Germany

Health system summary 2022

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AUTHORS

Miriam Blümel, Anne Spranger, Katharina Achstetter,
Anna Maresso, Yulia Litvinova, Reinhard Busse

Anna Maresso (Series Editor)

CONTENTS

This Health system summary is based on the *Germany: Health System Review* published in 2020 but is significantly updated, including data, policy developments and relevant reforms as highlighted by the Health Systems and Policies Monitor (HSPM) (www.hspm.org). For this Summary, key data have been updated to those available in July 2022 unless otherwise stated. Health system summaries use a concise format to communicate central features of country health systems and analyse available evidence on the organization, financing and delivery of health care. They also provide insights into key reforms and the varied challenges testing the performance of the health system.

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How is the health system organized?

The coexistence of mandatory statutory health insurance and private health insurance is a unique feature of the German health system

ORGANIZATION

Health insurance is compulsory in Germany and provided either under the statutory health insurance (SHI) scheme or through substitutive private health insurance (PHI). Health system governance in the country is complex and decentralized: it is divided between the federal and state levels, and corporatist bodies of self-governance (Box 1). While the federal level sets the overall legal framework, state governments are responsible for hospital planning and public health services, and for example, took leading roles in implementing measures to respond to the COVID-19 pandemic. However, most decision-making power within the SHI system is delegated to corporatist bodies (such as associations of providers and sickness funds). The public health, ambulatory and inpatient, and long-term care sectors in the health care system are subject to different legislation and thus are separated in terms of organization, financing and reimbursement.

PLANNING

Responsibilities for planning are divided between the federal government, the states and various institutions at the corporatist level. There is no national health plan to steer overall policy development in the health system. The federal government's tools to steer the health system are mainly based on high-level regulation and soft guiding through recommendations and project funding that aims to shape the different aspects of services. Disease-specific national plans, such as the National Cancer Control Plan, are the only example where there is direct policy development and implementation. In addition, various initiatives, such as the National Prevention Conference, aim to build consensus among stakeholders and develop national guidelines and health goals that can subsequently be translated into state law.

BOX 1 | GERMANY'S HEALTH SYSTEM IS MARKED BY COMPLEX SELF-GOVERNANCE

In Germany, most of the legal rights and responsibilities are vested in corporatist associations of payers and providers in a system of self-governance, while institutions at the federal level (e.g. the Federal Ministry of Health) are responsible for setting the legal framework and for the supervision of the main corporatist bodies (e.g. the Federal Joint Committee and the Federal Association of SHI physicians). Corporatist bodies within the SHI system play an important role in decision-making. These organisations are known as legitimized civil society organizations, such as associations of sickness funds, hospitals and other providers which meet in the Federal Joint Committee (*Gemeinsamer Bundesausschuss* or G-BA) to set out regulations in detail. The Federal Joint Committee is the paramount decision-making body in the SHI scheme's system of joint self-government. All decisions related to ambulatory, dental and hospital care are made through its Plenary Group. It also makes decisions on including new technologies, pharmaceuticals or medical devices in the benefits basket, negotiates pricing and reimbursement contracts and defines the standards of care.

PROVIDERS

The vast majority of health service providers in Germany serve both those covered by the SHI scheme and those with PHI. Patients can freely choose their physicians, general practitioners (GPs) and specialists alike. GPs are usually the first point of contact with the health system: although their competences to coordinate patients have been strengthened over time, they are not official gatekeepers. Both national and international data sources show high utilization rates for both outpatient and inpatient care. Primary and ambulatory health care are mainly provided by private for-profit providers, while the dense network of hospitals comprises a mix of public, private not-for-profit and for-profit institutions.

How much is spent on health services?

FUNDING MECHANISMS

Germany's health expenditure is among the highest in Europe

Contributions towards SHI constitute the major system of financing health care. The sickness funds are responsible for collecting contributions which are then transferred to a central reallocation pool known as the *Gesundheitsfonds*, which then reallocates the revenues according to a risk-adjustment mechanism. The general fixed SHI contribution rate is 14.6% of gross income and in addition sickness funds can charge a supplementary contribution which is, on average, 1.3% in 2022. Both contributions are shared equally between employer and employee. In contrast to SHI, PHI premiums are not dependent on income, but on age and health risk. General tax revenue is also used for various purposes in the health care system. All tax-based budgets, at federal as well as state level, are determined by legislatures acting on proposals from their governments. Capital investments in hospitals come from states' budgets.

HEALTH EXPENDITURE

Health spending in Germany has gradually increased over the past two decades. It has remained above 10% of GDP since 2005 (Fig. 1). In 2019, current health expenditure per capita was US$PPP 6739 (adjusting for differences in purchasing power), representing 11.7% of GDP. This places Germany among the top five spenders on health across EU countries and within the WHO European Region (Fig. 2). The strictly public share of current health expenditure was 78% in 2019 (but rising to 84.6% when the mandatory PHI scheme is counted). Complementary and supplementary Voluntary Health Insurance (VHI) only accounts for 2.7% of private sources of funding, with the remainder attributable to cost-sharing.

OUT-OF-POCKET PAYMENTS

There is a relatively low degree of cost sharing in Germany, with 12.7% of health spending coming from household out-of-pocket payments in 2019 (Fig. 3), below the EU average of 15.4%. User charges apply to inpatient stays, pharmaceuticals, some ambulatory services, dental care and most of all the health services related to long-term care. In particular, around one third of OOP expenditure is related to long-term care provided in inpatient facilities as the long-term care insurance scheme in Germany usually covers only part of the costs.

FIG. 1 TRENDS IN HEALTH EXPENDITURE, 2000–2019

Note:
GDP: gross domestic product;
PPP: purchasing power parity.

Source: WHO Global Expenditure Database, 2022.

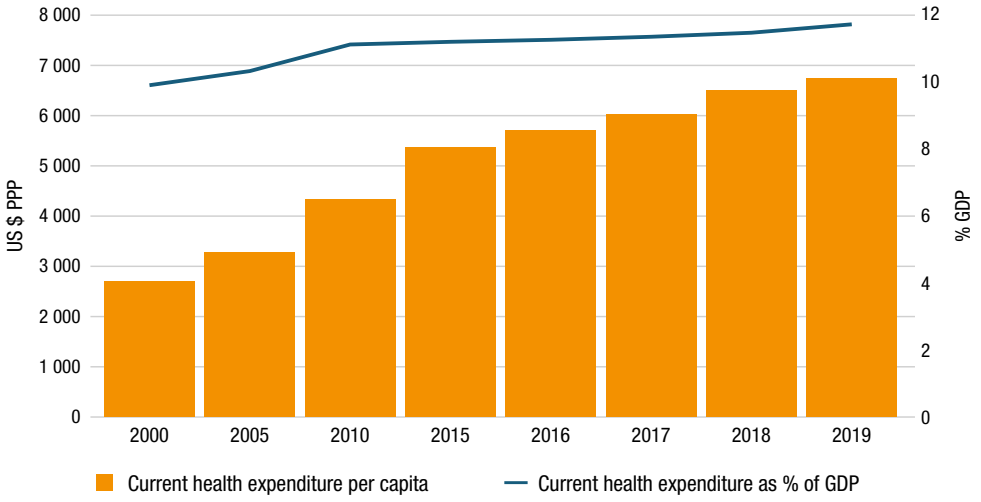


FIG. 2 CURRENT HEALTH EXPENDITURE (US$ PPP) PER CAPITA IN WHO EUROPEAN REGION COUNTRIES, 2019

Notes: CHE: current health expenditure; EEA: European Economic Area; EU: European Union; PPP: purchasing power parity.

