Germany's social health protection reforms: main legislation (1883–2025)

This document complements the timeline of Germany's social health protection (SHP) reforms on the Germany country page on p4h.world. It provides key dates of German SHP acts and, for each of them, a snapshot explanation, extracted from a selected source.

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Methodology:

- Use of the International Labour Organization's definition of SHP
- Search of related key legislation, using, in the following order, (1) artificial intelligence (AI), (2) cross-checking results from AI with GIZ's health financing (HF) reforms' assessment[1], and (3) again using AI, searching key sources that explain the key legislation
- Review of key sources and selection of one source per legislative act,
- Identify one or more key passages to extract and reproduce from the source

Limit:

Describing the history of SHP reforms in Germany by year of adoption of key legislative acts – while a logical approach – has two main limitations.

First, Germany's SHP system, starting with Otto von Bismarck's Health Insurance Act of 1883, did not develop in a single, decisive legislative act. Instead, related

[1] Swiss Tropical and Public Health Institute. *Draft Report: Assessment of the German Health Financing System*. Forthcoming.

laws and policies expanded and were revised incrementally. New laws and amendments often built on or modified previous ones[2].

Second, acts function as umbrellas. Under them, regulatory and administrative adjustments are made to the initial act, effectively creating a multilayered series of reforms that, all together, are revolutionary. These acts and adjustments are designed to coordinate and streamline a wide range of measures, such as new funding mechanisms, coverage decisions or administrative procedures, under one legal umbrella. For example, the Statutory Health Insurance Modernization Act of **2003** both changed the structure of health fund regulation and established the Federal Joint Committee, a central body that brings together health funds, physicians, hospitals and patient representatives to make coverage and quality decisions.

Main German social health protection acts (1883–2025)

1883 – Health Insurance Act

The following extract from the social security website of the government of the United States of America describes the influence of Otto von Bismarck on Germany's SHI system.

> Germany became the first nation in the world to adopt an old-age social insurance program in 1889, designed by Germany's Chancellor, Otto von Bismarck. The idea was first put forward, at Bismarck's behest, in 1881 by Germany's Emperor, William the First, in a ground-breaking letter to the German Parliament. William wrote: *". . .those who are disabled from work by age and invalidity have a well-grounded claim to care from the state."*
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> Bismarck was motivated to introduce social insurance in Germany both in order to promote the well-being of workers in order to keep the German economy operating at maximum efficiency, and to stave-off calls for more radical socialist alternatives. Despite his impeccable right-wing credentials, Bismarck would be called a socialist for introducing these programs, as would President Roosevelt 70 years later. In his own

[2] Busse, Reinhard, et al. "Statutory Health Insurance in Germany: A Health System Shaped by 135 Years of Solidarity, Self-Governance, and Competition." *The Lancet*, vol. 390, no. 10097, 2017, p. 883, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31280-1/fulltext.

speech to the Reichstag during the 1881 debates, Bismarck would reply: *"Call it socialism or whatever you like. It is the same to me."*

The German system provided contributory retirement benefits and disability benefits as well. Participation was mandatory, and contributions were taken from the employee, the employer and the government. Coupled with the workers' compensation program established in 1884 and the "sickness" insurance enacted the year before, this gave the Germans a comprehensive system of income security based on social insurance principles. (They would add unemployment insurance in 1927, making their system complete.)

Citation: "Social Security History: Otto von Bismarck" *Social Security*, Social Security Administration of the United States.

1911 – Imperial Insurance Code

The following extract by the European Observatory on Health Systems and Policies provides some historical context for the 1911 Imperial Insurance Code.

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 channeling the conflict into constructive negotiations and introducing the beginnings of today's system of joint self-government within the SHI scheme.

Citation: "Germany: Health Systems in Transition (HiT) Profile: 2.1. Historical Background" *Health Systems and Policy Monitor (HSPM),* European Observatory on Health Systems and Policy, 10 May 2024.

