



**DESCRIPTIONS OF HEALTH CARE SYSTEMS:  
GERMANY AND THE NETHERLANDS**

# The German Health Care System

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## Who is covered?

Public (“social”) health insurance (SHI) is compulsory for people earning up to around €48,000 per year, including dependents who are included in the insurance. This applies to around 75% of the population. Individuals with earnings above €48,000 per year (around 20% of the population) are currently not required to be covered. If they wish, they can remain in the publicly-financed scheme on a voluntary basis (and 75% of them do), they can purchase private health insurance, or they can theoretically be uninsured. The publicly-financed scheme covers about 88% of the population. In total, 10% of the population are covered by private health insurance, with civil servants and self-employed being the largest groups (both of which are excluded from SHI). Less than 1% of the population has no insurance coverage. From 2009, health insurance will be mandatory, depending on previous insurance and/or job status either in the social or in the private health insurance scheme.

## What is covered?

*Services:* The SHI benefits package covers preventive services; inpatient and outpatient hospital care; physician services; mental health care; dental care; prescription drugs; medical aids; rehabilitation; and sick leave compensation. Since 1995, long-term care is covered by a separate insurance scheme, which is mandatory for the whole population.

*Cost-sharing:* Traditionally, the SHI scheme has imposed few cost-sharing provisions (mainly for pharmaceuticals and dental care). However, in 2004 co-payments were introduced for visits by adults

aged 18 years and older to physicians and dentists (€10 each for the first visit per quarter or subsequent visits without referral); other co-

payments were made more uniform: €5 to €10 per pack of outpatient medications (except if the price is at least 30% below the so-called reference price, i.e. the maximum reimbursable amount for drugs of equivalent effectiveness, which is the case for more than 12,000 drugs), €10 per inpatient day (up to 28 days per year), and €5 to €10 for prescribed medical aids. For dental prostheses, patients receive a lump sum which on average covers 50% of costs. In total, out-of-pocket payments accounted for 13.8% of total health expenditure in 2005.

*Safety Nets:* Cost-sharing is generally limited to 2% of household income. For additional family members, part of the household income is excluded from this calculation. For the chronically ill, the cost-sharing limit is 1%. A directive sets out the conditions for qualifying as chronically ill; since 2008 it is also necessary to demonstrate that the person has received counselling on screening measures prior to the illness.

## How is the health system financed?

*Publicly-Financed Scheme (SHI):* The SHI scheme is operated by over 200 competing health insurance funds (sickness funds; SFs): autonomous, not-for-profit, non-governmental bodies regulated by law. The scheme is funded by compulsory contributions based on wages up to a limit of around €43,000 per year. For 2008, the average insured employee (or pensioner) contributes almost 8% of the gross wage, while the employer (or the pension fund) adds another 7% on top of the gross wage, so the combined maximum contribution is around €540 per month. This includes dependents (non-earning spouses and children) who are covered through the primary SF member. Unemployed people contribute in proportion to their unemployment entitlements, but for long-term unemployed people with a fixed low entitlement (so-called “Hartz IV”), the government employment agency pays a fixed per capita premium. Currently, SFs are free to set their own contribution rates for

all other insured. Beginning in 2009, a uniform contribution rate will be set by the government and, although SFs will continue to collect contributions, all contributions will be centrally pooled by a new national health fund, which will allocate resources to each SF based on an improved risk-adjusted capitation formula. This formula will, in addition to age and sex, take morbidity from 80 chronic and/or serious illnesses into account, i.e. SFs will receive considerably more for patients with cancer, AIDS or cystic fibrosis than for “ordinary” insured. In 2009, SFs may charge an additional nominal premium if the received resources are insufficient. In 2005, public sources of finance accounted for 77.2% of total health expenditure.

*Private health insurance (PHI):* Private health insurance plays a substitutive role in covering the two groups excluded from SHI (civil servants, who are refunded parts of their health care costs by their employer, and the self-employed), as well as high earners who choose to opt out of the publicly-financed scheme. All pay a risk-related premium, with separate premiums paid for dependents; the risk is assessed upon entry only, though as contracts are based on life-time underwriting. Substitutive private health insurance is regulated by the government to ensure that the insured do not face massively increasing premiums by age and that they are not overburdened by premiums if their income decreases. Starting in 2009, private insurers offering substitutive cover will be required to take part in a risk adjustment scheme (separate from SHI) to be able to offer insurance for persons with ill health who could otherwise not afford a risk-related premium. PHI also plays a mixed complementary and supplementary role, adding certain minor benefits to the SHI basket, providing access to better amenities, such as single/double rooms, and covering some co-payments, especially for dental care. In 2005, PHI accounted for 9.1% of total health expenditure.