Source: WHO Global Expenditure Database, 2022.

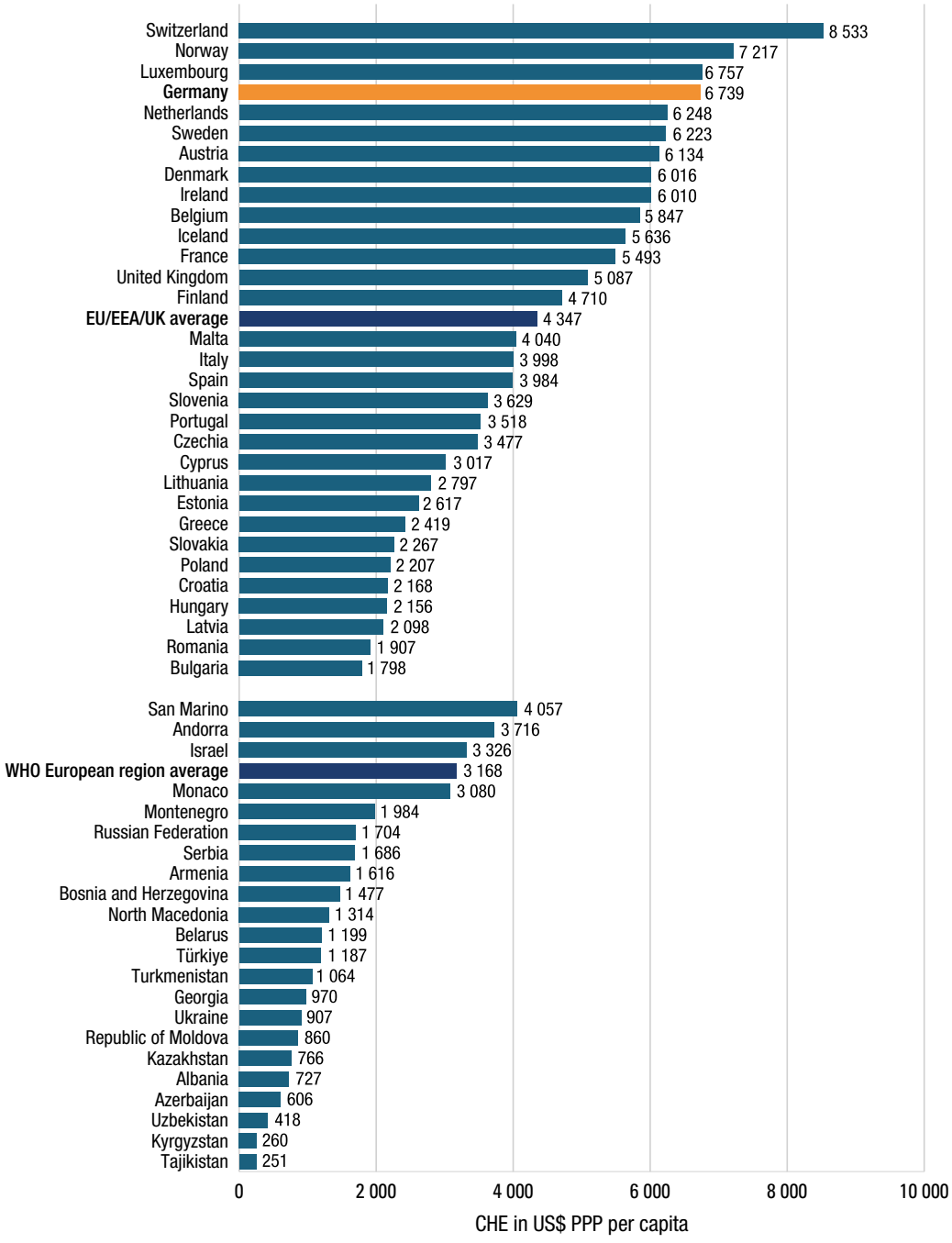
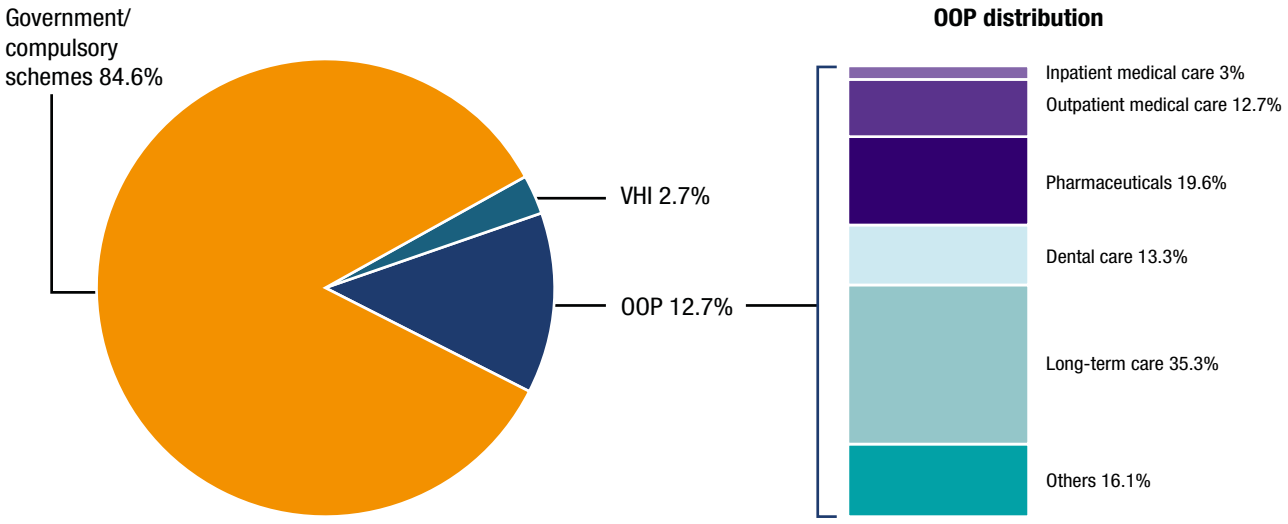


FIG. 3 COMPOSITION OF OUT-OF-POCKET PAYMENTS, 2019



Note: OOP: out-of-pocket; VHI: voluntary health insurance.

Sources: OECD Health Statistics; Eurostat Database, 2022 (data refer to 2019).

