

TranState Working Papers

THE SELF-REGULATORY
GERMAN HEALTH CARE SYSTEM
BETWEEN GROWING COMPETITION
AND STATE HIERARCHY

Claus Wendt
Heinz Rothgang
Uwe Helmert

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Universität Bremen • University of Bremen
Hochschule Bremen • University of Applied Sciences
Internationale Universität Bremen (IUB) • International University Bremen (IUB)

Staatlichkeit im Wandel • Transformations of the State
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*Claus Wendt
Heinz Rothgang
Uwe Helmert*

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Claus Wendt, Heinz Rothgang, and Uwe Helmert

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Staatlichkeit im Wandel / Transformations of the State

Postfach 33 04 40

D - 28334 Bremen

Tel.:+ 49 421 218-8720

Fax:+ 49 421 218-8721

Homepage: <http://www.staatlichkeit.uni-bremen.de>

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ABSTRACT

This article focuses on the changing role of the state in financing, providing and regulating health care services under the German health care system from 1970-2000. While a reduced role of the state can be observed in terms of *financing*, our analysis of *service provision* indicates inconsistent developments. Monetary resource flow analyses indicate a decrease in private service provision as a percentage of total health expenditure, but when analysing the development of health employment we see a growth in “private” health care personnel. The most important changes, however, have taken place in terms of *regulation*. Since the early 1990s, the traditionally self-regulatory German health care system has simultaneously faced growing competition *and* state hierarchy.

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1 INTRODUCTION

Within the prevalent environment of globalisation and ongoing austerity, the role of the state in the German health insurance system – as is the case with many other advanced health care systems – is undergoing significant changes. While many health care system comparisons more or less exclusively focus on financing and expenditure data (see e.g. OECD 1994, 1995, 1996; Comas-Herrera 1999; Leidl 2001; Castles 2004), the aim of our paper is to link the financing dimension with those of service provision and regulation. For many years, the German system operated predominantly on a self-regulatory basis, but since the early 1990s, competition as well as state hierarchy has become increasingly important. The self-regulatory German health care system therefore increasingly incorporates modes of co-ordination that are characteristic of other types of health care systems. In order to evaluate our main thesis that the role of the state as well as modes of regulation are changing in the direction of stronger market mechanisms *and* more direct state intervention while at the same time the principle of self-regulation is waning, this article analyses German health care reforms (*Section 2*) as well as changes in health care financing (*Section 3*), health service provision (*Section 4*) and regulation (*Section 5*) in Germany. The main focus thereby is on the years 1970-2000, as this long-term perspective enables us to capture the effects of the oil price shocks of the 1970s as well as the process of accelerating globalisation in the 1990s and the resulting cost-containment measures in health care systems.

2 HEALTH CARE REFORMS FROM 1950 TO 2004

Statutory health insurance is the central pillar of the German health care system. As the earliest social insurance system worldwide, institutionalised health care in Germany has experienced a long tradition of path dependency. The federal government is responsible for the legislative framework, while the specific conditions of health care financing and health care provision are regulated by the social insurance institutions through mutual self-governance. The Self-Government Act of 1951 gave the stakeholders of the social insurance system the status of autonomous collective actors. Statutory health insurance is almost exclusively financed by income-related contributions on a pay-as-you-go basis. Up until 2004, social insurance contributions were shared equally between employers and employees.¹ Social insurance funds are self-administered by a professional

¹ From 2005 onwards a separate contribution for dental insurance has to be paid by the employees alone, thus ending the long tradition of equal contributions by employers and employees.

board and a supervisory board, generally consisting of employees' representatives (i.e. mostly trade unionists) and employers. Sickness funds and their federal and regional associations have been public bodies since 1955. In the same year their negotiating partners in the provision of ambulatory medical care – i.e. the federal and regional panel doctors' associations – also received the status of public corporations, while the Federal Association of Hospitals, which is designated as the legal bargaining partner for this sector in the German Social Code Book (SGB V), has remained a private association. The panel doctors' associations were assigned the task of guaranteeing health service provision in the out-patient sector and controlling the suitability and economic efficiency of medical services provided by panel doctors. To this end the associations received – by state regulation – the monopoly for providing out-patient health care services. In 1960, the Constitutional Court overruled the existing restrictions on access to the health care market for panel doctors, which in effect led to an increase in the number of self-employed doctors in the subsequent decades.

