Germany

Health system summary 2024

European Observatory on Health Systems and Policies
a partnership hosted by WHO

Authors

Miriam Blümel
Anne Spranger
Katharina Achstetter
Philipp Hengel
Astrid Eriksen
Anna Maresso
Reinhard Busse

Anna Maresso (Series Editor)

Contents

This Health System Summary is based on the *Germany: Health System Review* (HiT) 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 edition of the Health System Summary, key data have been updated to those available in September 2024 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.

Main sources:

Blümel M, Spranger A, Achstetter K, Maresso A, Busse R (2020). Germany: Health system review. *Health Systems in Transition*, 22(6): pp.i–273.

Health Systems and Policy Monitor (HSPM) – Germany (2024). European Observatory on Health Systems and Policies, https://eurohealthobservatory.who.int/monitors/health-systems-monitor.

Please cite this publication as: Blümel M, Spranger A, Achstetter K, Hengel P, Eriksen A, Maresso A, Busse R. *Germany: Health System Summary, 2024*. Copenhagen: European Observatory on Health Systems and Policies, WHO Regional Office for Europe; 2024. Licence: CC BY-NC-SA 3.0 IGO.

ISSN 2958-9193 (online)

ISBN 9789289059954 (PDF)

How is the health system organized?

One of the most notable features of Germany's decentralized health system is the delegation of governmental power to corporatist bodies within the statutory health insurance system

Organization

The health system in Germany serves a population of 84.7 million (2023) (Federal Statistical Office, 2024). Health insurance in Germany is compulsory and is provided either through statutory health insurance (SHI) or substitutive private health insurance (PHI).

The governance of the health system is complex and decentralized, involving both the federal and state levels, as well as corporatist bodies of self-governance (Box 1). The Federal Ministry of Health (MoH) sets the overarching legal framework, while the 16 state governments manage tasks such as hospital planning, public health services and supervising regional associations of sickness funds and outpatient care providers. A key feature of Germany's decentralized health care system is the delegation of governmental power to corporatist bodies, such as associations of providers and sickness funds, within the SHI system. The Federal Joint Committee, the main decision-making body, comprises 13 members, several subcommittees and external expert consultations. Public health, ambulatory, inpatient and long-term care systems are regulated by different laws, resulting in separate organization, financing and reimbursement structures for each sector.

Box 1 Capacity for policy development and implementation

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 MoH) are responsible for setting the legal framework and for the supervision of the main corporatist bodies. Corporatist bodies within the SHI system play an important role in decision-making. These organizations 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. Most 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.

Planning

Responsibilities for health system and health service planning in Germany are divided among the federal government, states and various corporatist institutions, without a national health plan guiding overall policy development. The federal government mainly uses high-level regulations and soft guidance through recommendations to shape the different aspects of services. The states are responsible for hospital planning, while the regional associations of SHI physicians are responsible for providing outpatient physician care. The municipalities organize public health services.

Providers

Most health service providers in Germany serve SHI and PHI patients, allowing individuals to choose their physicians, general practitioners (GPs) and specialists, freely. GPs are typically the first point of contact with the health system, and although their role in patient coordination has grown, they are not official gatekeepers. Private for-profit providers mainly offer primary and ambulatory health care, while the extensive hospital network includes public, private not-for-profit and for-profit institutions.

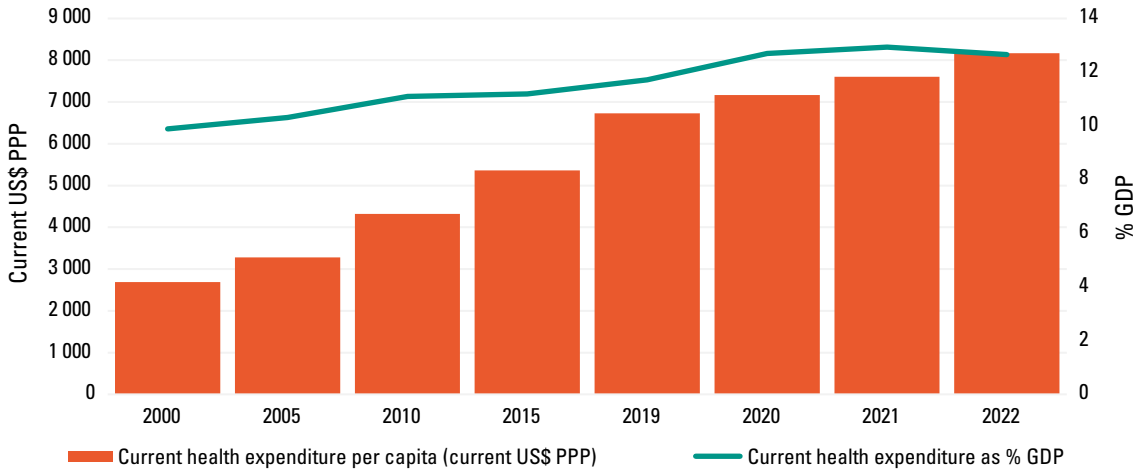
How much is spent on health services?

The majority of the population pays statutory health insurance contributions to one of 95 sickness funds