COVERAGE

Health insurance is compulsory in Germany and it is provided either under the SHI scheme or through substitutive PHI. Around 88% of the population is covered through SHI, while approximately 11% has substitutive PHI coverage (Box 2). Employees are usually insured in the SHI, but people whose income is above a fixed threshold or who belong to a certain professional group, e.g. the self-employed or civil servants, must or can opt to enroll in PHI for substitutive full coverage. SHI covers a broad benefits basket, well beyond essential services, and benefits are the same for all those insured. Individuals covered by substitutive PHI usually enjoy benefits equal to or better than those covered by SHI.

BOX 2 | WHAT ARE THE KEY GAPS IN COVERAGE?

Health insurance is mandatory in Germany, resulting in nearly universal coverage for residents. However, the complex coverage mechanisms mean that certain population groups are at risk of not having health insurance due to financial or administrative hurdles. One such group is low-income, self-employed people, since it can be difficult for them to afford SHI contributions or PHI premiums. To reduce the financial burden for this group and to close coverage gaps, SHI stipulations were changed in January 2019. The reference amount used to calculate the minimum contribution (irrespective of the actual income) was lowered from €2284 to €1038 per month.

PAYING PROVIDERS

Services in ambulatory SHI care, provided by office-based physicians (GPs and specialists), dentists, pharmacists, midwives and many other allied health professionals, are subject to predetermined price schemes (which are different for SHI and PHI patients) and are usually paid on a fee-for-service basis (Fig. 4). In the inpatient sector hospitals are mainly paid through case payments (Diagnostic-related groups, DRGs). Since 2018, hospitals providing psychiatric and psychosomatic services have been reimbursed via a specially tailored framework (the PEPP system) for day-based payments and covers inpatient as well as outpatient hospital services.

FIG. 4 | **PROVIDER PAYMENT MECHANISMS IN GERMANY**

GPs	Specialists	Acute Hospitals	Hospital Outpatient services	Dentists	Pharmacies
Contact capitation + fee for service	Contact capitation + fee for service	Mainly diagnosis-related groups (DRGs)	Mostly contact capitation or fee for service	Fee for service	Margin + fee for service

What resources are available for the health system?

Overall, the numbers of doctors and nurses have been rising in Germany but nevertheless there are health workforce shortages in key areas. Infrastructure investment, particularly in hospitals, has declined in some states

HEALTH PROFESSIONALS

Health care is an important employment sector in Germany, with almost 5.7 million people working in the health sector, accounting for 12.3% of total employment. With an average of 453 practising physicians and 1206 practising nurses per 100 000 population, Germany's health workforce in these two professions was well above the EU averages in 2021 (Fig. 5). But despite strong increases in the overall numbers of all health professionals over the past two decades, disparities in physician densities across states persist. In 2017 the Ministry of Labour reported a critical shortage of health workers, particularly for GPs, dentists, nurses, emergency care staff and midwives.

HEALTH INFRASTRUCTURE

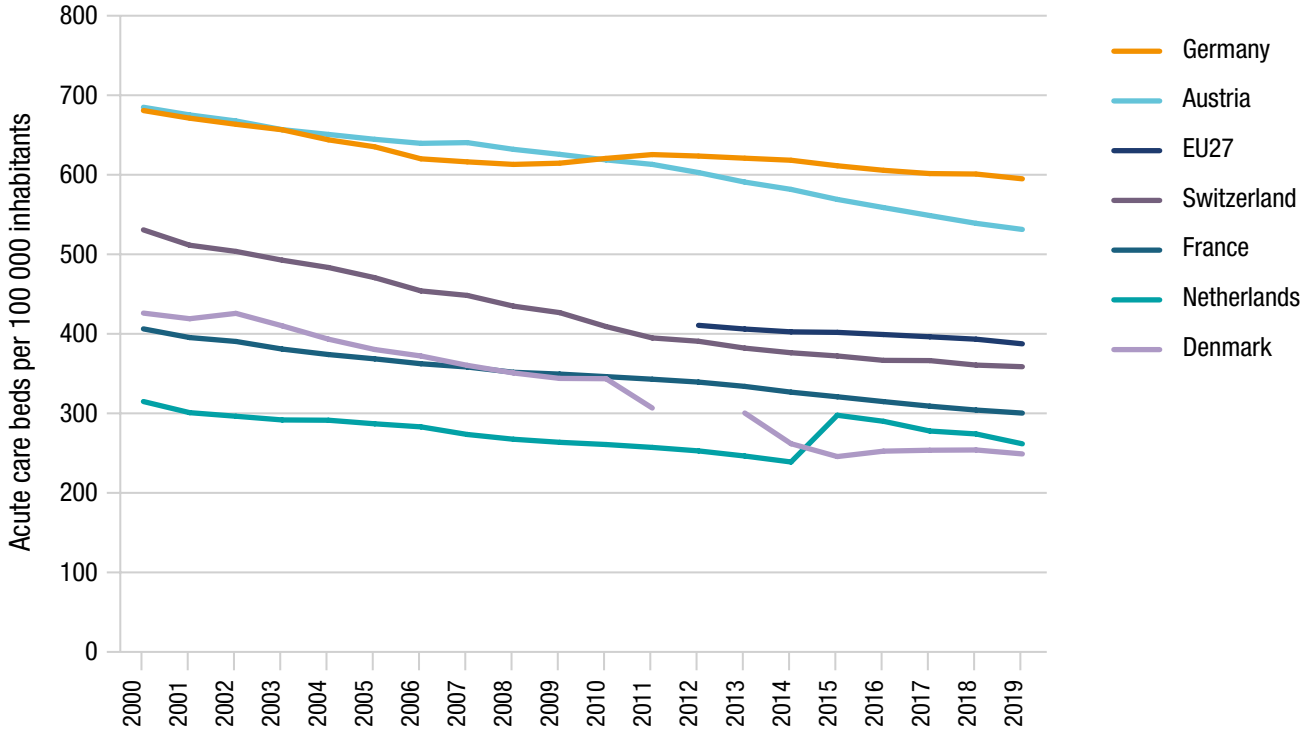
Germany has the second highest number of acute beds (595 per 100 000 population) in the EU, after Bulgaria (see also Fig. 6). There is a dense network of hospitals, with on average one hospital per 68 000 population, which ensures that there is a high level of availability of inpatient care. Virtually everyone in the country can reach an acute care hospital within 30 minutes by car; in urban areas 90% of people can do so within 15 minutes.

Nevertheless, discrepancies in hospital density persist between states, which are responsible for capital investment and hospital planning. In a variety of states there has been a decrease in capital investment over the past 20 years. In 2017 only around half of the estimated investment needs (e.g. for medical equipment or renovation) was met in the inpatient sector. Hospitals attempt to fill this investment gap through high activity levels and reimbursement of services by the sickness funds or by delaying renovation (such as the comprehensive modernization of IT-infrastructure). Germany is well-equipped with expensive diagnostic and therapeutic medical technologies in both hospitals and ambulatory care (Fig. 7). In comparison to other EU Member States, Germany had the highest density of MRI units per 100 000 population in 2018 and among the highest density of CT scanners.