The reforms of the 1950s determined the structure and the development of the German health care system over the next decades (Alber 1992: 41). Their monopoly over out-patient service provision, for instance, enabled the panel doctors' associations to push through fee-for-service reimbursement for their members (Rosewitz and Webber 1990: 291). In the 1950s, a “complex system of multiple regulation” (Alber 1992: 29) was institutionalized through the co-operation between government (both federal and state governments) and self-regulatory associations. Rosewitz and Webber (1990) as well as Alber (1992) attribute the subsequent lack of structural reforms in the German health care system to this “system of multiple regulation”. From the early 1990s onwards, however, a number of structural reforms were implemented, and negotiations between the social insurance funds and the panel doctors' associations increasingly took place in the “shadow of state hierarchy” (Scharpf 1991).

In the early 1970s, health policy in Germany was still on an expansion course. In 1972 a dual system of hospital financing was introduced under which the Länder (in cooperation with the federal government until 1984) were responsible for investments (hospital construction, renovation etc.), while the health insurance funds had to finance cost-covering hospital allowances. Under the Service Improvement Act of 1974, and through further health reforms in 1973 and 1974, additional health care services were included in the benefit package. By the mid-1970s coverage, too, had expanded with the compulsory inclusion of farmers, people with disabilities, students, and artists in the statutory health insurance system.

The recessions of the 1970s provided the signal for cost containment measures to be undertaken in the field of health policy. A first sign of this reorientation was the Social Insurance Development Act of 1976 that obliged panel doctors' associations, in co-

operation with health insurance fund associations, to develop need plans for out-patient medical services. In contrast to the 1960 Constitutional Court ruling, this led to a (weak) form of state control over the number of panel doctors in the out-patient sector (Alber 1992: 46f). One year later, the Health Insurance Cost Containment Act introduced a first attempt at “global regulation” within the German health care system. The Act stipulated that in their negotiations on their overall reimbursement, medical doctors and insurance funds now had to take into consideration developments in the size of the payroll tax base. These reforms signaled the institutionalisation of concerted action in the health care system, and from 1985 onwards the “Advisory Council for Concerted Action in the Health Care System” was responsible for making recommendations for the overall reimbursement of panel doctors on the basis of national economic developments. The Cost Containment Amendment Act of 1981, beside further laws implemented in the 1980s, extended the authority of doctors’ associations and insurance fund associations to increase control over individual service providers with a view to guaranteeing the quality and efficiency of health service provision (Rosewitz and Webber 1990). Initial restrictions on the benefit package, such as co-payments for dentures, pharmaceuticals and remedies, were also introduced during this period. The Health Care Reform Act (GRG) of 1989 granted the state the right of greater direct intervention in the social health insurance system while at the same time requiring it to retreat from direct service provision and financing. As an example, some preventive health care services, which had traditionally been under the supervision of governmental organisations, were now transferred to the ambit of social health insurance (Rothgang and Dräther 2003).

The Health Care Structure Act (GSG) of 1993 can be considered the first path-breaking structural reform of the German health care system (Jost 1998). By 1997 a free choice of sickness funds had been installed under this act for almost all of the insured population. The launch of competition between sickness funds and the introduction of a corresponding risk-adjustment mechanism established competition for the first time as a co-ordinating mechanism in its own right (Wendt, Grimmeisen, Rothgang 2005). Besides these and other structural changes, such as the improved co-ordination of in-patient and out-patient health care, for instance, budgets for different health care sectors were implemented by state regulation.