### **How is the delivery system organised?**

*Physicians:* General practitioners have no formal gatekeeper function. However, in 2004 SFs were required to offer their members the option to enroll in a “family physician care model” which provides a bonus for complying with gatekeeping rules. Ambulatory care in all specialities is mainly delivered by physicians working in solo practices, although

polyclinic-type ambulatory care centres with employed physicians have been allowed since 2004. Physicians in the outpatient sector are paid by a mixture of fees per time period and per medical procedure. SFs annually negotiate with the regional associations of physicians to determine aggregate payments, which ensures cost control.

*Hospitals:* Hospitals are mainly non-profit, both public (about half of all beds) and private (around one-third of all beds). The private, for-profit segment has been growing over the last years (around one-sixth of all beds), mainly through takeovers of public hospitals. Independent of ownership, hospitals are principally staffed by salaried doctors. Senior doctors may also treat privately-insured patients on a fee-for-service basis. Doctors in hospitals are typically not allowed to treat outpatients. Exceptions have been made if necessary care cannot be provided on an outpatient basis by specialists in private practice. Since 2004, hospitals may also provide certain highly specialized services on an outpatient basis. Inpatient care is paid through a system of diagnosis-related groups (DRG) per admission, currently based on around 1,100 DRG categories. The system was introduced in 2004 and is revised annually to take new technologies, changes in treatment patterns, and associated costs into account.

Individuals have free choice of ambulatory care physicians and, if referred to inpatient care, of hospitals.

*Disease Management Programs (DMPs):* Legislation in 2002 created DMPs for chronic illnesses in order to give the SFs an incentive to care for chronically ill patients. DMPs currently exist for diabetes types 1 and 2, breast cancer, coronary heart disease, asthma and chronic obstructive lung disease. DMP participants are accounted separately in the risk-adjusted reallocation mechanism between SFs, i.e. they generally receive higher per-capita allocations than for non-DMP participants. Through that mechanism, SFs with higher shares of DMP patients receive higher compensation. There are currently 14,000 regional DMPs with 3.8 million enrolled patients (as of late 2007).

*Government:* The German government delegates regulation to the self-governing corporatist bodies of both the SFs and the medical providers’ associations. The most important body is the Federal Joint Committee,

created in 2004 to increase efficacy and compliance; it replaced several sectoral committees. However, more purchasing powers are also given directly to the individual SFs, e.g. to contract providers directly, to negotiate rebates with pharmaceutical companies or to procure medical aids.

### **What is being done to ensure quality of care?**

Quality of care is addressed through a range of measures: *Structural quality* is addressed by the requirement to have a quality management system for all providers, the obligation for continuous medical education for all physicians, and health technology assessment for drugs and procedures (for which the Institute for Quality and Efficiency, IQWiG, was founded in 2004), while hospital accreditation is voluntary. Minimum volume requirements were introduced for a number of complex procedures (e.g. transplantations), thereby requiring hospitals to provide this number in order to be reimbursed. *Process and partly outcome quality* is addressed through the mandatory quality reporting system for all 1800+ acute care hospitals. Under this system, more than 150 indicators are measured for 30 indications covering about one-sixth of all inpatients in Germany. Hospitals receive an individual feedback. Since 2007, around 30 indicators are made public in annual, mandatory hospital quality reports.

### **What is being done to improve efficiency?**

Besides the measures to increase quality listed above, a set of other measures addresses efficiency more directly. All drugs, both patented and generic, have been subject to reference prices since 2004, unless they can demonstrate a clear added medical benefit. From 2008, IQWiG will explicitly evaluate the cost-effectiveness of drugs, thereby adding pressure on pharmaceutical prices. As mentioned, all hospitals are reimbursed through DRGs, so hospitals are paid the same for the same type of patient. As DRGs weights are calculated based on average costs, this puts enormous pressure on less efficient hospitals.