Funding mechanisms

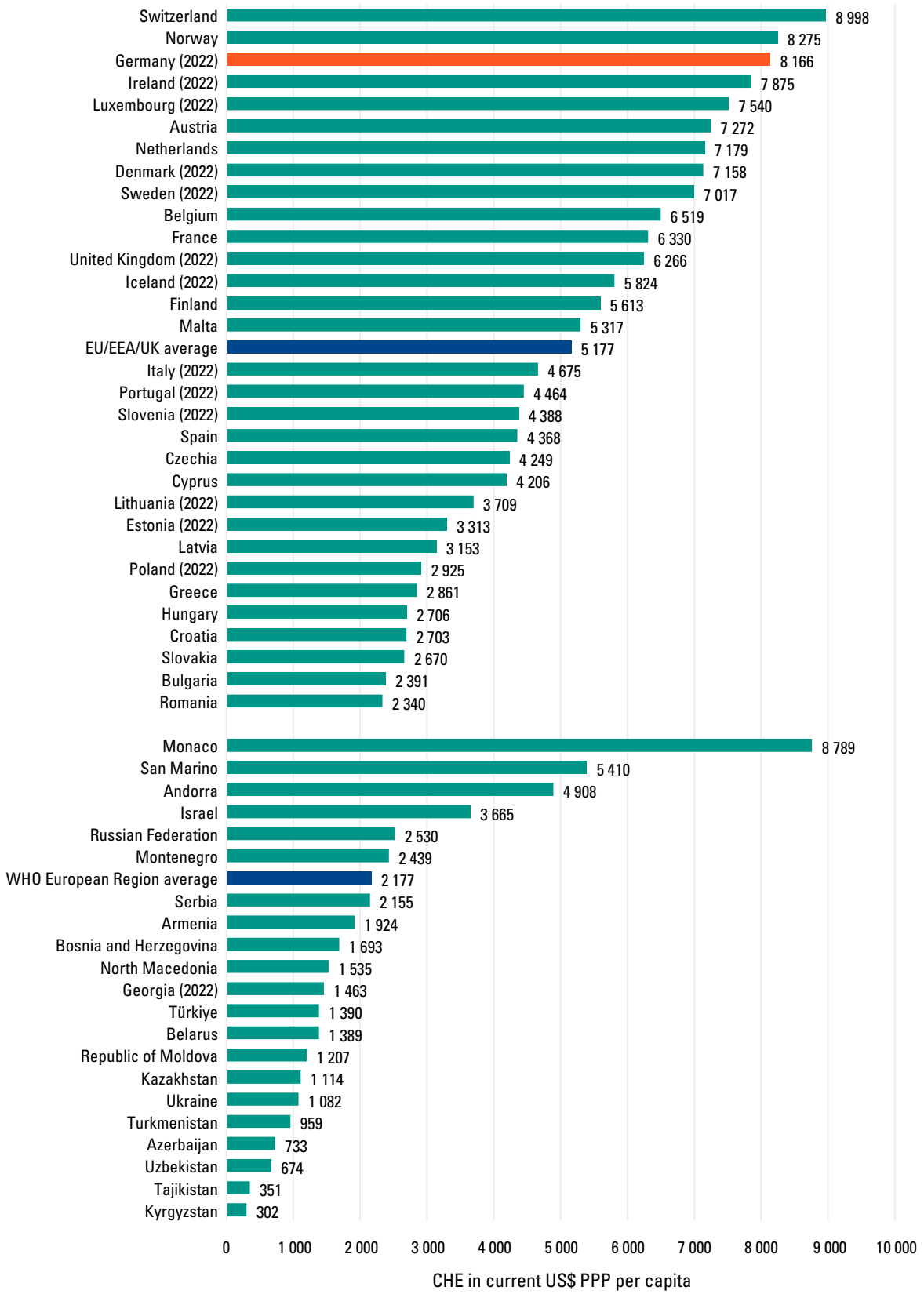
Health care in Germany is primarily funded through the SHI system, which in 2024 comprised 95 sickness funds. The sickness funds collect contributions, which are pooled and reallocated via the *Gesundheitsfonds* based on risk adjustment. The general fixed SHI contribution rate is 14.6% of gross income and in addition sickness funds can charge a supplementary contribution which is, on average, 1.7% in 2024. Both contributions are equally split between employer and employee. Unlike SHI, PHI premiums are based on age and health risk profiles rather than income. There are 52 PHI companies. General tax revenue also funds various purposes in the health care system, with legislatures determining budgets at both federal and state levels. Capital investments in hospitals come from states' budgets.

Fig. 1 Trends in health expenditure, 2000–2022 (selected years)



Notes: GDP: gross domestic product; PPP: purchasing power parity.
Source: WHO, 2024.

Fig. 2 Current health expenditure (US$ PPP) per capita in WHO European Region countries, 2021 or latest available year



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

Source: WHO, 2024.

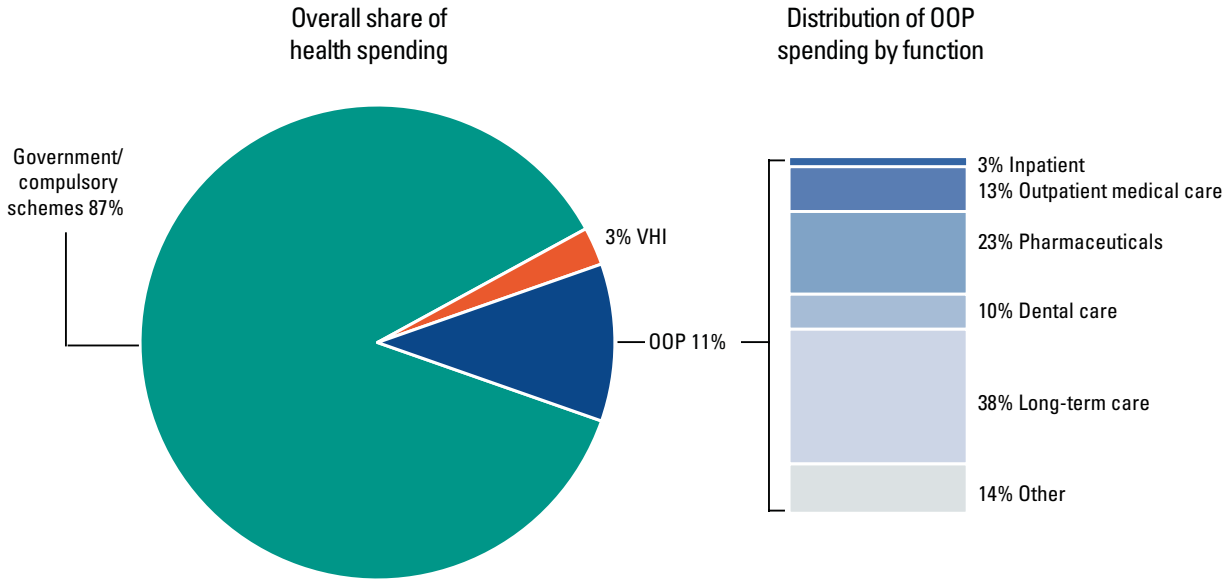
Health expenditure

Total health spending in Germany has increased since 2000, and has remained above 11% of GDP since 2010. In 2022, Germany spent 12.7% of its GDP on health (Fig. 1). Current health expenditure per capita reached a new high in 2022 as the country devoted US$ 8166 (adjusted for differences in purchasing power) to health, which is the highest among EU countries and one of the highest within the WHO European Region (Fig. 2). In 2022, public expenditure on health as a share of current health expenditure was 87%. Complementary and supplementary voluntary health insurance (VHI) play a small role in the German health system, accounting for 3%, while 11% comes from out-of-pocket (OOP) payments (Fig. 3).

Out-of-pocket payments

OOP payments account for a modest share of health expenditure. In 2022, the majority of OOP payments went to long-term care (38%), followed by pharmaceuticals (23%), outpatient medical care (13%), and dental care (10%). Germany has one of the highest shares of OOP payments for long-term care and one of the lowest for dental care among EU countries. The relatively high proportion of health-related OOP payments for long-term care in Germany results from the fact that statutory long-term care insurance covers only a portion of the costs.

Fig. 3 Composition of out-of-pocket payments, 2022



Notes: OOP: out-of-pocket; VHI: voluntary health insurance.
Source: OECD, 2024.

Coverage

Health insurance has been mandatory in Germany since January 2009. It is provided either under the SHI scheme or through substitutive PHI. SHI covers around 89% of the population, while approximately 11% has purchased substitutive PHI. Employees are usually insured with SHI, but people whose income is above a fixed threshold or who belong to a certain professional group, such as the self-employed or civil servants, can opt to enroll in PHI for substitutive full coverage.