1972 – Hospital Financing Act

The following extract from the Reimbursement Institute, written in German and translated into English using Google Translate, explains the 1972 Hospital Financing Act.

> The Hospital Financing Act (KHG) regulates the economic security of hospitals in Germany. The aim of this law is to provide the population with needs-based care at socially acceptable care rates. The safeguarding of non-profit and private hospitals must be guaranteed. In this sense, economic security refers to the assumption of investment costs by way of public funding, as well as the receipt of performance-related proceeds from care rates, remuneration for pre- and post-inpatient treatment and outpatient surgery. This form of financing is called the dual financing model. With the money from public funding (tax money) and care rates (health insurance contributions), the hospital undertakes to operate economically and independently and thus to contribute to the goal of contribution stability set out in the health reform of 2000. The law was passed on July 1, 1972, in Bonn.

Citation: "KHG – Krankenhausfinanzierungsgesetz" *Reimbursement Institute*

1989 – Health Care Reform Act

The following extract from the article "Reform of Health Care in Germany" in the *Health Care Financing Review* describes the Health Care Reform Act of 1989.

> Finally, following a jump in average contribution rates from about 11.5 percent to nearly 13 percent in the mid-1980s, which was a result both of rising unemployment and of further increases in expenditures, the government introduced a further bulky package of reforms in the Health Care Reform Act of 1989. This has been described as the most important statute on the statutory health insurance system since the Law of 1911 (Schneider, 1990). It was aimed both at cost containment and at financing some selected improvements to benefits.

Citation: Hurst, Jeremy W. "Reform of Health Care in Germany" *Health Care Financing Review*, vol. 12, no. 3, 1991, p. 80.

1993 – Health Care Structure Act

The following extract from Germany's Federal Agency for Civic Education, written in German and translated into English using Google Translate, provides the historical context for the Health Structure Act of 1993.

> The Health Structure Act of December 21, 1993, comes into force for the most part. It is intended to stop the avalanche of costs in the health care system, which is in a severe financial crisis ("immediate brake"). For this reason, expenditure on service providers (doctors, dentists, hospitals, pharmaceutical manufacturers, pharmacists,

masseurs, physiotherapists, etc.) is budgeted: it must not increase more than the contributory incomes of the statutory health insurance funds over the next three years. The fees for prosthetic, orthodontic and dental services will be reduced by ten and five percent respectively. The costs for medicines and remedies must also be budgeted and thus reduced. The principle of cost recovery no longer applies to hospitals; it is being replaced by market-based incentives (performance-oriented fixed prices) and demand planning. The licensing of new statutory health insurance doctors and dentists in oversupplied regions will be restricted. Insured persons have to pay increased co-payments for hospitals, cures, expensive medicines and complex dentures. Hardship regulations are intended to cushion these burdens socially. The most comprehensive reform of statutory health insurance since 1945 was initiated by the new Health Minister Horst Seehofer (CSU). It met with resistance, especially from doctors, dentists, dental technicians and pharmacists.

Citation: "Deutschland-Chronik bis 2000: 1 Januar 1993" *Bundeszentrale für politische Bildung*.

1994 – Long-Term Care Insurance Act

The following extract from the Journal of Population and Social Security explains Germany's long-term care insurance act of 1995.

> The new social long-term care insurance scheme (*Pflegeversicherung*) came into force at three different stages: from January 1, 1995 on compulsorily insured persons were liable to pay contributions, whereas benefits for domiciliary care were granted from April 1, 1995 on and benefits for residential care only from July 1, 1996. Besides, the law gives those who are entitled to benefits the right of substituting services in kind, i.e. professional services by cash benefits, i.e. it makes it possible for persons who are entitled to benefit to replace benefits in kind for the services of professional carers by cash benefits in cases when non-professional family members provide the care.

Citation: Schulte, Bernd. "Social Long-Term Care Insurance Act in Germany" *Journal of Population and Social Security: Social Security Study*, vol. 1, no. 2, 2002, pp. 15–16.

