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THE GERMAN HEALTH CARE SYSTEM

The German health system health care is two-part: a statutory system tied to payroll and a private system for those with financial means. Recent reforms have sought to infuse competition and market principles.

The German health care system can be viewed as the prototypical Bismarck-style health system in the world. Established in 1883, the [German Health Insurance Act](#) introduced compulsory insurance for industrial workers. Over time and after multiple modifications, Germany possesses dueling health care systems. The first (the Statutory Health Insurance, or SHI) system is characterized by private, nonprofit insurance companies (196 different sickness funds) selling a pre-defined set of policies to individuals. Premium amounts are intertwined with an individual's income through a percentage of payroll. High income individuals can opt out of the SHI and join the second system of private health insurance (PHI). PHI is purchased by individuals from 47 different for-profit insurers and is subject to risk-rating.

Recent health care reforms in 2004 and 2007 introduced cost-sharing mechanisms, promoted competition among health care

providers and insurers, and mandated that all Germans either get insurance from either the SHI or PHI system.

When Germany implemented a 10 euro co-pay into the system, visits to physician offices declined by about 8 percent. As shown in the United States, by [the RAND Health Insurance Experiment](#), both necessary and unnecessary visits were decreased by introducing cost sharing mechanisms.

Competition within the SHI system was promoted while standardization of benefits became the norm following the unification of decision-making between payers and providers through a basic benefits package. Although some variability exists in what is covered and what is not, approximately 95 percent of all benefits are identical between the sickness funds.

Sickness funds are forced to compete among subscribers because remaining in the SHI system (about 85 percent of the population) are allowed to freely switch



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Lisac, M, et al. "Access and choice - competition under the roof of solidarity in German health care: an analysis of health policy reforms since 2004." Health economics, Policy, and Law. 2010; 5: 31-52.

Highlights

- Switzerland's health reforms (1994) require compulsory health insurance and ban profit on the basic benefit package.
- The Netherlands' health reforms (2006) also have an individual mandate but a significant portion of health insurers are for-profit companies in their system
- Germany's reforms (2004, 2007) foster managed competition but in a backdrop of a society predominated by non-profit insurers
- The American health reform (2010) begins the transformation to managed competition for the 2/3rds of Americans who have employer-sponsored or privately purchased insurance
- 1/3rd of Americans have public insurance (Medicare, Medicaid, VA/Military, or Indian Health Service)

between insurers. Twenty-five percent of enrollees have switched at least once, the most common reason being the contribution rate required by each fund.

Those opting for PHI have a more restricted path in order obtain private coverage. Enrollees must demonstrate sufficient income for three consecutive years (formerly one year) in order to opt-out of the SHI system.

Once in the PHI system, switching plans has been far more difficult as this would require enrollees to undergo medical underwriting to qualify for new insurance.

To promote competition within the PHI system, the reforms allowed enrollees to switch insurers and retain coverage defined by the basic benefits package.

Another crucial reform was the implementation of the Health Fund (operational in 2009) which serves to filter funds collected and distribute them to the sickness funds in a risk-adjusted manner. Sickness funds that go over budget must charge enrollees additional premiums; those under budget can provide refunds. Thus, the funds can compete for patients based on their relative efficiency at delivering care.

Commentary

Many view the German health care system as the prototype for universal health care in the world. However, it was only recently that all Germans were mandated to carry health insurance. Now (since 2007) every citizen is obliged, yet entitled, to health care defined by a basic benefits package. Germany still possesses two different systems - the statutory and the private - although recent reforms are attempting to merge the two into one another. Germany has taken a step similar in nature to the reforms of [the Dutch \(2006\)](#) and [the Swiss \(1994\)](#), which similarly instituted individual mandates

and insurance market regulations to promote managed competition within the framework of social solidarity. A major difference between these societies is that health insurers in the Netherlands are predominantly for-profit and in Germany are mostly non-profit (the Swiss ban profit-making on their basic insurance package). As the United States transitions to a partial system of managed competition (excluding, of course, Medicare, Medicaid, and the VA), these European nations will serve as international experiments on whether or not health insurance should be delivered on a for-profit or non-profit basis.