2.1. Historical background

Germany is widely regarded as the first country to have introduced a national system of social and health insurance. A mandatory health insurance requirement was introduced at the national level in 1883 during the chancellorship of Otto von Bismarck and was expanded over the following century to the areas of occupational accidents and disease (1884), old age and disability (1889), unemployment (1927) and LTC (1994). Despite a series of historical breaks, the guiding principles of the "Bismarckian" system have remained until today: solidarity among the insured (e.g. non-risk-related contributions and entitlement to benefits according to need); mandatory membership and shared payment of contributions between employer and employee; and a strong reliance on self-government (Busse et al., 2017a). The development of the German health care system is best described following the main strands of the country's political history (Table2.1).

Table2.1

Main phases of the health system's development

Period	Year	Development
1871–1918 GERMAN EMPIRE AND FIRST WORLD WAR		**EXTENSION OF POPULATION AND BENEFIT COVERAGE**
	1881:	Kaiser Wilhelm I's Royal Proclamation on Social Policy
	1883:	Establishment of SHI by Bismarck's Health Insurance Act, covering initially 10% of population
	1911:	Health, pension and accident insurance became integrated into the Imperial Insurance Code (in force from 1914)
	1913:	Berlin Convention on Ambulatory Care, the first step towards joint self-governance in SHI system
	1913:	35% of population are covered by SHI
1919–1933 WEIMAR REPUBLIC		**STRENGTHENING OF MEDICAL PROFESSION**
	1923:	Imperial Committee of Physicians and Sickness Funds
	1925:	Majority of population (51%) is covered by SHI
	1931–1933:	Special presidential directives on ambulatory care; create Regional Associations of SHI Physicians and a "total payment" for ambulatory care
1933–1945 NAZI REGIME AND SECOND WORLD WAR		**FUNDAMENTAL STRUCTURES OF SHI REMAINED, *BUT***
	1933:	Withdrawal of self-administration and exclusion of socialist and Jewish workers from the committees of the sickness funds
	1933–1938:	Work prohibition for Jewish physicians; denied access to health care for Jews and other minorities
	1934:	Regional Associations of SHI Physicians are merged into one National Association of SHI Physicians
	1934–1935:	Redefining organizational framework along the rules of Nazi-dictatorship: centralization of sickness funds, welfare organizations, and community health services by the Nazi Party
	1941:	SHI coverage for retired persons
1945–1989 GERMAN SEPARATION		**WEST** CONTINUATION OF SHI SYSTEM IN THE FEDERAL REPUBLIC OF GERMANY
	1955:	Restoration of self-administration of sickness funds (after a long and fierce debate)
	1960–1964:	Failed reform acts
	1972:	Hospital Care Financing Act
	1972/1975/1981:	SHI coverage for farmers, students, disabled and artists
	1977:	First Cost Containment Act
	1988:	Health Care Reform Act
		EAST STRONG FOCUS ON PUBLIC HEALTH IN THE GERMAN DEMOCRATIC REPUBLIC
	1945:	Establishment of the Central administration for the East German health care system
	1950:	Central Planning Act – introduction of universal health coverage, managed by two national social insurance agencies
	1974:	Introduction of Disease Management Programmes
	1989:	Only a few weeks before the fall of the Berlin wall, a National Health Conference decided to implement substantial health care reforms with increased investment
1989–TODAY GERMAN RE-UNIFICATION		**TRANSFER OF THE FRG HEALTH CARE SYSTEM TO THE EASTERN PART OF GERMANY**
	1989:	Transformation of the Imperial Insurance Code of 1914 into the Code of Social Law (Sozialgesetzbuch – SGB), divided into books; the fifth book (SGB V) covers SHI
	1990:	Re-unification Acts
	1993–2020:	see Section 6 *Principal Health Reforms*

Source: Busse et al., 2017a

German Empire and First World War (1871–1918)

The Health Insurance Act introduced a mandatory health insurance requirement along occupational lines and initially only for industrial workers, skilled craftsmen and blue-collar workers in 1883. Bismarck's mandatory insurance built on traditions and already existing structures, broadening them (e.g. industrial workers' mutual-aid organizations, company-based mutual aid schemes), creating a patchwork of sickness funds throughout the German Empire. In 1885, 10% of the population was insured within a total of 18 776 sickness funds (Alber, 1992).

In the beginning the key principle of self-governance applied only to the sickness funds. Employees subject to the mandatory insurance requirement paid two thirds of the health insurance contributions, whereas employers paid one third. At the same time, both employers and employees appointed representatives to each sickness fund's administrative board proportionate to the 2:1 employer–employee contributions ratio. The administrative board set the contribution rate, defined optional benefits and addressed other issues related to sickness fund by-laws. Indeed, the Health Insurance Act addressed neither the relationship between the sickness funds and ambulatory care physicians, nor the qualifications of health care professionals, leaving both matters to the discretion of the sickness funds.