### **How are costs controlled?**

In line with placing more emphasis on quality and efficiency, the previously imposed, relatively crude, but successful cost-containment measures (especially sector-wide budgets for ambulatory physicians, hospital budgets, collective prescription caps for physicians on a regional basis) are carefully revised. The prescription cap, which complemented the reference prices for pharmaceuticals, was lifted in 2001, initially leading to an unprecedented increase in spending on pharmaceuticals by the SFs. Then, prescription caps with individual liabilities were introduced. More recently negotiated rebates between SFs and pharmaceutical manufacturers and incentives to lower prices below the reference prices are the major instruments. Hospital budgets are being phased out between 2005 and 2008, while per-case DRGs become the main instrument to reimburse inpatient care. From 2009, the fixed budgets for ambulatory care will be replaced by more flexible budgets that take population morbidity into account.

# The Dutch Health Care System

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## Who is covered?

Since January 1, 2006, all residents or those paying income tax in the Netherlands are required to purchase health insurance coverage<sup>1</sup>. Coverage is statutory under the Health Insurance Act (Zorgverzekeringswet; ZVW) but provided by private health insurers and regulated under private law. The uninsured proportion of the population is estimated to be 1.5%, a figure that is likely to rise further (Maarse 2007). Asylum seekers are covered by the government and several mechanisms are in place to reimburse the health care costs of illegal immigrants unable to pay for care. New legislation regarding the health care costs of illegal immigrants is being debated in parliament.

Prior to 2006, people with earnings above approximately €30,000 (\$43,130) per year and their dependants (around 35% of the population) were excluded from statutory coverage provided by public sickness funds and could purchase cover from private health insurers. This form of substitutive private health insurance<sup>2</sup> was regulated by the government to ensure older people and people in poor health had adequate access to health care and to compensate the publicly-financed health insurance scheme for covering a disproportionate amount of high risk individuals. Over time, growing dissatisfaction with the dual system of public and private coverage led to the reforms of 2006.

## What is covered?

*Services:* Insurers are legally required to provide a standard benefits package covering the following: medical care, including care by general

practitioners (GPs), hospitals and midwives; hospitalisation; dental care (up to the age of 18; coverage from age 18 is confined to specialist dental care and dentures); medical aids; medicines; maternity care; ambulance and patient transport services; paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy and dietary advice). Insurers may decide by whom and how this care is delivered, which gives the insured a choice of policies based on quality and costs. In addition to the standard benefits package, all citizens are covered by the statutory Exceptional Medical Expenses Act (AWBZ) scheme for a wide range of chronic and mental health care services such as home care and care in nursing homes. Most people also purchase complementary private health insurance for services not covered by the standard benefits package, although insurers are not required to accept applications for private health insurance.

*Cost sharing:* The insured pay a flat-rate premium (set by insurers) to their private health insurer. Everyone with the same policy pays the same premium. In 2006 an insured person was eligible for a refund of €255 (\$367) if they incurred no health care costs. If they incurred costs of less than €255, they would receive the difference at the end of the year. This 'no claims bonus' system was abolished in 2007, following a change of government, and has been replaced by a system of deductibles. Every insured person aged 18 and over must now pay the first €150 (\$216) of any health care costs in a given year (with some services excluded from this general rule). Out of pocket payments as a proportion of total health expenditure are around 8% (Statistics Netherlands 2007; World Health Organization 2007).

*Safety nets:* Children are exempt from cost sharing. The government provides 'health care allowances' for low income citizens if the average flat-rate premium exceeds 5% of their household income.

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<sup>1</sup> The exceptions are those with conscientious objections and members of the armed forces on active service.

<sup>2</sup> Substitutive private health insurance covers people excluded from the publicly-financed health insurance scheme.

## **How is the health system financed?**

*Statutory health insurance:* The statutory health insurance system (ZVW) is financed by a mixture of income-related contributions and premiums paid by the insured. The income-related contribution is set at 6.5% of the first €30,000 (\$43,130) of annual taxable income. Employers must reimburse their employees for this contribution and employees must pay tax on this reimbursement. For those who do not have an employer and do not receive unemployment benefits, the income-related contribution is 4.4%. The contribution of self-employed people is individually assessed by the Tax Department. Contributions are collected centrally and distributed among insurers based on a risk-adjusted capitation formula. In 2006 the average annual premium was €1,050 (\$1513). The government pays for the premiums of children up to the age of 18. In 2005 public sources of finance accounted for 65.7% of total health expenditure (World Health Organization 2007). In 2006 this proportion had risen to around 78% (Statistics Netherlands 2007).

