiring private insurers to offer a basic benefit package at lower premiums.

In terms of availability of services, Germany ranks at the top with regard to the ratio of physicians, hospital beds, nurses etc. to the population. The SHI benefit basket ranks among the most comprehensive of all European countries. The needs of an aging population and of individuals with long-term care conditions will be better met by transforming rehabilitative and palliative services into SHI reimbursable benefits from April 2007 on.

The subsequent increase and implementation of new co-payments deliberately established barriers to access in Germany. The share of private expenditures on health care has risen over the last years, possibly complicating access to health care for certain socio-economic groups. Empirical studies on the impact of the 10€ practice fee on utilization and access show mixed results and further studies will be necessary to shed light on its effects.

From the perspective of sickness funds, the facilitation of mergers and the introduction of the Health Fund will increase competition among SHI carriers via the additional premium. However, competition is limited given the ceiling for the premium. A greater variety of tariffs yields more choice to sickness funds. The centralization of sickness funds in a new federal organization indicates a development towards a more uniform health care system with more state influence and less corporatistic interventions from health care bodies and interest groups. Private health insurances partially converge towards the SHI system because of the new basic tariff. The portability of old-age provisions will not substantially increase competition since it will be limited to the basic tariff.

New forms of care such as GP schemes, DMPs, and integrated care models that reduce patient choice and increase patient guidance slowly find their way into the German health care system. With the extension of start-up financing until the end of 2008 and the ease of administrative requirements to establish and run integrated care programs the government further promotes better coordinated systems of health care. However, preliminary studies indicate that patients do not yet fully embrace these new forms of care. Many fear that their choice of providers will be too strongly restricted. For new forms of care to be successfully implemented in Germany, conditions under which insurees are willing to participate in such programs need to be researched more in-depth²³. Whereas new forms of care may result in less choice for patients, they enable payers to contract selectively and to become players responsible for quality and efficiency of services (from payer to player).

²³ Becker and Zweifel 2006

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7. Appendix: German health care reforms from 1988 to today and their impact on access and choice

Reform (Year passed)	Impact on access and choice from the perspective of...			
	...the insured	...patients	...insurers	...providers
Health Care Reform Act (1988)	<ul style="list-style-type: none"> - Benefit basket extended to include new benefits for home-based nursing care, health promotion, and preventive services - Introduction of right for blue-collar workers whose income surpasses the income limit to opt out of SHI (so far only possible for white-collar workers) 	<ul style="list-style-type: none"> - Increase in co-payments for pharmaceuticals that fall within the reference price system, for transportation costs, and treatments at health resorts - Restructuring of co-payments for dentures: amount to be paid out-of-pocket depends upon on how regularly a person visits dentist for dental examinations 	<ul style="list-style-type: none"> - introduction of no-claim bonus model 	<ul style="list-style-type: none"> - Sickness funds are allowed to selectively contract with hospitals
Health Care Structure Act (1992)	<ul style="list-style-type: none"> - From 1996 on, most insurees are allowed to freely choose their sickness fund 	<ul style="list-style-type: none"> - Increase of co-payments for reference-priced pharmaceuticals (co-payments are differentiated by price or package volume) 	<ul style="list-style-type: none"> - Introduction of competition between sickness funds 	<ul style="list-style-type: none"> - Abolition of strict separation between outpatient and hospital sector: Ambulatory surgery can be performed in hospitals
Health Insurance Contribution Rate Exoneration Act (1996), First and Second Statutory Health Insurance Restructuring Acts (1997)	<ul style="list-style-type: none"> - Exclusion of dental treatment and dentures from the benefit basket for individuals born after 1978 (abolished in 1998) - Rehabilitative care and health promotion services again excluded from the benefit basket 	<ul style="list-style-type: none"> - Increase of co-payments for pharmaceuticals and rehabilitative care (partly lowered again in 1999 and 2000) as well as for inpatient care, medical aids, ambulance transportation and dentures 	<ul style="list-style-type: none"> - Sickness funds can offer no-claim bonus models, deductible health plans 	<ul style="list-style-type: none"> - Increased possibilities for sickness funds to selectively contract with health care providers
Act to Strengthen Solidarity in Statutory Health Insurance (1998)		<ul style="list-style-type: none"> - Lowering of co-payment rates for pharmaceuticals and dentures 	<ul style="list-style-type: none"> - Option for sickness funds to offer above mentioned tariffs to insurees revoked 	