A further aim of the act of 1993 was to change the hospital financing system. Similarly, the Social Insurance Health Reform Act of 2000 set up a “diagnosis related groups (DRG) system”, which was then introduced by the DRG Reform Act of April 2002 (leading to a change in hospital financing that is intended to be completed by 2007). In 2004, the Health Care Modernisation Act (GMG) granted patients the (limited) right to choose between different health service packages, the possibility to opt for a cost reimbursement scheme, and the right to obtain a receipt for the health care services they re-

ceived. However, the act also entailed cuts in the benefit package and new forms of co-payments (such as an “office fee”). These constitute first indications that increased competition in the German health care system is accompanied by more information and transparency. The introduction of a German “Institute for Quality and Efficiency in Health Care” and the strengthening of the role of the (joint) Federal Commission through the GMG are further examples of attempts to improve the cost-effectiveness and efficiency of the self-regulatory system through state regulation. On the other hand, the GMG allowed sickness funds to contract on a selective basis, particularly in the area of “integrated care provision”. This, again, gave rise to more competition among sickness funds.

3 HEALTH CARE FINANCING

From 1970 to 2000, total health care financing increased from 6.0% to 10.4% of the GDP. The most dynamic increases, however, took place from 1970 to 1975, and again from 1991 to 1996. The changes in total health care financing have almost completely been fed by increases in social insurance financing (OECD Health Data 2002). The “leap” from 1970 to 1975 took place in a period of continuing health care service expansion. In the out-patient sector, for instance, doctors' associations managed to push through a system of fee-for-service payment that, in combination with an ever-growing number of doctors, can be considered a major cause of cost increases in that period. But the main cause for the increase in relative health care financing as a percentage of GDP was the economic recession following the oil price shocks of the 1970s.²

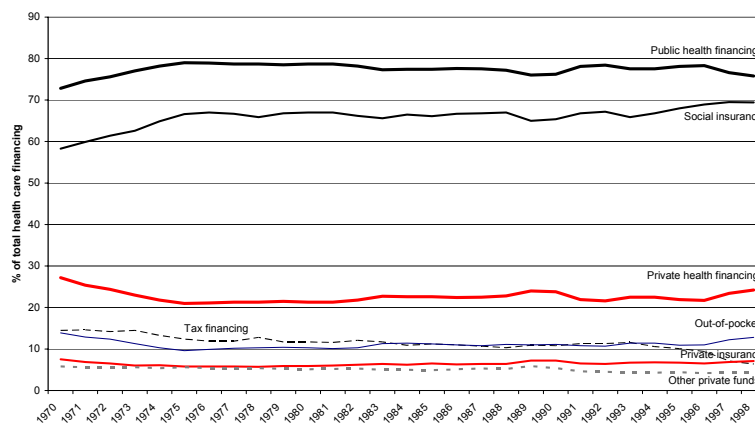
From 1975 to 1988 total health care financing only increased from 8.6% to 9.1% of the GDP. By 1989, total health care financing had even reached the 1975 level again, a development equally as noteworthy as the cost increases in the years before. Within this period, a wide range of cost containment measures was implemented (see above). The second “leap”, which helped Germany to rank third among OECD countries with respect to health care costs, took place in the years following German unification. Again, this is explained by a combination of increased health care costs and economic stagnation. In 1989/90, however, the short-term economic revival, in combination with a stabilisation of costs owing to the Health Care Reform Act resulted in a relative decrease in total health expenditure.

When breaking down the total health care budget into different health care funds we find an increase in public health care financing in the first half of the 1970s, followed by a stable development for more than two decades, then a drop from 1996 onwards. Private financing, by contrast, decreased until the mid-1970s, maintained a level of about

² The GDP (in 1995 prices) decreased from 1974 to 1975, followed by an only slow process of economic recovery in the following years.

20% until the mid-1990s, and then climbed to nearly 25% in 1998 (see *Figure 1*). Within the period under investigation, therefore, only a minor change in the public-private mix took place. Social insurance financing, as part of public financing, however, increased from less than 60% in 1970 to about 70% in 1998, while within the same period tax financing dropped from about 15% of total health care financing to its lowest level thus far (less than 6.5%). Thus, in terms of financing, the social insurance principle can be considered to be even stronger in 2000 than in 1970. The state (i.e., the federal government and especially the Länder), on the other hand, reduced its direct responsibility in health care financing over this period. We hardly see any change in the proportion of private health care financing through private health insurance. That remained on a level between 6% and 7.5% for the whole period under consideration. Private out-of-pocket payments decreased from 14% in 1970 to less than 10% in 1975, followed by an increase in the second half of the 1990s up to 13% in 1998.