FIG 5 PRACTISING NURSES AND PHYSICIANS PER 100 000 POPULATION, 2021 OR LATEST AVAILABLE YEAR

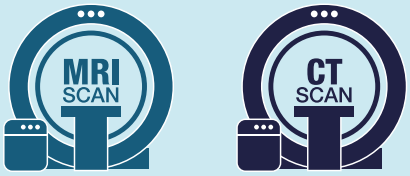
Source: Eurostat, 2022.

FIG. 6 BEDS IN ACUTE HOSPITALS PER 100 000 POPULATION IN GERMANY AND SELECTED COUNTRIES, 2000–2019



Source: Eurostat, 2022.

FIG. 7 MAGNETIC RESONANCE IMAGING (MRI) AND COMPUTED TOMOGRAPHY (CT) SCANNERS IN GERMANY

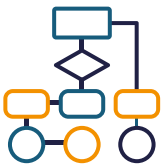


	MRI scanners per 100 000 population	CT scanners per 100 000 population
Germany	3.45	3.53
Range in EU countries	0.90 – 3.45	1.42 - 3.97

Note: Data is for 2018.
Source: Eurostat, 2022.

DISTRIBUTION OF HEALTH RESOURCES

Although Germany ranks among the highest in international comparisons for the number of health workers, the distribution of health professionals within the country varies greatly. Differences can be seen between the states in general and between urban and rural areas for physicians, dentists and psychotherapists. Moreover, the number of physicians in some specialties, such as GPs, is decreasing despite an increasing demand. This imbalance leads to a shortage of health workers and deficits in health care, especially in rural areas. Weaker infrastructure in rural areas reduces their attractiveness for health workers, mainly physicians in ambulatory care, as places to settle and practise. Several policy strategies have aimed at improving the number of health workers in rural areas: for example, allowing physicians in rural areas with a shortage to practise beyond the age of 68 and granting medical studies places to students who commit to practising as GPs in rural areas once they have qualified.



How are health services delivered?

The main challenges for the provision of care are the strong sectoral separation of services and the undersupply of some providers. Patients are free to choose their health provider for primary and hospital care

PRIMARY AND AMBULATORY CARE

Primary and ambulatory health care is mainly provided by private for-profit providers, including physicians, dentists, pharmacists, psychotherapists, midwives and allied health professionals. Except for a few specialties, e.g. radiology or laboratory services, patients can directly access ambulatory care specialists without a referral. Since 2004, sickness funds have been obliged to offer their insured the option of enrolling in a GP-centred model (*Hausarztzentrierte Versorgung*), and some provide a bonus for complying with the gatekeeping rules. Participation in these models is voluntary for both providers and insured (see Box 3). To improve the coordination of services provided by family physicians and specialists, structured treatment programmes, called Disease Management Programmes (DMPs), were introduced in 2003. DMPs aim to organize and coordinate the treatment and care of chronically ill patients across the boundaries of individual service providers, in line with individual patients' requirements, and in a more efficient manner.

BOX 3 | **WHAT ARE THE KEY STRENGTHS AND WEAKNESSES OF PRIMARY CARE?**

Germany has a well-developed outpatient sector with a high density of GPs and good access. For the majority of the population, the closest GP is less than 1.5 km away. Primary care has always been dominated by solo practice-based physicians. More recently, there has been a trend towards more cooperative structures, e.g. interdisciplinary medical care centres. The traditionally strong separation of ambulatory primary and specialist care on the one hand and ambulatory and inpatient care on the other leads to fragmented and uncoordinated service provision, especially in the absence of a gatekeeping system. Incentives to enhance coordination and collaboration have been introduced over the past two decades, but the quality of ambulatory care (as measured against avoidable hospital admissions) is still only moderate compared to other European countries.

HOSPITAL CARE

Due to the strict separation between the ambulatory care and the hospital care sectors, hospital services in Germany were restricted to inpatient settings for a long time. In the past 20 years the scope for hospitals to provide outpatient services has expanded significantly. German hospitals have been allowed to offer surgery on an ambulatory or day-case basis since 1993 with numbers steadily growing. Furthermore, ambulatory care for patients with certain rare diseases and diseases with severe progressive forms, as well as highly specialized services (e.g. CT/MRI-aided interventional pain therapy), are areas that largely take place in hospital settings. Currently, there are few structural incentives to promote greater integration of care (Box 4). Planning and regulation of treatment facilities for inpatients are carried out at the state level, but based on a federal legal framework. The content and methods of the so-called hospital requirement plans differ substantially between states.

PHARMACEUTICAL CARE

Pharmaceuticals are distributed through institutional and community pharmacies. Authorized mail-order and online pharmacies are subject to the same legal requirements and control mechanisms as traditional on-site pharmacies and are used predominantly to purchase OTC medicines. If pharmaceuticals are not labelled pharmacy-only, they can also be authorized to be sold by drugstores, health food stores, supermarkets and food retail markets. Since the benefits package includes all licensed prescription pharmaceuticals and there is no positive list of SHI-covered pharmaceuticals, most new and often very expensive pharmaceuticals are reimbursed. Current reform plans focus on the distribution of pharmaceuticals and improving access, e.g. via electronic prescriptions, repeat prescriptions, and fair competition between online pharmacies and local on-site pharmacies.

MENTAL HEALTH CARE

The focus on mental health care is growing and currently it has the third highest spending by disease category. The provision of services remains fragmented along the lines of ambulatory, inpatient and rehabilitative care. Ambulatory care for mentally ill adults and children is supported by an increasing number of office-based psychiatrists, neurologists and psychotherapists. The past 20 years have seen an increase in capacity through specialized hospitals and specialized mental health wards housed within general hospitals, as well as community-based institutions, especially supervised residential arrangements, ambulatory crisis intervention centres, and centres for psychosocial counselling and social support.

BOX 4 | ARE EFFORTS TO IMPROVE INTEGRATION OF CARE WORKING?

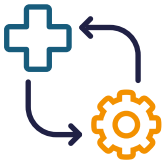
The German system separates provision of hospitals and ambulatory care, both in terms of organization and financing, leading to a clear split between these two types of care. Despite ongoing efforts to promote a patient-centred approach to care, there is a lack of incentives to enhance cross-sector collaboration.

Integrated care as a form of selective contracting between sickness funds and providers was introduced with the SHI Reform Act of 2000 and further strengthened with the SHI Modernization Act in 2004. Integrated care aims at cross-sector patient care to enhance service quality and cooperation between different providers within a sector and across sectors.

Sickness funds are required to negotiate selective contracts with single providers or a network of providers, as well as with pharmaceutical and medical device manufacturers. However, participation in integrated care projects is voluntary for the insured. As registering integrated care projects is not mandatory, there are no current figures about the number of contracts.