Statutory Health Insurance Reform Act (1999)	<ul style="list-style-type: none"> - Exclusion of ineffective or disputed technologies and pharmaceuticals from the benefit basket; strengthening of Health Technology Assessment (HTA carried out by German Institute of Medical Documentation and Information) - Increase of income limit determining mandatory membership in the SHI 		<ul style="list-style-type: none"> - Introduction of voluntary GP-centered care tariffs (sickness funds can offer their insured a bonus if they first see their GP) 	<ul style="list-style-type: none"> - Promotion of cooperation between providers from different health care sectors (groups of providers can contract with sickness funds to offer both outpatient and inpatient care)
Statutory Health Insurance Modernization Act (GMG, 2003)	<ul style="list-style-type: none"> - Reduction of benefit basket: exclusion of drugs for petty diseases - Dentures are kept in benefit basket but insurees have to pay a special contribution of 0.4% (not shared by employers) - Sick pay remains in benefit basket but insurees have to pay a special contribution of 0.5% (not shared by employers) 	<ul style="list-style-type: none"> - 10€user fee for out-patient services - Increased co-payments for pharmaceuticals, aids, transport costs, rehabilitation services, etc. 10 % or at least 5 Euros and maximally 10 Euros per good or service - Introduction of new exemption rules: patients have to pay maximally 1%, chronically ill 2% of their gross income privately 	<ul style="list-style-type: none"> - Sickness funds are required to offer their insured voluntary GP-centered care tariffs 	<ul style="list-style-type: none"> - Promotion of coordination of care and patient guidance: Introduction of medical care centers - Introduction of financial incentives to promote integrated care (start-up financing: 1% of funds available for outpatient and inpatient care are redirected to integrated care from 2004-2006) - Lowering of organisational barriers to integrated care: Regional Associations of SHI Physicians do no longer have to be contract partners in integrated care projects
Statutory Health Insurance Competition Strengthening Act (GKV-WSG, 2007)	<ul style="list-style-type: none"> - Remaining closed sickness funds will be opened for all insurees (exception: farmer sickness funds and some company-based sickness 		<ul style="list-style-type: none"> - Introduction of portability provision in private health insurance: insurees can carry along reserves for old age when changing insurers (not 	<ul style="list-style-type: none"> - Extension of start-up financing for integrated care until the end of 2008 - Inclusion of rehabilitative care and non-medical health

	<p>funds)</p> <ul style="list-style-type: none"> - Higher barriers for opting out of SHI: income limit has to be exceeded three years in a row before individuals can opt out of SHI (until now, income threshold had to be exceeded only once) - Improved access to private health insurance for low-income earners: Private insurers have to offer a basic tariff at a lower premium (not to exceed highest contribution rate of SHI, i.e. ~ €260) - Introduction of mandatory universal coverage - Extension of benefit basket: Inclusion of rehabilitative and palliative care, vaccinations recommended by the federal institute responsible for disease control and prevention, and inclusion of treatment at rehabilitative resorts for families with children - Care necessary due to complications after plastic surgery or piercings excluded from benefit basket 		<p>possible so far)</p> <ul style="list-style-type: none"> - Promotion of new tariffs such as GP-centered care tariffs, deductible health plans, integrated care plans, etc. 	<p>professions (e.g. occupational therapists, speech therapists, etc.) into integrated care projects</p>
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Source: Busse and Riesberg 2004; Federal Ministry of Health 2007

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