Figure 1: Sources of financing in % of total health expenditure



Sources: OECD Health Data 2002; Statistisches Bundesamt 2001

Figure 2: Sources of financing across health care sectors

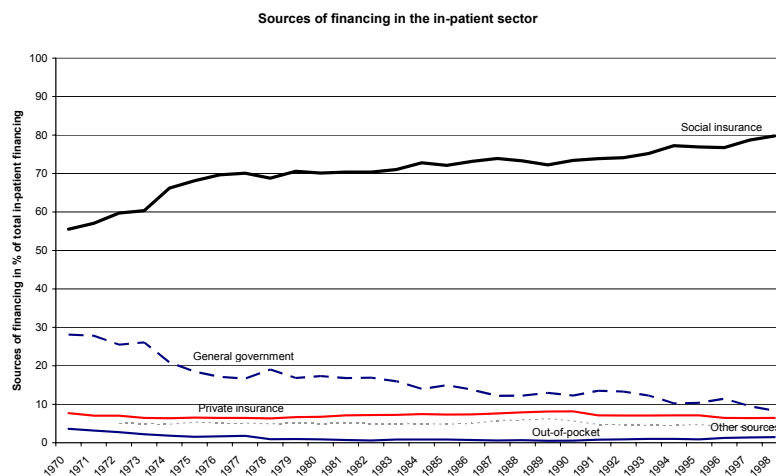
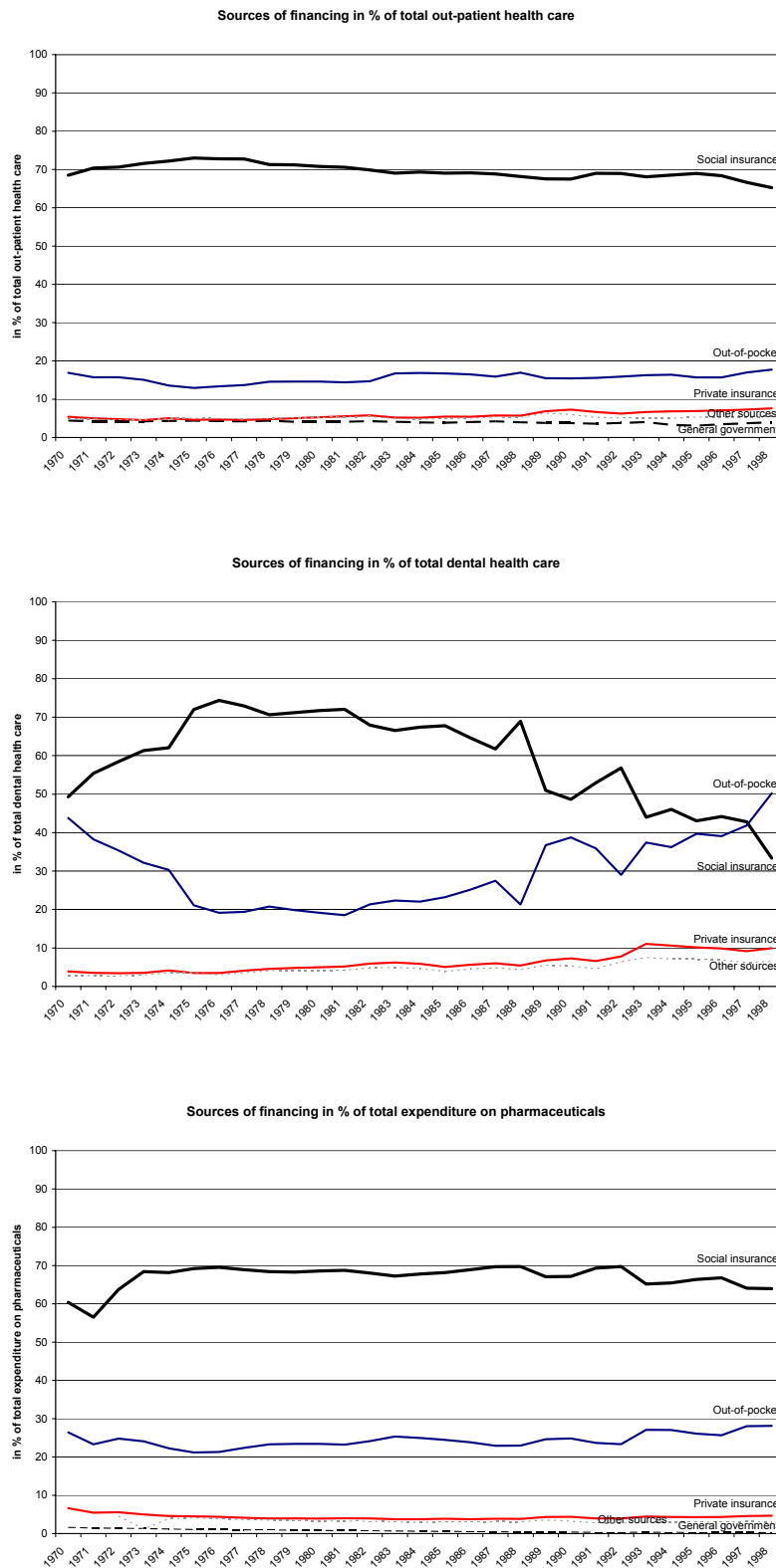