DENTAL CARE

Dental care is primarily delivered by privately owned dental practices, the vast majority of which are solo practices and about one fifth being team-based/group practices. Dental care is subject to explicit cost sharing in SHI and as SHI does not fully cover dental benefits, supplementary insurance plays an important role. Prophylactic treatments and basic dental care are covered by the sickness funds for all insured. Conservative surgical treatment and X-ray services are also included in the benefits package if used in the case of dentures and superstructures. Furthermore, SHI covers services of single and group prophylaxis of children up to 16 years of age in pre-schools and schools; prevention of dental diseases in care-dependent patients and patients with disabilities; and early detection examinations for children up to the age of 6 years.



What reforms are being pursued?

Policy developments have focused on equal access to ambulatory care, quality assurance in hospital inpatient care and strengthening care coordination

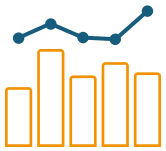
Since 2012 the German health care system has been mainly characterized by stability and adherence to the basic structures and principles of statutory health insurance. Nonetheless, the frequency of legislative changes is extraordinarily high. In most cases this activity is focused on incremental changes and implementation measures within individual sectors rather than landmark reforms, which were seen in previous times (Box 5).

Key areas of change have been in assuring equal access to ambulatory care, quality assurance in inpatient care, and strengthening coordination of care (i.e. disease management programmes for 10 chronic diseases, integrated care and strengthened competencies of GPs). Another reform area has been the curricula, training and qualification requirements for health personnel. The reforms to the national standards for curricula and examination are structured according to individual health professions and aimed at securing a sustainable health professional workforce.

Digitalization of the German health care system has been a major reform undertaking. At the core of this drive is the implementation of the electronic health card and a secure data exchange network among providers. Implementation of the original 2005 legislation on the electronic health card stalled, but picked up speed in 2019 and 2020. Since 2015 the use of electronic health cards has been compulsory for people to be entitled to SHI benefits, while a basic roll-out of card readers and other technical equipment in physician, dentist and psychotherapist practices was completed in July 2019.

BOX 5 | **KEY HEALTH SYSTEM REFORMS OVER THE LAST 10 YEARS**

- **2012** – Abolition of Co-payment per Physician Visit Act. Long-term Care Realignment Act
- **2013** – Patients' Rights Act
- **2015** – Healthcare Strengthening Act, Act to Strengthen Health Promotion and Disease Prevention, Reforms of Hospital Structures Act, E-health Act
- **2016** – Transplant Registry Act, Third Strengthening Long-Term Care Act
- **2017–2019** – Nursing Care Professions Act, Nursing Staff Empowerment Act, Increased Salaries for Nursing Professionals Act
- **2019** – Digital Provision Act
- **2020** – Intensive Care and Rehabilitation Strengthening Act, Patient Data Protection Act



How is the health system performing?

HEALTH SYSTEM PERFORMANCE MONITORING AND INFORMATION SYSTEMS

There is good overall access to health services of high quality, even if some challenges remain

At a system-wide level, performance reporting is hindered by the fragmentation of databases, the variety of stakeholders and their focus on either specific diseases or particular aspects of the health system. Even though there is a broad information basis for Health System Performance Assessment (HSPA) in Germany, information on some sectors (e.g. palliative care) is largely missing and thus cannot be used to inform health system performance reporting. A current initiative by the Federal Ministry of Health is piloting an HSPA of the German health care system, which should also address the issue of missing data availability.

At the national level, the introduction of the electronic health card is by far the most important project for the standardized exchange of information across health care sectors (see section on reforms). The eGK is designed to allow medical data to be stored in future expansion stages, such as emergency data (e.g. diagnosis, medications, allergies, contact details of GP or family members), an electronic patient file (obligatory from January 2021), medication plans and organ donation declarations, or a patient's living will (advance directives for medical treatment). Except for the mandatory administrative data, patients can voluntarily decide which parts of their medical data are accessible to different medical providers via the eGK.

ACCESSIBILITY AND FINANCIAL PROTECTION

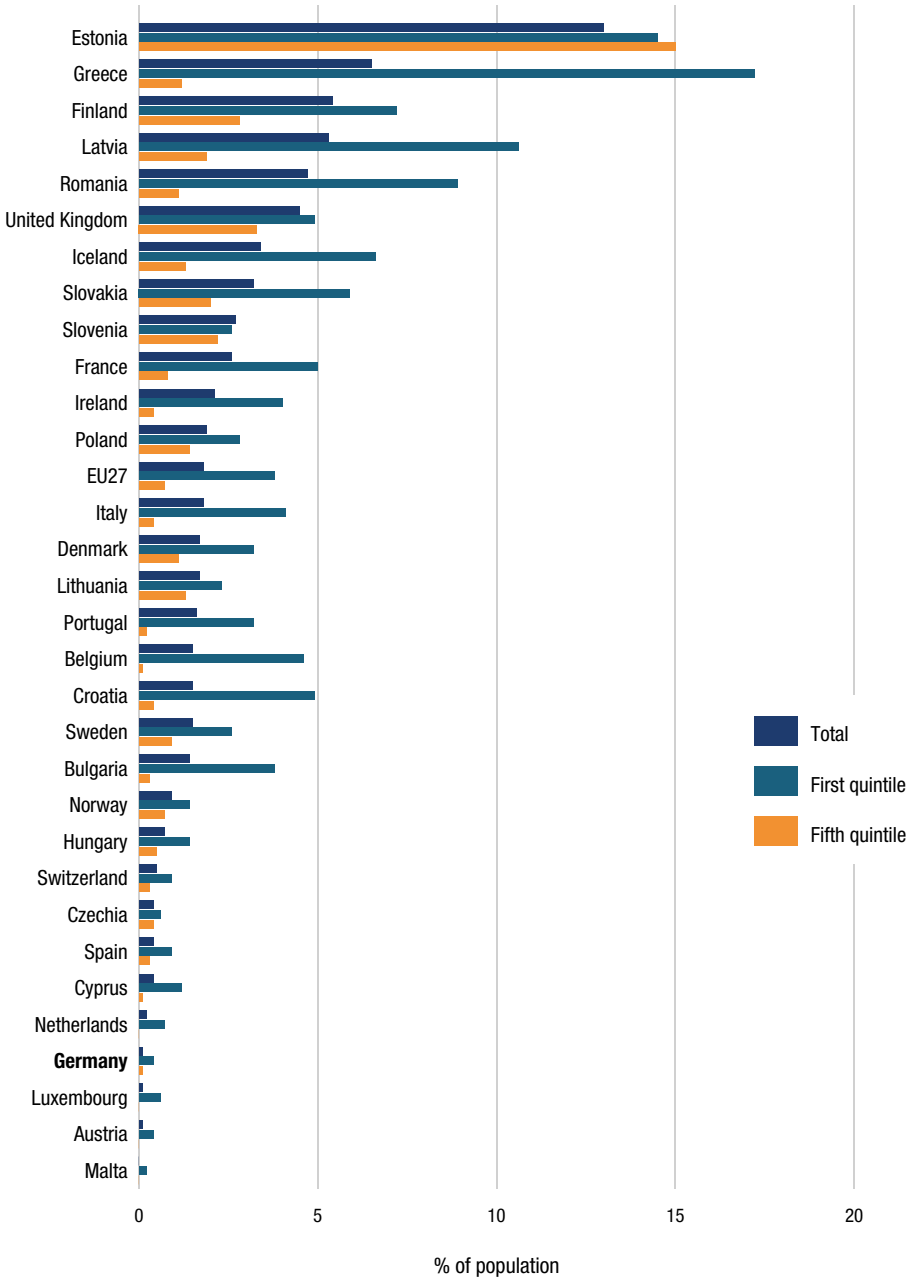
Germany provides universal health coverage to its population with a broad benefits package and low cost-sharing requirements. A dense network of health care providers ensures overall high availability of services across the country, albeit with lower accessibility in rural areas. The results of surveys show that reported unmet needs for medical care are very low (Fig. 8). What is more, current reforms aim to improve access to out-of-hours care, e.g. by establishing appointment service centres, and to enforce the legal mandate to take out either SHI or substitutive PHI.