2001 – Risk Structure Compensation Reform Act

The following extract was written in German and translated into English using Google Translate from *Wikipedia.*

> The Risk Structure Compensation (RSA) is a financial compensation mechanism in social health insurance systems with freedom of choice between health insurance companies. In order to reduce the problem of risk selection, either health insurers with a "good" risk structure of their policyholders pay compensation payments to

> insurers with a "bad" risk structure, or those with the "good" risk structure receive lower allocations from a central body than those with a "bad" risk structure. In the German statutory health insurance (GKV), a risk structure compensation has been introduced since 1994.
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> In the years 2000 and 2001, a decision of the German Bundestag in connection with the 2000 health reform was prepared by IGES/Cassel/J. Wasem for the Federal Ministry of Health with an inventory and proposals for the further development of the RSA. At the same time, K. Lauterbach/E. Wille prepared an expert opinion for the umbrella associations of health insurance companies. From the proposals in both reports, the expert groups developed a joint consensus paper, from which the ministry developed a draft law for an RSA reform; the law came into force on 1 January 2002.

Citation: "Risikostrukturausgleich" *Wikipedia*

2001 – Pharmaceutical Budget Replacement Act

The following excerpt, written in German and translated into English using Google Translate, from a press release by Germany's Federal Council describes the Pharmaceutical Budget Replacement Act of 2001.

> Today, the Bundesrat approved the *law on the replacement of the pharmaceutical and therapeutic products budget*. The attempt to achieve an economical method of prescribing medicines and therapeutic products in statutory health insurance by means of expenditure budgeting with sanctions has met with great resistance in practice and has led to considerable implementation problems. The present law is now intended to control expenditure in the area of medicines and therapeutic products more effectively by means of negotiations between the contracting parties. The "collective recourse" will be abolished. Instead, the associations of statutory health insurance physicians and the panel physicians can agree with the state associations of the statutory health insurance funds themselves on the expenditure volume to be updated annually. In the future, the parties to the collective agreements are to jointly regulate the consequences of exceedances. The expenditure volumes for medicines and medicines are also separated from each other.

Citation: "Arzneimittelbudgetierung wird abgeschafft" *Bundesrat*, 9 Nov. 2001

2003 – Statutory Health Insurance Modernization Act

The following extract, written in German and translated into English using Google Translate, from the website of AOK, the German public health insurance provider, provides some details about the Statutory Health Insurance Modernization Act of 2003.

> With the GKV Modernization Act (GMG), a large package of measures has been adopted that is primarily intended to counteract the continuous increase in contributions in statutory health insurance. Among other things, patients must now pay co-payments for all services.

Citation: "GKV-Modernisierungsgesetz (GMG)" *AOK*, 1 Jan. 2004.
See also "GKV-Modernisierungsgesetz" *Wikipedia*.

2007 – SHI Competition Strengthening Act

The following extract from the *CESifo Dice Report: Journal for Institutional Comparisons* describes the Social Health Insurance Pro Competition Act of 2007.

> On 1 April 2007 an act became effective which will radically change the German system of health care: the GKV-Wettbewerbsstärkungsgesetz (Social Health Insurance Pro Competition Act; henceforth cited as GKV-WSG). The list of provisions is long and diverse. It includes mandatory coverage for everyone by 2009, extended outpatient care by hospitals, new rules for pricing the services supplied by physicians in free practice and strengthened efficiency requirements for the approval of prescription drugs. Above all, the law changes the contractual relationships between the insured, the suppliers of insurance and the providers of health care services. The reform aims at fostering competition in the health care sector. This dominating objective explains the act's name. From an economic point of view the most interesting provisions are
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> • granting extended autonomy to the social health insurance (SHI) sickness funds which enables them to contract selectively with the suppliers of health care services
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> • breaking with a regime under which the sickness funds compete for membership by means of wage-related contribution rates and moving towards competition on the basis of payroll-tax financed vouchers
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> • obligating private insurers to transfer accumulated premium reserves when an insured switches to another insurance plan.