Figure 2 (continued): Sources of financing across health care sectors



Sources: Statistisches Bundesamt 2001, Fachserie 12

A variety of public-private combinations can be identified in the various health care sectors (see *Figures 2 and A1*). More than 80% of the *in-patient health care sector* was financed out of public sources in 1970, even growing to 85% in 1998. The growth in public spending was offset by a decrease in private spending by the same amount, indicating a high degree of public responsibility in the in-patient health care sector. A breakdown of public financing into governmental sources and social insurance financing shows a decrease in the former from 28% of total in-patient expenditure in 1970 to 8% in 1998. The share financed out of social insurance contributions, on the other hand, increased from 55% to 80% in the same period (see *Table A1*). These figures indicate a retreat of the state from direct financing responsibilities. This development can only partly be explained by specific health care reforms, however. The large increase in social insurance financing of hospital services in the 1970s, for instance, results from the decision that social insurance funds must pay cost-covering hospital allowances from 1972 onwards. In the same period, the *Länder*, too, invested heavily in hospital building and renovation. But since this increase was lower than the increase in allowances financed by social insurance funds, the relative share of funding through taxes was reduced.³ The drop in government funding in the second half of the 1980s and in the 1990s is mainly a result of lower investments in hospitals,⁴ and less a consequence of specific regulations. Furthermore, municipal hospitals are now increasingly sold to private hospital companies (Rosenbrock and Gerlinger 2004: 138). Private funds, on the other hand, today finance just about 15% of in-patient health care services. Although co-payments were introduced for hospital stays in 1983 (and stepped up through the Health Care Reform Act, the Health Care Structure Act and further reforms), the share of private out-of-pocket payments remained at a level below 2% from the mid-1970s onwards. The share of private insurance is higher than the share each patient pays out of their own pocket, but an expanding development can be detected in neither of the two sources of private health care financing (see *Table A1*).

In the *out-patient health care sector*, the private share is nowadays about twice as high as in the in-patient sector, and, as *Figures 2 and A1* show, figures for public and private funding converge from the mid-1970s onwards. The public share decreased from 75% in 1975 to 65% in 1998 while at the same time the private share increased. While general government funding remained below 5%, social insurance financing increased slightly to a level of more than 70% in 1975, followed by a relatively stable develop-

³ In 1984, the federal government ceased its involvement in the field of hospital financing, a decision that in the long term reduced the financial capacity of the state in the in-patient sector.

⁴ One effect of the low investment rate is that certain in-patient services become more and more expensive, which in turn increases the share financed by social insurance funds.

ment until the mid-1990s, then a reduction to about 65% in 1998. Other sources had to compensate the moderate development in social insurance financing. While private insurance financing increased only slightly, the share of out-of-pocket payments increased from 13% in 1975 to nearly 18% in 1998 (see *Table A1*) – a development that is mainly a result of increasing co-payments following the Health Care Reform Act of 1989 and the Health Care Structure Act of 1993. The introduction of a quarterly charge in 2004 for consultation with panel doctors (the so-called "office fee" mentioned above) increased the relative importance of private out-of-pocket payments even further. The percentage of private financing in the out-patient health care sector is therefore much higher than in the in-patient sector. Moreover, a further transfer of health care costs from public to private financing can be expected as a continuing trend.