The expansion of coverage to white-collar workers in 1901 and the shift to more in-kind benefits corresponded with a higher demand for health care services and a growth in the number of health care professionals, which resulted in a conflict over power and income between physicians and sickness funds. Physicians demanded unrestricted access to patients covered by SHI and a limited role for the sickness funds, and began to push for greater autonomy and higher income through lobbying and strikes.

The 1911 Imperial Insurance Code introduced a common legal framework for the different pillars of the social security system. The sections covering health insurance remained in force, with some modifications, until 1988. In 1989 health insurance regulations were transferred to the Social Code (V). However, the Imperial Insurance Code was passed without addressing any of the physicians' demands. Physicians threatened to go on strike shortly before the law was to take effect in 1914. In December 1913 the government intervened for the first time in the conflict: the resulting Berlin Convention stipulated that representatives of the physicians and sickness funds were to form joint commissions, thus channelling the conflict into constructive negotiations and introducing the beginnings of today's system of joint self-government within the SHI scheme.

Weimar Republic (1919–1933)

By 1925, 51% of the population was already insured with 7777 sickness funds and health expenditure had tripled since 1885. This growth was also due to the extension of coverage to non-working dependants, first on a voluntary basis by sickness funds and in 1930 by legal mandate. Initially, the benefits basket was limited and expenditure on benefits in kind rather small, while cash benefits in case of illness, death and childbirth dominated health expenditure. Both the scope and scale of the benefits basket were expanded incrementally (and were reduced for the first time only in 1977).

In 1931 office-based physicians were granted a monopoly over outpatient care and were required to hold membership of their respective Regional Association of Statutory Health Insurance Physicians, which was charged with negotiating collective contracts with the sickness funds. This concession to physicians disconnected ambulatory care from both population-based and public health institutions and from hospitals that had to limit their scope of work to inpatient services. The result was a fragmented provision of care, a situation that endures to this day.

Nazi regime and Second World War (1933–1945)

During the Nazi dictatorship the fundamental structures of the health system remained unchanged. SHI coverage was extended to pensioners in 1941, and sickness funds were legally obliged to provide coverage for hospital care not only to members but also to their dependants in 1936 (Alber, 1992). Despite this structural continuity, the principles of the social insurance system were grossly violated. Access to health care was restricted or denied for the Jewish population and other stigmatized minorities, and legislation prohibited Jewish physicians from treating patients and finally banned them from practising medicine altogether. The organization of the health system and the balance of power among sickness funds and professional associations were centralized and submitted to a director nominated by the Nazi Party. Members of the corporatist institutions within the system of joint self-government were chosen by the Nazi Party rather than being elected, and the participation of employers and employees was limited to service on an advisory council (Busse et al., 2017a).

German separation (1945–1989)

The self-governance structure was largely restored in 1955 with only slight modifications in West Germany. For instance, SHI contributions are now equally shared between employee and employer (compared to a ratio of 2:1 since 1883). Cost-containment was at the core of a series of health reforms, but not at the expense of a continued extension of coverage: by 1960, 83% of the population was insured with 2028 sickness funds. Furthermore, states were made responsible for capital investment in hospitals, while sickness funds covered operating costs, which led to a phase of infrastructural investment. In East Germany a central administration was established in 1945. Although the Central Planning Act of 1950 put the system under central state control, not all health care institutions in East Germany were formally nationalized and the principle of social insurance – with employers and employees sharing the cost of insurance contributions – was maintained *de jure*. Insurance was made universal, and administration was concentrated into just two large sickness funds, one for workers (89%) and one for other occupational groups, members of agricultural cooperatives, artists and the self-employed (11%) (Knieps & Reiners, 2015; Lüschen et al., 1997).

German reunification (since 1990)

Shortly after German reunification, the West German SHI was transferred to the eastern part of the country with only a few compromises in terms of delivery of care. The challenges derived from the reunification accelerated the speed of health reforms, although increased competition, quality assurance and cost-containment were commonly at their core. Competition was inherent to the SHI system through the free choice of providers, but competition among payers was lacking because people were mostly assigned to a particular sickness fund. Starting from 1996, insured individuals were granted the right to choose and change their sickness funds. At the same time, pro-competition regulations were buffered by measures to avoid adverse effects on equity and quality (e.g. the introduction of a risk-adjustment scheme and a uniform contribution rate). The gradual expansion of population coverage and enlarging the benefits basket, however, were untouched by the reforms: coverage with either substitutive PHI or SHI has been mandatory since 2009.

For a more detailed account of the background, political objectives and/or specific health reforms, see Busse & Blümel (2014) and Busse et al. (2017b). Health reforms from 2012 to early 2020 are described in Chapter 6.