Citation: Richter, Wolfram F. "Germany Goes Ahead with Health Vouchers" *CESifo Dice Report: Journal for Institutional Comparisons*, vol. 7, no. 3, 2009, p. 53.

2015 – Health Care Strengthening Act

The following extract from a case study by the European Agency for Safety and Health at Work describes the Preventative Health Care Act of 2015.

> In 2015, Germany passed an act to strengthen health promotion and preventive healthcare, the Act to strengthen health promotion and prevention (Das Gesetz zur Stärkung der Gesundheitsförderung und der Prävention, Präventionsgesetz - PrävG). This Act provides a strong legal basis for cooperation between actors involved in prevention and health promotion. It stipulates that a National Prevention Strategy (Nationale Präventionsstrategie) be developed by the country's different health insurance funds, to be implemented through a National Prevention Conference (Nationale Präventionskonferenz, NPK). The core of the law focuses on strengthening prevention and health promotion in the settings in which people live, work and learn, including daycare centres, schools and workplaces. This should be achieved through improving the coordination between the institutions responsible for these settings and involved in prevention and health promotion at the Federal Government, federal state (Länder) and municipal levels.
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> Expenditure on prevention and health promotion by the health insurance funds is to be almost doubled. The additional expenditure is expected to be offset in the medium and long term by cost savings in curative healthcare. As mentioned explicitly in the law, the goals developed under the National Prevention Strategy must take into account the goals of the Joint German Occupational Safety and Health Strategy (Gemeinsame Deutsche Arbeitsschutzstrategie, GDA). As of 2019, there will be common goals regarding healthy living and working under the two strategies. As a result of the concrete coordination and planning activities required by this law and the budget tied to it, this Act has laid important groundwork for MSD prevention in the workplace.

Citation: European Agency for Safety and Health at Work *Case Study: The Preventative Health Care Act of 2015 (Präventionsgesetz, GERMANY)*. 2019, p. 0.

2019 – SHI Contribution Relief Law

The following extract from the *Commonwealth Fund* describes the 2018 SHI Contribution Relief Law.

> The first new bill introduced in 2018 (the SHI-Contribution Relief Law, or *GKV-Versichertenentlastungsgesetz*) aims to reduce the mandatory contributions that individuals in SHI pay every month. While the general contribution of 14.6 percent has been equally shared between employers and employees since 2015, the

> supplementary contribution is paid by employees only. The law plans to reinstate the equal split of general and supplementary contributions between employers and employees. Furthermore, the law stipulates halving the reference amount used to calculate the minimum contribution for the self-employed insured. Until now, independent of their actual income, the self-employed have paid a contribution based on expected minimum income of EUR 221 (USD 284) per month. This is unmanageable for a large proportion of small-business owners and increases their risk of having no health insurance.

Blümel, Miriam, and Reinhard Busse. "International Health Care System Profiles: Germany" *The Commonwealth Fund*, 5 June 2020.

2019 – Appointment Service and Care Act

The following extract, written in German and translated into English using Google Translate, from Germany's Federal Ministry of Health, describes the Appointment Service and Care Act of 2019.

> Patients are to get doctor's appointments more quickly, and health insurance benefits and care are to be improved. These are the goals of the "Act for Faster Appointments and Better Care" (Appointment Service and Care Act, TSVG), which entered into force on 11 May 2019.

Citation: "Schnellere Termine, mehr Sprechstunden, bessere Angebote für gesetzlich Versicherte" *Bundesministerium für Gesundheit*, 10 May 2019.

2019 – Digital Health Care Act

The following extract from Germany's Federal Ministry of Health describes the Act to Improve Healthcare Provision through Digitalization and Innovation (of 2019.

> Apps on prescription, easy use of online video consultations and access to a secure healthcare data network for treatment everywhere – all achievements of the "Act to Improve Healthcare Provision through Digitalization and Innovation" (Digital Healthcare Act – DVG), which was approved on 7 November 2019 by the Bundestag and adopted on 29 November 2019 by the Bundesrat.