The *dental health care* sector is the only example of a German health care system in which private sources have become nearly as important as public ones. After an increase in the public funding of dental health services from 70% in 1970 to 80% in 1975, the public and private shares strongly converged. In 1998 about 55% of dental health care services were financed out of public sources and 45% out of private sources (see *Figures 2 and A1*). In 1972, dentures were included in the benefit package. After a Federal Social Court ruling in 1974 the loss of teeth was recognised as an illness, and as a result had to be covered by social health insurance (Alber 1992: 144). The financing of dental health care through social insurance thus increased considerably, with the financial responsibility for dental prostheses in particular increasing from 50% in 1970 to nearly 75% in 1976. The Social Insurance Cost Containment Act of 1977 reduced the proportion of dental prosthesis costs covered by social insurance by 20% and the Cost Containment Amendment Act of 1981 reduced it by a further 20%. The remaining amount had to be covered by the patients themselves or by private insurance. In the mid-1980s, the social insurance contribution was already down to 65%, and in 1997, only 43% of total dental care expenditures was financed out of social insurance contributions. The major part of the remaining expenses had to be paid out-of-pocket by the individual patient (20% in 1976, 25% in 1986, and 42% in 1997). The share of total expenses financed by private insurance also increased (3.5% in 1976, 5.7% in 1986, 9.2% in 1997), indicating that private insurance became more important as the financial risk was passed on to the individual patient. Taxes, however, were never used for covering dental prostheses (see *Table A1*).

Another area in which private financing increased is *pharmaceuticals*. While public financing increased from 65% to nearly 75% during the expansion period of the German health care system, in the early 1990s private financing became more important, reaching a level of more than 30% in 1998 (see *Figures 2 and A1*). The main shift, however, took place between social insurance payments and out-of-pocket financing; however,

tax financing and private insurance financing remained relatively stable at below 1% and 5% respectively. In 1977, co-payments for pharmaceuticals were introduced, and from then on increased regularly. From 1975 until the early 1990s, however, the share of total expenditures financed out-of-pocket remained relatively stable, i.e. at levels below 25%. Only when the Health Care Reform Act prescribed a fixed amount of money that social insurances had to pay for some pharmaceuticals did the share financed out of insurance contributions fall. However, private out-of-pocket financing has increased to 28% (see *Table A1*). In 2004, co-payments for pharmaceuticals were raised again considerably, and it can be expected that private co-payments will exceed the share that is financed through social insurance in the near future.

4 HEALTH SERVICE PROVISION

In this section we analyse how the total health care budget is spent, i.e. to what extent it is distributed among public, private non-profit or private for-profit service providers. Service provision can be broken down into monetary and non-monetary (health personnel etc.) inputs to the health care system. One way to measure health care resources is to check the distribution of the total budget among these categories of providers. An analysis of health care personnel, however, provides additional insights into the development of the health care services. Due to differences in income and prices, important distinctions concerning the development of monetary and non-monetary resources can be identified. The role of the state in health care provision will therefore be analysed in terms of both inputs, while outputs (doctor-patient contacts etc.) and outcomes (health status etc.) will not be dealt with in this context. In order to analyse the role of the state in terms of service provision we investigate whether resources are directed towards public, private non-profit or private for-profit institutions; and whether there is a tendency by the state to withdraw from direct service provision.