The comparatively low share of out-of-pocket payments in health financing and financial safety nets contribute to strong financial protection for the population. Current legislature has implemented measures to protect low-income sections of the population and the chronically ill from excessive financial burdens, placing a ceiling on co-payments applicable to them. Furthermore, children under 18 years of age are generally exempt from co-payments. Consequently, levels of catastrophic health expenditure among the population are lower than in most other European countries.

FIG. 8 UNMET NEEDS FOR A MEDICAL EXAMINATION (DUE TO COST, WAITING TIME OR TRAVEL DISTANCE), BY INCOME QUINTILE, EU/EEA COUNTRIES, 2020

Note: EEA: European Economic Area; EU: European Union. Data refer to 2020 except for Italy (2019), Iceland (2018) and United Kingdom (2018).

Source: Eurostat (2021), based on EU-SILC.



HEALTH CARE QUALITY

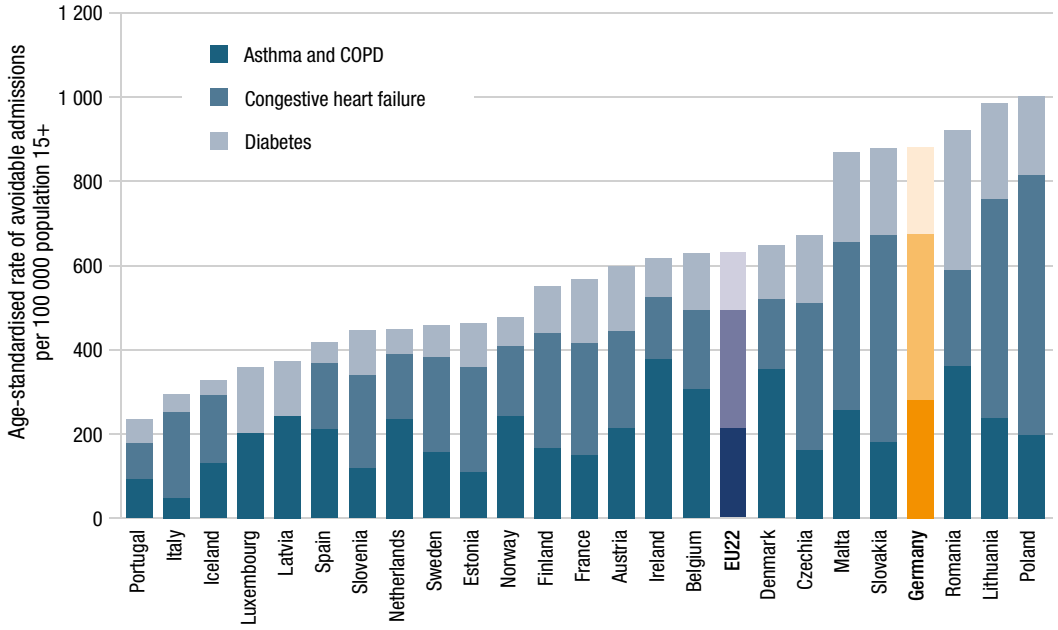
In terms of quality assurance, the Institute for Quality Assurance and Transparency in Healthcare (IQTIG) was founded in 2015 specifically to develop cross-sectoral quality indicators, all with the aim of improving the quality of care, and to link health and quality outcomes with the planning and payment of service providers.

The quality of primary and ambulatory care received by Germans is comparable to that in neighbouring countries (see also Box 6) but against specific metrics like avoidable hospital admissions for conditions that could be treated in primary care, there is room for improvement. For example, although rates for avoidable admissions between 2015 and 2019 fell for asthma and COPD (-0.9%), congestive heart failure (-2.4%) and for diabetes (-5.6%), they were still relatively high compared with other European countries for which data are available (Fig. 9). *

The quality of inpatient hospital health care, as measured by a set of defined indicators, has improved overall since 2000. Nevertheless, the results are mixed. While Germany scores comparatively well in the medical care of patients who have suffered a stroke, the results for hospital mortality within 30 days after admission for an acute myocardial infarction (AMI) (8.3% in 2020) are higher in Germany than in neighbouring countries such as Denmark (4.5%), the Netherlands (2.9%), France (5.6%) and Austria (6.6%).

* These high hospital admission rates might be partly explained by disease prevalence, but are also likely due to insufficient coordination, continuity and collaboration between the ambulatory and inpatient sectors.

FIG. 9 AVOIDABLE HOSPITAL ADMISSIONS FOR ASTHMA AND CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CONGESTIVE HEART FAILURE AND DIABETES, 2019



Note: Data for congestive heart failure not available in Latvia and Luxembourg.

Source: OECD Health Statistics, 2021 (data refer to 2019 or nearest year).

BOX 6 | WHAT DO PATIENTS THINK OF THE CARE THEY RECEIVE?

A Commonwealth Fund survey of user experiences found that in 2017, 85.8% of surveyed over the age of 16 years reported that they spent enough time with their regular doctor during a consultation (down from 92% in the 2010 survey wave, and 88.4% in 2013), ranking higher than the corresponding OECD average (80.6%). Also in 2017, 84.3% reported that they received easy-to-understand explanations from their regular doctor (down from 94.7% in 2010). Finally, 87.2% of those surveyed reported that they were involved in decision-making about their care and treatment, compared to the Netherlands (91.3%) and Switzerland (88.9%); the OECD average was 83.6% (Commonwealth Fund, 2016).