Citation: "Driving the digital transformation of Germany's healthcare system for the good of patients" *Bundesministerium für Gesundheit*, 22 April 2020.

2020 – Patient Data Protection Act

The following blog extract explains Germany's Patient Data Protection Act of 2020.

> On 3 July 2020, Germany's Federal Parliament, the Bundestag, passed the Patient Data Protection Act or Patientendaten-Schutz-Gesetz (PDSG). It entered into force less than four months later, on 20 October 2020.
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> The PDSG is part of a push for the digitalization of the German healthcare system. It introduces a number of innovative digital applications and requirements for the protection of patient information stored in an electronic format.

Citation: Coos, Andrada. "Germany's Patient Data Protection Act: All You Need to Know" *Endpoint Protector*, 22 Sept. 2021.

2022 – Statutory Health Insurance Financial Stabilization Act

The following extract from a paper called Implications of Germany's 2022 National Association of Statutory Health Insurance Funds Financial Stabilization Act (GKV-FinStG) explains key components of Germany's Statutory Health Insurance Financial Stabilization Act of 2022.

> **Financial Reserves:** The current health insurance financial reserves are used for the purpose of contribution rate stabilization with a cross-institutional solidarity equalization. The liquidity reserves' upper limit related to health insurance funds would be divided in half. To close the financial gap even further, the excess funds would be used for higher allocation of health insurance.
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> **Federal Subsidy:** The subsidy for GKV is increased for 2023 by EURO 2 billion, accounting for EURO 14.5 billion.
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> **Federal Loan:** For the year 2023, a non-interest-bearing loan of EURO 1 billion has been granted to the health funds by the federal government.
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> **Manufacturer's Discount:** Pharmaceutical manufacturers offer manufacturer discounts to help with cost-saving purposes. It has been increased by five percentage points for the year 2023. The increase was specially planned for patent-protected medicines. This measure would help with the overall financial burden on the health insurance system through lower prices for patent-protected medicines. The government tries to address medicine's budgetary and affordability issues within the GKV framework.

Reforms in AMNOG: AMNOG is the framework through which the new pharmaceutical assessment, pricing, and reimbursement are performed. The reform in this framework aims to change the pricing structure of medicines that provide no or only added therapeutical value. In addition, new measures are set to mitigate the increased spending on medicines with patent protection.

Pharmacy Discount: This discount refers to the mechanism through which the pharmacies receive price reductions to acquire medicines. The pharmaceutical discount increased for a fixed period of two years from EURO 1.77 to EURO 2 per drug pack. This increase stabilizes the financial situation and possibly cuts the government's budgetary spending.

Price Moratorium: refers to the freeze or limitation of medicine prices on a temporary basis. The new reform imposes a price moratorium on medical products for an extended period until 2026. The price moratorium is often imposed on medical products to control the prices and cost control within the healthcare system.

Care Budget: Only the costs of qualified nurses serving in bed-leading wards in direct patient care would be considered and accounted for in the care budget.

New patient rule: There was some extra-budgetary remuneration previously associated with the contract of medical services related to new patients, which this regulation aims to eliminate. To eliminate this extra-budgetary remuneration, a new remuneration incentive has been introduced, which makes faster treatment appointments for new patients possible through encouraging contract doctors.

Dentist Fees: Limitations on dentist fees are enforced, which means they cannot increase their fees. However, these limitations have some exceptions, including outreach services provided in outreach areas would be exempt. Further, cooperation agreements which cover inpatient facilities and the dentist are also exempt. Finally, periodontitis treatment for insured people with disabilities and care needs is also exempt.

Citation: Noori, Abdullah. "Implications of Germany's 2022 National Association of Statutory Health Insurance Funds Financial Stabilization Act (GKV-FinStG)" Seminar II, University of Dusseldorf, Germany, 2023, p. 3–4.