Approximately 61 000 people, or 0.08% of the German population, were uninsured in 2019. The uninsured mainly include low-income self-employed people, and wealthy people who object to having health insurance (see Box 2). SHI offers a wide range of benefits beyond essential services, with the same coverage for all insured. Those with substitutive PHI typically receive 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, ensuring nearly universal coverage for residents. However, certain population groups, such as low-income self-employed people, face financial or administrative barriers to accessing health care. To reduce the financial burden for this group and to close coverage gaps, the SHI minimal contribution calculation was changed in January 2019, lowering the reference amount from €2284 to €1038 per month. In 2024, the reference amount was €1178. Those who miss 3 months of PHI premiums receive reduced benefits, limited to emergency and maternity care. Asylum seekers in their first 18 months of stay, refugees, and undocumented migrants often receive only emergency and maternity care, but access to care can be complex.

Paying providers

Ambulatory SHI care services provided by office-based physicians (GPs and specialists), dentists, pharmacists, midwives and many other allied health professionals are subject to predetermined price schemes, differing for SHI and PHI patients. They are usually paid on a fee-for-service basis (Fig. 4). In the inpatient sector, hospitals are primarily paid through case payments (diagnosis-related groups, DRGs). However, the government is currently working on a major hospital reform which, among other measures, will introduce a flat fee covering 60%, while the remaining 40% will continue to be remunerated via 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 which covers inpatient as well as outpatient hospital services.

Fig. 4 Provider payment mechanisms in Germany

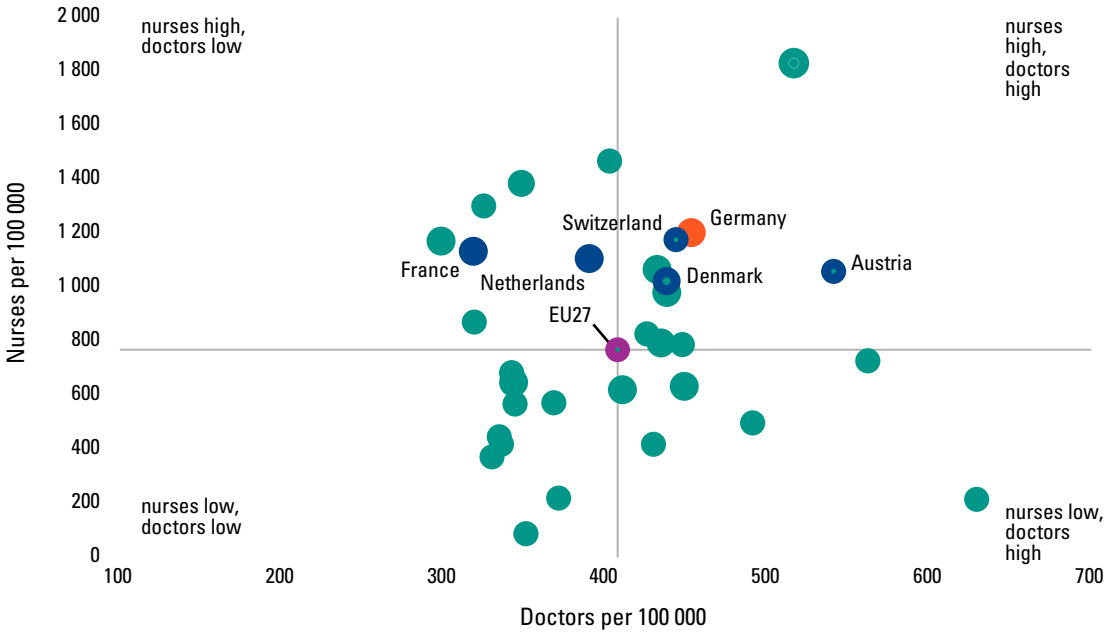
What resources are available for the health system?

The government has set up a commission to tackle concerns about efficiency and overcapacity in the German hospital sector

Health professionals

Germany has more nurses and doctors per capita than the EU averages (Fig. 5). In 2021, there were 1203 nurses and 453 doctors per 100 000 population compared to 770 and 407, respectively among EU countries. Despite having one of the highest densities of nurses per capita in the EU, Germany's nurse-to-bed ratio remains one of the lowest in the EU. Concerns over nursing staff levels in hospitals, exacerbated by the introduction of the DRG-based hospital payment system in 2004, led to reforms that excluded nursing costs from DRG fees from 2020 onwards, and legislation mandating minimum nursing staff levels in hospitals by 2025.

Fig. 5 Practising nurses and physicians per 100 000 population, 2021



Note: Nurse numbers are for practicing nurses (with EU recognized qualifications).
Source: Eurostat, 2024.

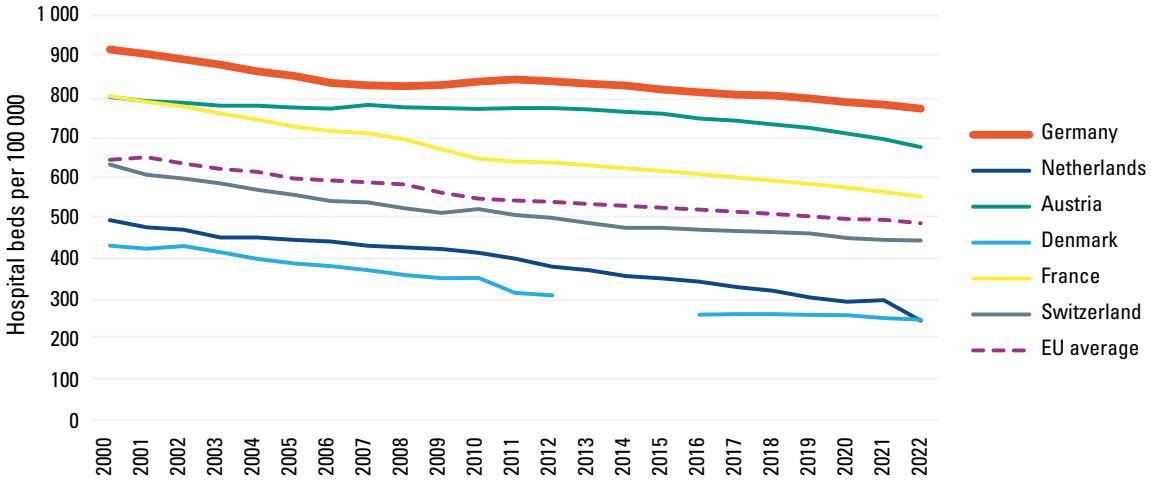
Health infrastructure

Germany has a comparatively large hospital inpatient sector, with 766 hospital beds per 100 000 population in 2022, compared to neighbouring countries such as the Netherlands (245), Denmark (248), Switzerland (442) and the EU average of 485 (Fig. 6). This high number of hospital beds raises concerns about efficiency and overcapacity. To address these issues and promote more outpatient services while ensuring

quality, a new government commission has proposed revising hospital remuneration and developing a new tool for hospital planning.