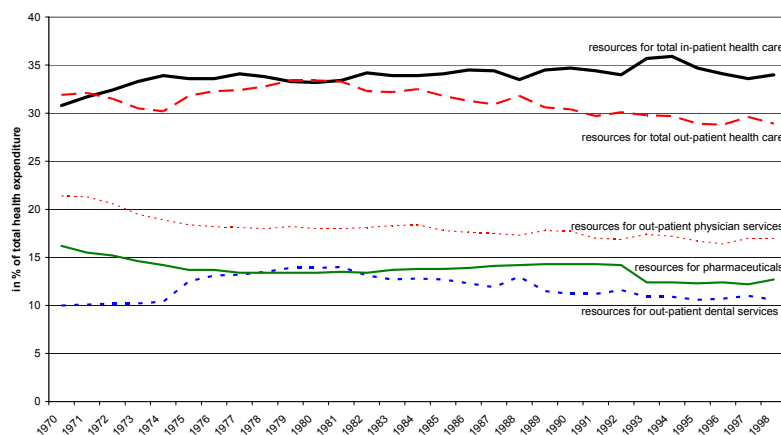
In the out-patient sector of the German health care system almost all health service providers can be defined as “private”. The incomes of panel doctors, dentists, pharmacists and other out-patient service providers are determined to a large extent by negotiations between collective actors, or by state regulation. However, these health care professionals work as private service providers, and not as the employees of public or social insurance institutions (Rothgang 1994: 115). Changes in the out-patient health care sector thus provide information on changes in private service provision. In contrast to other OECD countries, not only do general practitioners in Germany have the right to establish private practices, but specialists can do so as well, which makes the out-patient sector larger than in many other countries. The in-patient health care sector, on the other hand, can be divided into public, private non-profit, and private for-profit institutions. The public-private mix thus depends on the size of the out-patient sector, dental health

care and the pharmaceutical sector as well as on the distribution of public, private non-profit and private for-profit service provision in the in-patient sector.

4.1 Allocation of monetary resources

Health expenditure as a percentage of the German GDP increased significantly from 1970 to 1975 as well as from 1990 onwards. When analysing the allocation of resources among health care sectors we see that these increases were mainly driven by a growing demand for resources in in-patient health care. In the out-patient sector, an increase in monetary resources can only be detected until the mid-1970s, and after a short-term peak in 1981, the health reforms of 1976 and 1977 and the Cost Containment Amendment Act of 1981 stabilised the development of out-patient health care resources.

Figure 3: Allocation of monetary resources among health care sectors (in % of total health expenditure)



Source: OECD Health Data 2002

As illustrated in *Figures 3* and *A2* (see Appendix), expenditure for pharmaceuticals as a percentage of GDP has increased slightly, but its relative importance decreased from 16% of total health expenditure in 1970 to less than 13% in 1998. Expenditure for dental health care that is offered by private service providers increased as a percentage of the GDP until the mid-1980s. After this upwards trend, the percentage remained relatively constant, with the exception of two drops in the years 1989 and 1991. Dental health care expenditure as a percentage of total health expenses increased until the mid-1970s, and from then on decreased steadily. Resources spent on out-patient physician services also decreased as a percentage of total health expenditure from over 21% in 1970 to 17% in 1998. In total, expenditure in the out-patient health care sector, which is exclusively provided by private health personnel, decreased from about 32% in the 1970s to less than 29% in 1998.

The proportion of monetary resources used for the in-patient sector, on the other hand, has been growing – not only as a percentage of the GDP (see *Figure A2*) but also as a percentage of total health expenditure (from 31% in 1970 to 34% in 1998; see *Figure 3*). This health care sector, in which the state has traditionally been substantially involved in the form of direct service provision, is therefore larger today than it was in the 1970s. At the same time, we find a slight retreat of the state from direct in-patient service provision.⁵ While technical innovation and demographic changes mean that more and more services are provided in hospitals, these hospitals are increasingly owned and organised by private agencies.

4.2 Health service providers

Total health employment increased from less than 13 per 1,000 population in 1970 to more than 30 per 1,000 population in 2001 (OECD Health Data 2002). In contrast to the changes in monetary resource flows, out-patient health employment in particular increased, while the growth rate for in-patient health employment levelled out from the early 1990s onwards. While in the first half of the 1970s just about 30% of total health personnel worked in the out-patient health care sector, today more than half of all people working in health care belong to the out-patient sector (OECD Health Data 2002). An expansion of private out-patient health care employment can thus be seen to have taken place. The number of practising physicians, dentists and pharmacists as a percentage of total health employment, however, remained stable for the whole period under consideration. The ratio of non-medical service providers (medical assistants, physiotherapists, nurses etc.) to total health employment, on the other hand, has increased at a high rate.