HEALTH SYSTEM OUTCOMES

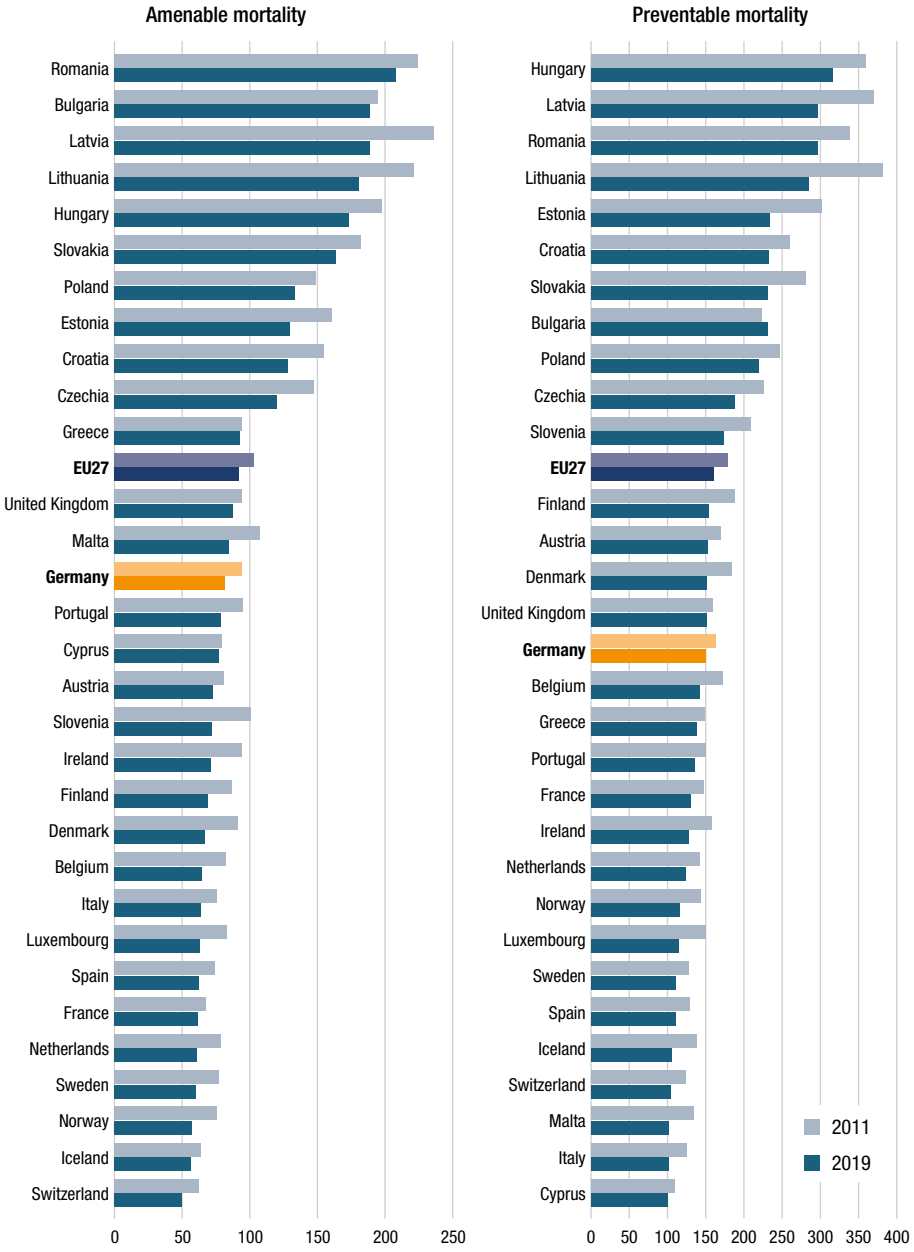
Population health outcomes, reflected by rates of amenable mortality (otherwise known as treatable mortality) have improved over the past decade and are lower than the EU average (Fig. 10). The leading causes of these deaths that could be avoided through timely and effective health care interventions (including secondary prevention and treatment) are ischaemic heart disease, colorectal cancer and breast cancer. The extent to which changes in amenable mortality are due to health care or health policy factors is difficult to determine. Regarding treatable diseases, the introduction of Disease Management Programmes (DMPs) to improve the quality of care for patients with chronic diseases is certainly worth mentioning as they are based on the provision of coordinated and structured care, following clinical guidelines, and seek to strengthen patients' self-care competencies in order to control the course of their disease and reduce mortality.

In terms of preventable mortality (that is, deaths from causes that could be avoided through public health policies and prevention) these rates have also improved, although Germany does not perform as well as many other western European countries. Such preventable deaths are mainly attributable to lung cancer, alcohol-related disease, ischaemic heart disease and chronic lower respiratory disease, which particularly underline the important role of public health interventions aimed at regulating tobacco and alcohol use (see Box 7).

FIG. 10 AMENABLE AND PREVENTABLE MORTALITY PER 100 000, GERMANY AND EU COUNTRIES, 2000 AND 2019 OR LATEST AVAILABLE YEAR

Note: EEA: European Economic Area; EU: European Union. Data refer to 2020 except for Italy (2019), Iceland (2018) and United Kingdom (2018).

Source: Eurostat (2021), based on EU-SILC.



BOX 7 | ARE PUBLIC HEALTH INTERVENTIONS MAKING A DIFFERENCE?

With regard to preventable deaths, smoking is a major contributor to preventable mortality. Smoking rates in Germany have decreased among adults and adolescents over the past decade, but are still higher than in many other EU countries (OECD/European Observatory on Health Systems and Policies, 2019). Germany has lagged behind other countries with regard to tobacco regulations, and was the last country in the EU to prohibit billboard advertising for tobacco, which was finally banned in January 2022. The prohibition will also apply to e-cigarette advertising from 2024. Furthermore, measures to prevent people from smoking in public places vary between states, ranging from weak regulations to full smoking bans in all public institutions. A new challenge is the use of e-cigarettes and shisha pipes.

More generally, primary prevention measures, screening and early detection services in Germany, are delivered mainly by SHI physicians; these include cancer screening and regular check-ups such as screening for cardiovascular disease, renal disease and diabetes. For children and adolescents, SHI ensures regular check-ups, along with screening for specific diseases (eg. pulse oximetry screening, cystic fibrosis) as well as the administration and monitoring of immunizations. Since March 2020 vaccination against measles has been mandatory for medical staff as well as children, adolescents and staff in community facilities (e.g. childcare, schools, asylum seekers' homes). The law stipulates that non-vaccinated children can be excluded from visiting childcare facilities, but not from school. Non-vaccinated personnel may not take up any activity in community or health facilities. In addition, states can impose penalties for non-compliance.

HEALTH SYSTEM EFFICIENCY

Germany has large human, technical and infrastructural capacities at its disposal and makes frequent use of these resources. Utilization of both inpatient and outpatient care is high. The allocation of resources at the federal level mostly reflects the bargaining process between corporatist bodies, rather than a restrictive budget plan. Although there are mechanisms in place to secure the (cost-)effectiveness of benefits covered under SHI using tools such as Health Technology Assessment, there is no priority setting by, for example, formulating goals.

At a very general level, it is clear that in terms of the quantity of services provided, Germany's health system ensures a high level of care for almost the entire population. If we only consider activity of the health system, such as the number of hospital days, number of performed inpatient procedures, number of diagnostic procedures and the number of ambulatory consultations as outputs of the health system, the overall activity level is outstanding and higher than (or comparable to) neighbouring countries for each indicator. Set against the inputs to the health system, such as human resources and health expenditure, this suggests an overall good level of technical efficiency. However, there are some indications of oversupply of services, a phenomenon that is also visible in high pharmaceutical consumption (Box 8).