Furthermore, discrepancies in hospital density persist between states, which are responsible for capital investment and hospital planning. Some states have reduced capital investment over the past 20 years. In 2017, only about half of the estimated investment needs (such as for medical equipment or renovation) were met in the inpatient sector. Hospitals attempt to fill this investment gap through high activity levels, reimbursement from sickness funds or by delaying renovation such as the IT-infrastructure modernization. Germany is well equipped with expensive diagnostic and therapeutic medical technologies in both hospitals and ambulatory care. The density of MRI units and CT scanners per 100 000 population Germany in 2022 was in the higher range among EU countries (Fig. 7).

Fig. 6 Hospital beds per 100 000 population in Germany and selected countries, 2000–2022



Source: Eurostat, 2024.

Fig. 7 Magnetic resonance imaging (MRI) and computed tomography (CT) scanners in Germany, per 100 000 population, 2022

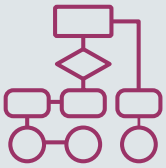
	MRI scanners per 100 000 population	CT scanners per 100 000 population
Germany	3.5	3.6
Lowest and highest in EU (range)	0.6 (Hungary) - 3.7 (Greece)	1.1 (Hungary) - 4.9 (Greece)

Source: Eurostat, 2024

Distribution of health resources

Despite Germany having high numbers of health professionals, there is significant variation in their distribution across the country. Differences exists between states and between urban and rural areas for physicians, dentists and psychotherapists. Furthermore, even while the total number of physicians is growing, increasing demand due to demographic trends, for example, can barely be met because of factors such as the growing numbers of doctors working part-time. Moreover, weaker infrastructure in rural areas reduces the attractiveness of these areas for health professionals (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 experiencing shortages to practise beyond the age of 68 years, and granting medical degree places to students who commit to practising as GPs in rural areas for a set period of time after qualification, which varies between the federal states (for example, 5 years in Bavaria).

How are health services delivered?



The primary challenge in delivering care includes the strong separation between different service sectors. Patients have the freedom to choose their health provider for both primary and hospital care

Public health

Various national and state-level institutions undertake public health initiatives in Germany. At the national level, the Robert Koch Institute (RKI) advises authorities on the prevention and control of infectious diseases. Under the Infection Protection Act, it also oversees surveillance and responses to infectious diseases, including immunization recommendations and outbreak management, and played a pivotal role during the COVID-19 response. The Federal Centre for Health Education (*Bundeszentrale für gesundheitliche Aufklärung*, BZgA) is the key authority for disease prevention and health promotion through mass media campaigns and projects promoting health-related behaviours.

Public health services are mainly decentralized to the states, with a wide range of tasks often delegated to municipalities, including prevention, surveillance and containment of infectious diseases, health reporting, hygiene supervision, and physical examinations of schoolchildren and certain other groups. These services are provided by 380 public health offices across Germany, which vary widely in size, structure, and tasks. In addition, public health services are carried out by a multitude of actors operating at municipal, state and federal levels (and by private, public and corporatist bodies of the SHI). The relevance of public health institutions grew during the COVID-19 pandemic due to key tasks like contact tracing.

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 such as physiotherapists and occupational therapists. Ambulatory physician care includes primary care (family physician care) which is mainly provided by general practitioners (GPs) and secondary care provided by office-based specialists. Patients have free choice among physicians, psychotherapists, dentists, pharmacists and urgent care services. While SHI patients can choose other allied health professionals, access to reimbursed care requires a referral.

GPs are often the first point of contact in the health system but are not official gatekeepers. Since 2004, sickness funds must offer their insured the option of enrolling in a GP-centered model of care (*Hausarztzentrierte Versorgung*), with some providing bonuses for compliance with gatekeeping rules. Participation in these models is voluntary for both providers and the insured (see Box 3).

Disease Management Programmes (DMPs) were introduced in 2003 to improve coordination between primary care and specialists. DMPs organize and coordinate care for patients with chronic conditions using evidence-based guidelines, focusing on efficient treatment within the ambulatory care level. They include quality assurance measures, such as standardized documentation, feedback reports to physicians, patient information, and reminder systems, ensuring consistent care across different service providers.

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, but single practices still account for the vast majority of providers. 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 and hospital care sectors, German hospitals were historically limited to inpatient services. Over the past 20 years, however, hospitals have increasingly provided outpatient services. They also offer ambulatory care for rare diseases, severe progressive conditions, and highly specialized services. Despite these expansions, few structural incentives exist to promote integrated care. Hospital planning and regulation are state-level responsibilities, leading to significant differences between states. Germany's large inpatient sector raises concerns about efficiency and overcapacity. In response, a government commission has proposed changes to the hospital payment system and new planning instruments to encourage outpatient services and ensure quality care. Further instruments to incentivize outpatient hospital care and lower sectoral boundaries are currently being implemented, for example, equal reimbursement for outpatient and inpatient care for a limited number of procedures. However, the impact of these measures will likely remain small for the next few years (see Box 4).

Box 4 Are efforts to improve integration of care working?

Hospital and ambulatory care in Germany are separately organized and financed. Several measures have been implemented to encourage more coordinated types of care, such as treatment plans that involve pre- and post-inpatient care for hospital treatments without an overnight stay, specialized day care clinics for psychiatric and geriatric patients, and outpatient/day-case surgeries at hospitals with equivalent reimbursement to office-based physicians. Despite these measures, most specialized care continues to be provided within the separate silos of the hospital and ambulatory care sectors.

Recent instruments, based on recommendations from the Government Commission for Modern and Needs-based Hospital Care, aim to enhance intersectoral, patient-centred care and to optimize resources. Firstly, as of February 2023, hospitals can allow certain admitted inpatients to leave without an overnight stay if medically acceptable and with the patient's consent. This so-called day inpatient care is reimbursed through the DRG system, with deductions for nights spent at home. Secondly, hybrid DRGs have been introduced to ensuring equal remuneration for specific procedures performed by both hospitals and outpatient specialists. Implementation started in early 2024 with a limited number of procedures and DRGs.

Pharmaceutical care

Pharmaceuticals are distributed through institutional and community pharmacies. Authorized mail-order and online pharmacies, which follow the same legal requirements and control mechanisms as traditional on-site pharmacies, primarily sell OTC medicines but are gaining popularity. Non-pharmacy-only pharmaceuticals can also be sold by drugstores, health food stores, supermarkets and food retail markets.

Current policies revolve around tackling supply shortages of pharmaceuticals, including specific legislation from July 2023 and a new pharmaceutical strategy (from December 2023) to create additional incentives for pharmaceutical companies to engage in activities, especially research and development (R&D), in Germany.

Long term care

The statutory long-term care insurance (LTCI), introduced in 1994, manages long-term care in Germany. The system includes both mandatory social and private LTCI, covering nearly the entire population. Contributions are split between members and employers. Long-term care benefits are available upon application and evaluation by Medical Review Boards. These boards determine care needs and assign one of five care grades. Eligible individuals can choose between cash benefits or professional care at home or in nursing homes. Professional home and residential care services, with varying monthly limits based on care needs, are also provided.

The Long-term Care Support and Relief Act, adopted on 26 May 2023, increased a number of resources for service users:

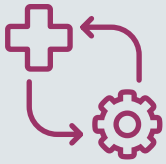
- LTCI contribution rates (differentiated by the number of children);
- cash and in-kind benefits for home and ambulatory care; and
- subsidy rates for co-payments for long-term care facilities.