*Private health insurance:* Substitutive private health insurance was abolished in 2006. Most of the population purchase a mixture of complementary and supplementary private health insurance from the same health insurers who provide statutory coverage. This has given rise to concerns about the potential for risk selection, as the premiums and products of voluntary coverage are not regulated. In 2005, private health insurance accounted for 20.1% of total health expenditure (World Health Organization 2007). In 2006 this proportion had fallen to about 7% (Statistics Netherlands 2007).

## **How is the delivery system organised?**

*Health insurance funds:* Insurers are private and governed by private law. They are permitted to have for-profit status. They must be registered with the Supervisory Board for Health Insurance (CTZ) to enable supervision of the services they provide under the Health Insurance Act and to qualify for payments from the risk equalisation fund. The insured have free choice of insurer and insurers must accept every resident in their coverage area (although most already operate nationally). A system of risk equalisation/adjustment is used to prevent direct or indirect risk selection by insurers.

*Physicians:* Physicians practise directly or indirectly under contracts negotiated with private health insurers. GPs receive a capitation payment for each patient on their practice list and a fee per consultation. Additional budgets can be negotiated for extra services, practice nurses, complex location etc. Experiments with pay-for-performance for quality in primary and hospital care are underway. Most specialists are hospital based. Two-thirds of hospital-based specialists are self-employed, organised in partnerships and paid on a capped fee for service basis. The remainder are salaried. Future payments will increasingly be related to activity through the Dutch version of DRGs known as Diagnosis Treatment Combinations (DTCs).

*Hospitals:* Most hospitals are private non-profit organisations. Hospital budgets are developed using a formula that pays a fixed amount per bed, patient volume and number of licensed specialists, in addition to other factors. Additional funds are provided for capital investment, although hospitals are increasingly encouraged to obtain capital via the private market. From 2000, for several years payments to hospitals were rated according to performance on a number of accessibility indicators. Hospitals that produced fewer inpatient days than agreed with health insurers were paid less, a measure designed to reduce waiting lists. A new system of payment for specific products (DTCs) is currently being implemented. Ten percent all hospital services are now reimbursed on the basis of DTCs (up to 100% of all services in some hospitals). In the future, it is expected that most care will be reimbursed using DTCs, although there is still considerable debate about the desired speed of further liberalization of the hospital market (for example, through giving hospitals greater freedom in negotiating the price and quality of DTCs).

## **What is being done to ensure quality of care?**

At the health system level, quality of care is ensured through legislation regarding professional performance, quality in health care institutions, patient rights and health technologies. A national inspectorate for health is responsible for monitoring and other activities. Most quality assurance is carried out by health care providers in close co-operation with patient and consumer organisations and insurers. Mechanisms to ensure quality in the care provided by individual professionals involve

re-registration/re-validation for specialists based on compulsory continuous medical education; regular on site peer assessments organised by professional bodies; profession-owned clinical guidelines, indicators and peer review. The main methods used to ensure quality in institutions include accreditation and certification; compulsory and voluntary performance assessment based on indicators; and national quality improvement programmes based on the breakthrough method (Sneller Beter). Patient experiences are systematically assessed and since 2007 a national centre has been working with validated measurement instruments comparable to the CAHPS approach in the United States. The centre also generates publicly-available information for consumer choice.

### **What is being done to improve efficiency?**

The main approach to improving efficiency in the Dutch health system rests on regulated competition between insurers combined with central steering on performance and transparency about outcomes via the use of performance indicators. This is complemented by provider payment reforms involving a general shift from a budget-oriented reimbursement system to a performance-related approach (for example, the introduction of DTCs mentioned above). In addition, various local and national programmes aim to improve health care logistics and/or initiate 'business process re-engineering'. At a national level, health technology assessment (HTA) is used to enhance value for money by informing

decision making about reimbursement and encouraging appropriate use of health technologies. At the local level, several mechanisms are used to ensure appropriate prescribing.

### **How are costs controlled?**

The new Health Insurance Act aims to increase competition between private health insurers and providers to control costs and increase quality, but it is still too early to say whether these aims have been met. Increasingly, costs are expected to be controlled by the new DTC system in which hospitals must compete on price for specific services.

### **Sources**

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