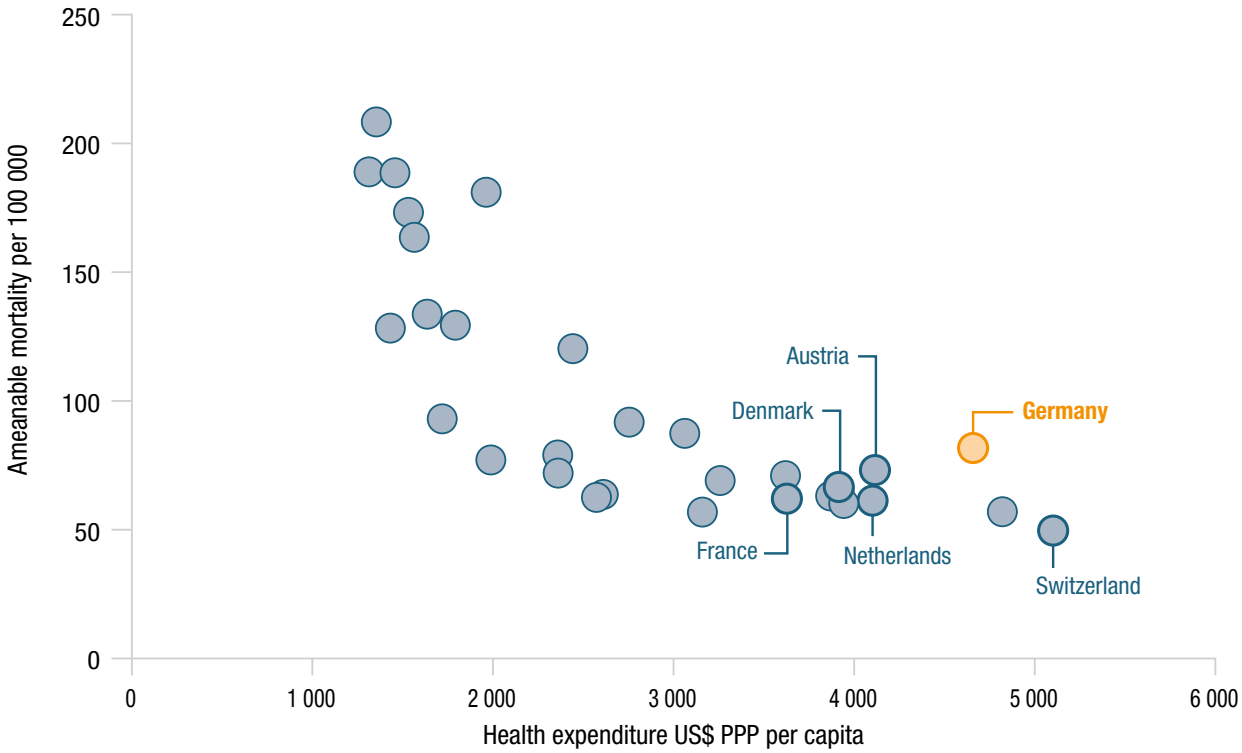
A very cursory illustration of how the health system is performing in terms of input costs and outcomes is achieved by plotting current expenditure on health against the amenable mortality rate. Although we must be mindful that it is not possible to effectively disentangle the role of health behaviours and other determinants of the health care system in influencing the level of amenable mortality, Fig. 11 provides a useful point for discussion. Germany's amenable mortality rate has been falling continuously, but it has remained higher than in neighbouring countries; at the same time, the country is among the highest health spenders in Europe. The results suggest that the other countries have been able to secure better outcomes on this metric at lower cost.

BOX 8 | IS THERE WASTE IN PHARMACEUTICAL SPENDING?

Germany has the highest per capita expenditure on pharmaceuticals in the EU (OECD, 2022). Between 2004 and 2015 the consumption of prescribed defined daily doses (DDD) increased by more than 50% (Busse et al., 2017). This has been raising concerns about oversupply and adequacy of care. Policies targeting rising expenditures and the efficiency of pharmaceutical care include the early benefit assessment, introduced in 2011, which requires manufacturers of newly licensed pharmaceuticals to prove the potential added benefit over existing pharmaceuticals in the first 12 months after market authorization. The Federal Association of Sickness Funds negotiates a reimbursement amount with the manufacturer for pharmaceuticals with added benefit. This price-setting mechanism aims to ensure that pharmaceutical prices are economically efficient without inhibiting innovation. However, during the pharmaceutical's first year on the market, manufacturers can determine the price freely and without restriction, potentially leading to high SHI expenditure for some innovative medicines.

Although pharmaceutical prices are high, Germany has been successful at shifting pharmaceutical consumption to generics. The market shares of generics by volume and by value are among the highest in comparison with other EU and OECD countries. Nevertheless, despite the increased use of generics, the overall volume expansion of pharmaceuticals (including branded medicines) means that there has not been a decrease of overall SHI expenditures for pharmaceuticals.

FIG. 11 AMENABLE MORTALITY PER 100 000 POPULATION VERSUS HEALTH EXPENDITURE PER CAPITA, GERMANY AND SELECTED COUNTRIES, 2019



Note: PPP: purchasing power parity. Data is for 2019 except for France (2017), Malta (2018) and United Kingdom (2018).

Source: Eurostat, 2022.

Summing up

Strong silos of care and complex stewardship are among the main health system challenges

The German health care system is often regarded as one of the best health care systems in the world, offering its population universal health insurance coverage and a comprehensive benefits basket with comparably low cost-sharing requirements. It provides good access to care with free choice of provider and short waiting times, which is partly due to good infrastructure with a dense network of ambulatory care physicians and hospitals, and a quantitatively high level of service provision. On the other hand, it is an expensive system, with the second highest per capita spending among EU countries in 2019, and given the high volumes of care, there are questions about oversupply of services, as well as some comparatively moderate health and quality outcomes.

Additional challenges for the health system may be identified in:

- the strong separation of ambulatory and inpatient care in terms of organization and payment, which tends to hinder the coordination and continuity of patient treatment;
- the coexistence of SHI and substitutive PHI, which weakens the principle of solidarity;
- and a complex stewardship framework which promotes incrementalism and makes it more difficult to implement reforms.

POPULATION HEALTH CONTEXT

KEY MORTALITY AND HEALTH INDICATORS

LIFE EXPECTANCY (YEARS)	
Life expectancy at birth, total	81.1
Life expectancy at birth, male	79.0
Life expectancy at birth, female	83.7

MORTALITY (SDR PER 100 000)	
All causes	1 030.2
Circulatory diseases*	373.6
Malignant neoplasms*	245.9
Communicable diseases*	19.02
External causes*	46.17
Infant mortality rate (per 1 000 live births)	3.2
Maternal mortality rate (per 100 000 live births)	7

Notes: *Age-adjusted rates with the European standard population 2010. Life expectancy data are for 2020. Mortality data are for 2019. Infant mortality data are for 2019. Maternal mortality data are from 2017.

Source: Eurostat, 2021; World Bank, 2022 for maternal mortality.

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