The legislation also introduced measures to improve working conditions in inpatient facilities as well as measures to increase transparency and provide more information to people in need of care.

Dental care

Dental care in Germany is primarily provided by privately owned dental practices, with most being solo practices and about one fifth being team-based or group practices. Dental care involves explicit cost sharing under SHI, which does not fully cover dental benefits, making supplementary insurance important for many. Sickness funds cover prophylactic treatments and basic dental care for all insured. Conservative surgical treatment and X-ray services are included in the benefits package when used for dentures and superstructures. Additionally, SHI covers single and group preventive care for children up to 16 years of age in pre-schools and schools, prevention of dental diseases in care-dependent patients and those with disabilities, and early detection examinations for children up to 6 years old.

What reforms are being pursued?



A major hospital reform will change hospital remuneration and planning while developments in the digitalization of the health system are continuing

The frequency of legislative changes in the German health system is extraordinarily high, primarily focusing on incremental changes and sector-specific implementation measures rather than landmark reforms (see Box 5).

One continuous reform effort has centered around the digitalization of the German health care system since 2005. However, several factors have resulted in slow progress. A recent legislative change, the Act to Accelerate the Digitalization of the Healthcare System, 2023 (*Gesetz zur Beschleunigung der Digitalisierung des Gesundheitswesens*), aims to streamline healthcare for both doctors and patients through digital solutions. A key provision is introducing electronic patient records (ePA) for all statutory health insurance holders starting in early 2025, with an opt-out option available. Private health insurers can also offer an opt-out-to ePAs. The ePA will provide insured individuals with a comprehensive, largely automated digital medication overview, enhancing treatment by minimizing drug interactions. Concurrently, e-prescription was introduced mandatorily in 2024 after several years of preparation and slow adoption (Bundesministerium für Gesundheit, 2023). Furthermore, the reform introduced a disease management programme for diabetes based on the patients' health data from the ePA, medication plan, health apps and other records.

Since 2022, with the establishment of a Government Commission for Modern and Needs-based Hospital Care, reforming the German hospital landscape has been high on the health reform agenda.

Based on one of the Government Commission proposals, a flat-fee remuneration will supplement the current DRG-based hospital payment system. Additionally, the reform currently underway is intended to enhance the quality of inpatient care through mandatory structural and staffing criteria for different types of treatments or services (for example, general internal medicine or stroke). Another recommendation, implemented since January 2023, mandates hospitals to perform treatments that were previously inpatient procedures as day treatments when appropriate, easing staffing and capacity challenges.

Recent developments related to public health include the legalization of recreational cannabis use in April 2024. With the Cannabis Act, the government aims to contribute to improved health protection, strengthen cannabis-related education and prevention, enhance child and youth protection and curb organized drug crime (Bundesministerium für Gesundheit, 2024).

Box 5 Key health system reforms over the past 10 years

- 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
- 2023: Act to Tackle Supply Shortages of Pharmaceuticals
- 2023: Act to Accelerate the Digitization of the Healthcare System
- 2024: Cannabis Act
- 2024: Hospital Care Improvement Act (adoption planned for late 2024)

How is the health system performing?

The German health system provides good access to health services while ensuring financial protection. While health spending is high, challenges remain in reflecting this investment in quality metrics and in improving efficiency

Health system performance monitoring and information systems

System-wide performance reporting in Germany's health system is challenged 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 (such as palliative care) is largely missing and thus cannot be used to inform health system performance reporting. Commissioned by the federal MoH, the first pilot for a German HSPA was published in January 2024, covering more than 100 indicators in different health system dimensions like access and quality, which are part of a previously developed conceptual framework of Germany's health system (Busse et al. 2024).

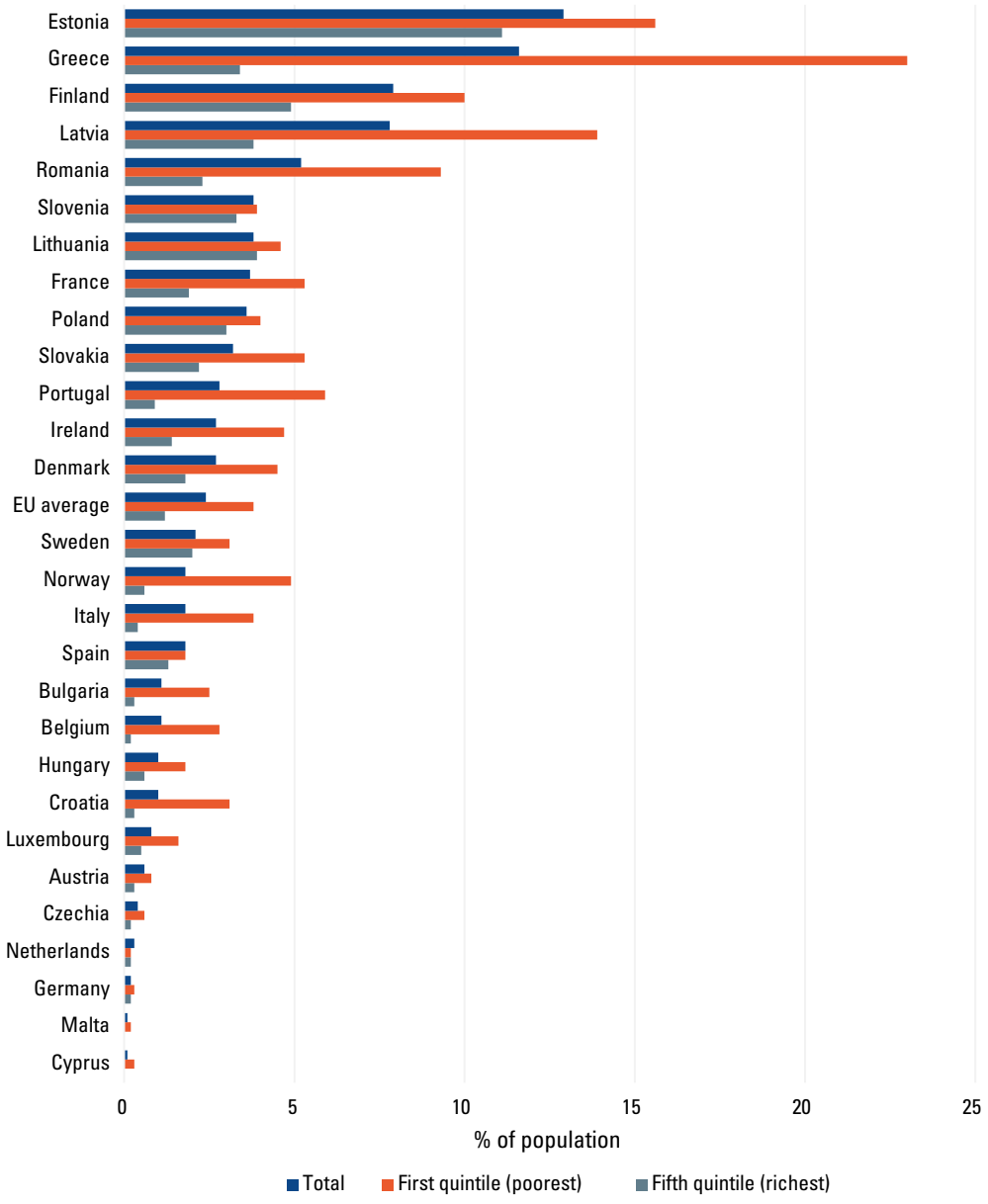
Accessibility and financial protection

Germany offers universal health coverage with a comprehensive benefits package and low cost-sharing. A dense network of healthcare providers ensures overall high service availability across the country, though accessibility is lower in rural areas. Survey results indicate very low reported unmet needs for medical care (Fig. 8). Reforms have aimed to improve access to out-of-hours care, such as establishing appointment service points available 24/7 since 2020 using the nationwide telephone number 116117 and a website.