2023 – Digitalization Acceleration Act

The following extract from the Swiss Institute for Data Protection and Data Security illustrates the key changes resulting from Germany's Digitalization Acceleration Act of 2023.

Electronic Health Records (ePA): From January 2025, the electronic health record (ePA) will be introduced for all legally insured persons, with an opt-out option. A

corresponding ePA will also be offered to privately insured individuals on an appeal basis by private health insurance companies.

Digital Medication Overview: The introduction of the ePA provides insured persons with a comprehensive digital medication overview, generated automatically. This supports physicians in avoiding adverse drug interactions and optimizes treatment processes.

E-Prescription: The e-prescription is standardized and established as an integral part of medication supply. Additional access is available via the ePA app.

Digital Health Application (DiGA): Digital health applications (DiGA) are increasingly being integrated into care processes, with greater transparency in their use. The expansion of DiGA to include digital medical devices in risk class IIb enables their use in more advanced treatments, such as telemonitoring.

Telemedicine: To establish telemedicine more firmly in the healthcare system, quantity restrictions are being removed. Assisted telemedicine will also enable easier access to care. University outpatient clinics, psychiatric outpatient clinics, and psychotherapeutic consultations can now offer telemedical services.

Digital Advisory Board: A Digital Advisory Board is being established, which includes representatives from the Federal Commissioner for Data Protection and Freedom of Information (BfDI) and the Federal Office for Information Security (BSI). Ethical and medical perspectives are specifically considered in its composition. The board will provide ongoing support by offering balanced recommendations on issues such as data protection, data security, data use, and usability.

Citation: "Act to Speed Up the Digitization of Healthcare" *SIDD: Institute for Data Protection and Data Security*.

2025 – Hospital Care Improvement Act

The following extract, written in German and translated into English using Google Translate, from Germany's Federal Ministry of Health describes the goals of the 2025 Hospital Care Improvement Act.

- The economic pressure will be relieved of the hospitals: In the future, hospitals that are essential for needs will be secured to a relevant extent regardless of the provision of services. In the short term, the calculation basis for the payment of hospitals (state base case value) will be adjusted.
- Additional funds will be granted for stroke units, traumatology, pediatrics, obstetrics, intensive care, coordination tasks, university hospitals, emergency care.

- In order to improve the quality of care, criteria are defined for 65 service groups (LG) and all services of the hospitals are clearly assigned to one of the service groups.
- The responsibility of the states for hospital planning remains unaffected. They decide which hospital should offer which service groups.
- Quality standards must be met for the assignment of performance groups. The prerequisite for the assignment of performance groups is the fulfilment of nationwide quality criteria.
- In principle, the fulfilment of the quality criteria is also permissible within the framework of cooperations and associations.
- In order to ensure nationwide care, exemptions are provided for which apply indefinitely to hospitals in rural areas that are necessary for needs. The existing surcharges for these hospitals will be increased.
- The quick accessibility of clinics remains ensured. Temporary exemptions of up to three years can be granted to hospitals if a hospital cannot be reached within a legally defined distance (30 car min for LG general surgery and general internal medicine; 40 car min for all other LG)
- Basic care close to home remains secured. Through cross-sectoral care facilities (Level 1i), inpatient hospital treatment close to home is combined with outpatient and nursing services in addition to the hospitals in rural areas that are necessary for needs, which are awarded a contract. These facilities ensure basic medical care close to home by bundling interdisciplinary and interprofessional services.
- A transformation fund will provide the necessary financial resources to promote the structural changes. Over 10 years, a total of up to 50 Billion. euros.
- In order to reduce the administrative burden on hospitals, documentation will be streamlined and the system will be reduced in bureaucracy. The introduction of the retention fee will reduce the effort involved in accounting audits, as structured random audits are to replace the previous case-by-case audits.

Citation: "Bundeskabinett beschließt Krankenhausreform" *Bundesministerium für Gesundheit*.