The comparatively low share of OOP payments in health financing and financial safety nets contribute to strong financial protection for the population.

Legislation has implemented measures to protect low-income individuals and the chronically ill from excessive costs by capping co-payments. Additionally, children under 18 years of age are generally exempt from co-payments. Consequently, levels of catastrophic health expenditure in Germany are lower than in most other European countries (Siegel & Busse, 2018).

Fig. 8 Unmet needs for a medical examination (due to cost, waiting time, or travel distance), by income quintile, EU/EEA countries, 2023



Notes: EEA: European Economic Area; EU: European Union.
Source: Eurostat, 2024.

Health care quality

The Institute for Quality Assurance and Transparency in Healthcare (IQTIG), founded in 2015, develops cross-sectoral quality indicators to enhance the quality of care and links health and quality outcomes with service provider planning and payment.

Despite several publicly available hospital registers offering detailed information such as case numbers, staffing and quality indicators, research

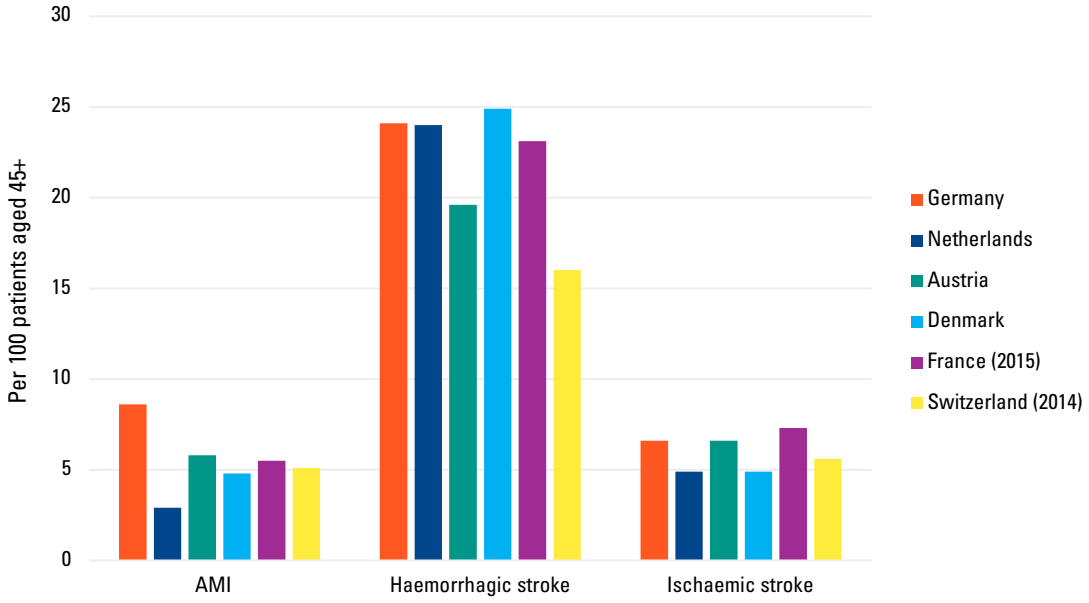
indicates that patients rarely use or are aware of these resources when choosing a hospital. In response, the Hospital Transparency Act 2024 (*Krankenhaustransparenzgesetz*), launched a new register in May 2024. This register provides comprehensive details on case volumes, quality indicators, certifications, staffing levels, hospital levels, and emergency care capabilities for each hospital site.

A recent study piloting an HSPA for Germany found overall mixed results for quality of care in comparison to eight neighbouring countries (Busse et al. 2024). For instance, Germany performs well in stroke care, yet its 30-day mortality rate after hospital admission for an acute myocardial infarction (AMI) is higher (8.6% in 2021) compared to countries like Denmark (4.8%), the Netherlands (2.9%), Switzerland (5.1%) and Austria (5.8%) (Fig. 9).

Box 6 What do patients think of the care they receive?

A 2021 Commonwealth Fund survey revealed that 86.9% of German respondents aged over 16 felt that their regular doctor spent enough time with them during consultations, a decrease from 92% in 2010 but a slight increase from 85.8% in 2017 and above the OECD average of 82.2%. Additionally, 93.7% reported receiving easy-to-understand explanations from their doctor, above the OECD average of 90.6, but down from 84.3% in 2017. Being involved in decisions about care and treatment was reported by 88.6% of respondents, a decrease from 87.2% in 2017 but higher than the OECD average of 83.6% (OECD, 2024).

Fig. 9 In-hospital mortality rates (deaths within 30 days of admission) for admissions following acute myocardial infarction, haemorrhagic stroke and ischaemic stroke, Germany and selected countries, 2021 (or nearest year)

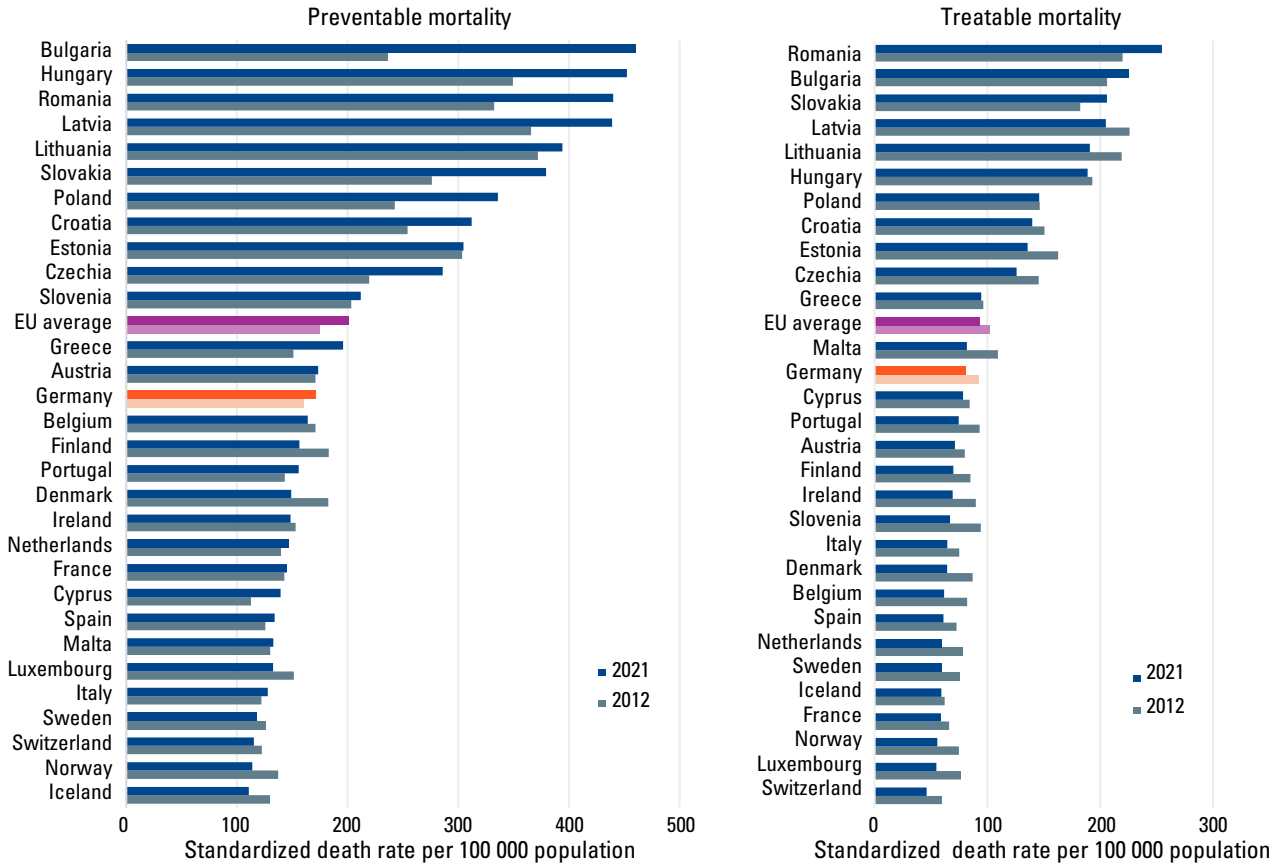


Notes: Data refer to 2021 or nearest year where indicated. AMI: acute myocardial infarction.
Source: OECD, 2024

Health system outcomes

Mortality from treatable causes has improved, decreasing from a rate of 92.0 deaths per 100 000 population in 2012 to 81.3 in 2021, and it remains below the EU average of 93.3 (Fig. 10). The leading causes of treatable deaths in 2021 include ischaemic heart disease, colorectal cancer and breast cancer (Eurostat, 2024), which could be reduced through timely and effective health care interventions (including

Fig. 10 Mortality from preventable and treatable causes, 2012 and 2021



Note: After 2020, deaths due to COVID-19 are counted as preventable deaths, resulting in an increase in mortality from preventable causes for most countries.

Source: Eurostat, 2024.

secondary and preventive treatment). While it is challenging to pinpoint how much of the improvement is due to health care or health policy factors, the introduction of Disease Management Programmes (DMPs) for chronic diseases has likely contributed. These programmes focus on patient self-care that is well-coordinated and guideline-based, in order to manage the course of their disease and reduce mortality.

Mortality from preventable causes (that is, deaths from causes that could be avoided through public health policies and prevention), had been declining incrementally between 2012 and 2019 but the rate increased in both 2020 and 2021, to 171 deaths per 100 000 population mainly due to the fact that COVID-19 deaths are classified as preventable deaths. Although Germany's preventable mortality rate is below the EU average of 201 per 100 000 population, it is still higher than many other western European countries (Fig. 11). Key causes of preventable deaths, such as lung cancer, alcohol-related disease, ischaemic heart disease and chronic lower respiratory disease, highlight the critical role of public health interventions, particularly those addressing tobacco and alcohol use (see Box 7).

Health system efficiency

Germany has large human, technical and infrastructural capacities at its disposal and high utilization of both inpatient and outpatient services. Resources allocation at the federal level primarily reflects negotiations between corporatist bodies, rather than strict budgetary limits. While tools like Health Technology Assessment are in place to secure the (cost-)effectiveness of SHI-covered benefits, there is no priority setting, for example, through goal formulation.

Box 7 Are public health interventions making a difference?

Smoking remains a major contributor to preventable mortality in Germany. Although smoking rates have declined among adults and adolescents over the past decade, they remain higher than in many other EU countries (OECD/European Observatory on Health Systems and Policies, 2023). Germany has been slower than other countries in implementing tobacco regulations, only prohibiting billboard advertising for tobacco in January 2022 (the last country in the EU to do so) and e-cigarettes in January 2024. Furthermore, smoking prevention measures in public places vary by state, ranging from weak regulations to full smoking bans in all public institutions. The rising use of e-cigarettes and shisha pipes presents a new public health challenge.

Generally, SHI physicians mainly provide primary prevention measures, screening and early detection services in Germany, including cancer screening and regular check-ups such as screening for cardiovascular disease, renal disease and diabetes. Furthermore, SHI ensures regular check-ups, specific diseases screening (e.g. pulse oximetry screening, cystic fibrosis) and immunization monitoring for children and adolescents. Since March 2020, measles vaccination 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.

Germany's health system delivers a high volume of services 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).

Evaluating a health system's performance regarding input costs and outcomes can be challenging. One approach to provide a cursory overview is to compare current health expenditure with the treatable mortality rate. While it is difficult to completely disentangle the role of health behaviours and other determinants of the health care system in influencing the level of treatable mortality, this comparison provides a useful starting point for discussion. The treatable mortality

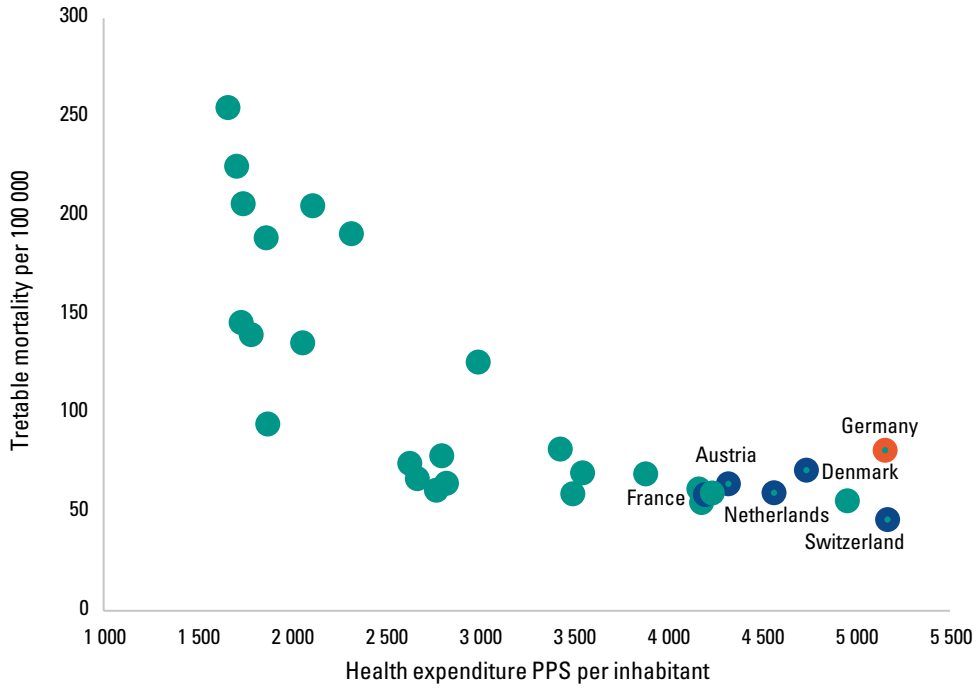
Box 8 Is there waste in pharmaceutical spending?

In 2022, Germany spent €946 per capita (current prices, adjusted for differences in purchasing power) on pharmaceuticals, the highest in the EU (OECD, 2024). Between 2004 and 2015 the consumption of prescribed defined daily doses (DDD) increased by over 50% (Busse et al., 2017). To address rising costs and improve efficiency, Germany introduced an early benefit assessment in 2011, requiring 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 reimbursement rates with the manufacturers for pharmaceuticals that demonstrates added benefits. This pricing mechanism seeks to ensure that pharmaceutical prices are economically efficient while encouraging innovation. However, during the pharmaceutical's first year on the market, manufacturers can set prices freely and without restriction, which can result in high SHI expenditure for some innovative medicines.

Despite high pharmaceutical prices, Germany has effectively shifted consumption towards generics, achieving some of the highest market shares by volume and value among EU and OECD countries. However, even with 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.

rate in Germany has steadily decreased over the last decade but remains higher than in neighbouring countries. Meanwhile, Germany ranks among the EU countries with the highest health spending (Fig. 11). The results suggest that other countries have been able to secure better outcomes on this measure at a lower cost.

Fig. 11 Treatable mortality per 100 000 population versus health expenditure per capita, Germany and selected countries, 2021



Note: PPS: purchasing power standard.
Source: Eurostat, 2024.

Summing up

Key health system challenges in Germany include strong sector silos and complex stewardship

The German health care system offers its population universal health insurance coverage and a comprehensive benefits basket with comparably low cost-sharing requirements. There is relatively good access to care with free choice of provider and short waiting times, partly due to good infrastructure, 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 highest per capita spending among EU countries in 2022. Furthermore, the strong separation of ambulatory and inpatient care regarding organization

and payment hinders the coordination and continuity of patient treatment. Another core challenge is the complex stewardship of the health system which promotes incrementalism and makes it more difficult to implement reforms. The country also has a comparatively large hospital inpatient sector, which raises concerns about efficiency and overcapacity. A new government commission is addressing these hospital sector issues, with a focus on promoting more outpatient services while ensuring quality.

Population health context

Key mortality and health indicators

Life expectancy (years)	2022
Life expectancy at birth, total	80.7
Life expectancy at birth, male	78.3
Life expectancy at birth, female	83.0
Mortality	**2021**
All causes (SDR per 100 000 population)	1 045.22
Circulatory diseases (SDR per 100 000 population)	345.05
Malignant neoplasms (SDR per 100 000 population)	235.74
Communicable diseases (SDR per 100 000 population)	14.99
External causes (SDR per 100 000 population)	45.47
Infant mortality rate (per 1 000 live births)	3.0
Maternal mortality per 100 000 live births (modelled estimates)*	4.4

Note: Maternal mortality data is for 2020.
Source: Eurostat, 2024; WHO Regional Office for Europe, 2024

References

Bundesministerium für Gesundheit (2023). Gesetz zur Beschleunigung der Digitalisierung des Gesundheitswesens (Digital-Gesetz – DigiG) [Act to accelerate the digitalization of the healthcare system (Digital Act - DigiG)] (https://www.bundesgesundheitsministerium.de/ministerium/gesetze-und-verordnungen/guv-20-lp/digig, accessed 20 June 2024).

Bundesministerium für Gesundheit (2024). Fragen und Antworten zum Cannabisgesetz [Questions and answers about the Cannabis Act] (https://www.bundesgesundheitsministerium.de/themen/cannabis/faq-cannabisgesetz.html, accessed 20 June 2024).

Busse R, Blümel M, Spranger A (2017). Das deutsche Gesundheitssystem. Akteure, Daten, Analysen. 2. Auflage. Berlin: Medizinisch Wissenschaftliche Verlagsgesellschaft.

Busse R, Achstetter K, Blümel M, Haltaufderheide M, Hengel P (2024). Pilotierung einer systematischen Messung der Leistungsfähigkeit und Effizienz des deutschen Gesundheitssystems (Health System Performance Assessment – HSPA) [Piloting a systematic measurement of the performance and efficiency of the German healthcare system (Health System Performance Assessment - HSPA)] (https://www.bundesgesundheitsministerium.de/service/publikationen/details/hspa.html, accessed 9 September 2024).

Eurostat (2024). Eurostat Database. Luxembourg: European Commission.

Federal Statistical Office (2024): Genesis Online databank, table 12411-0001. (https://www-genesis.destatis.de/, accessed 10 September 2024).

OECD (2024). OECD Health Statistics. Paris: OECD Publishing.

OECD/European Observatory on Health Systems and Policies (2023). Germany: Country Health Profile 2023, State of Health in the EU. Paris: OECD Publishing (https://doi.org/10.1787/21dd4679-en).

Siegel, M., & Busse, R. (2018). Can people afford to pay for health care? New evidence on financial protection in Germany. WHO Regional Office for Europe.

WHO (2024). Global health expenditure database [online database]. Geneva: World Health Organization.

WHO Regional Office for Europe (2024). European Health for All database (HFA-DB). Copenhagen: WHO Regional Office for Europe.

Keywords:
DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEM PLANS – organization and administration
GERMANY

© World Health Organization, 2024 (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies)

Some rights reserved. This work is available under the Creative Commons Attribution-NonCommercial-ShareAlike 3.0 IGO licence (CC BY-NC-SA 3.0 IGO; https://creativecommons.org/licenses/by-nc-sa/3.0/igo).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the WHO and the European Observatory on Health Systems and Policies or any of its Partners concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the WHO or the European Observatory on Health Systems and Policies or any of its Partners in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters. All reasonable precautions have been taken by the European Observatory on Health Systems and Policies to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied.

The responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO, the European Observatory on Health Systems and Policies or any of its Partners be liable for damages arising from its use. The named authors alone are responsible for the views expressed in this publication. The views and opinions expressed in Observatory publications do not necessarily represent the official policy of the Participating Organizations.

The European Observatory on Health Systems and Policies is a partnership that supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of health systems in the European Region. It brings together a wide range of policy-makers, academics and practitioners to analyse trends in health reform, drawing on experience from across Europe to illuminate policy issues. The Observatory's products are available on its web site (http://www.healthobservatory.eu).