In-patient health care employment as a percentage of total health employment decreased from 70% in 1970 to less than 50% in 2000, reflecting developments in out-patient sector employment. The in-patient sector itself can be broken down into public, private non-profit, and private for-profit hospitals. Public hospitals are in general owned by the Länder or municipalities. The second group of hospitals are private non-profit institutions, most of them in the ownership of charitable institutions. Private for-profit hospitals, finally, are often owned by renowned medical specialists (Rothgang 1994: 115f.).

OECD data show a growth in private (for-profit and non-profit) hospital beds from about 45% of total beds in 1970 to 54% in 2000. In the long run, Rothgang (1994: 116) concludes, there has been a clear trend: as the number of public hospitals and in-patient beds declined, private institutions gained more importance. When taking national data

⁵ According to OECD data the share of private hospital beds has increased from 1970 to 1988 and, after a drop following German unification, again from 1991 to 2000.

into account, however, a rather different picture emerges (Statistisches Bundesamt, various issues). Here, the percentage of public hospitals and hospital beds remains almost unchanged. Moreover, the (small) growth in the market share of private hospitals is fed by private non-profit hospitals only, while the share of private for-profit hospitals even declines – with respect to both the number of hospitals and hospital beds. This does not hold true for hospital employment, however. Overall, there has been a vast increase in hospital employees in proportion to the (decreasing) number of hospital beds. While figures for hospital doctors have increased in public hospitals, they have decreased in private ones. For nurses, however, the opposite is true: here, the share has decreased in public and increased in private hospitals. In both cases, developments were more pointed in private for-profit rather than in private non-profit hospitals. These results also hold true when the ratio of staff to hospital beds is calculated.

The relative expansion of out-patient service provision, at the expense of the relative importance of in-patient service provision, results in a strengthening of private service provision. Since OECD data also show an increase in private service provision in the in-patient health care sector (while national data show a more stable development), it can be assumed that a privatisation of non-monetary health care provision has taken place. If we focus on private for-profit health care provision only, we observe a similar tendency. The private for-profit component of the in-patient sector, however, is much smaller than the private non-profit one.

5 REGULATION

Under the German health care system, not only financing but also regulation is delegated to non-governmental actors. Social health insurance institutions decide through mutual self-regulation over issues such as overall reimbursement, conditions for service provision, remuneration methods, benefit packages etc.. Moreover, sickness funds determine their respective contribution rates. The state, however, defines the scope for self-regulation and has the authority to monitor the regulatory actors and, if necessary, to intervene directly in the otherwise largely state-independent system. Competition and other market mechanisms, on the other hand, were hardly institutionalised until the 1990s (Döhler und Manow 1995: 140). While state hierarchy has generally been an important factor in the German health care system, the introduction of competition and other market principles as a co-ordination mechanism in its own right is a rather new development, dating back to the Health Care Structure Act in 1993. The following overview of six areas of regulation (coverage, system of financing, remuneration methods, access of service providers to the health care market, access of patients to service providers, contents of the benefit package, see Wendt, Grimmeisen, Rothgang 2005) will show that the introduction of market principles should not be considered an isolated

episode, but that these principles have the tendency to spread from one to other areas of regulation.

5.1 Coverage

Health policy in Germany is guided by the principle that no societal group should be systematically excluded from access to health care. This idea, however, can also potentially challenge one of the basic tenets of a (social) insurance system, which is that only those persons should have a right to health services who have paid their insurance contributions. The German system corresponds with this principle insofar as (white and blue collar) employees, up to a certain income ceiling, are compulsorily integrated into the social health insurance. In 1930 and 1931 spouses and children were taken up into social health insurance without having to pay their own insurance contributions, and since 1941 pensioners have been covered as well. In the 1970s, farmers, handicapped persons, students and artists were incorporated into social health insurance. Far from being a pure workers' insurance, therefore, the current system covers employees, some self-employed who may insure themselves voluntarily, as well as persons who are not members of the labour market at all. The basic principle of entitlement to treatment on the basis of former contribution payments has been transformed into the idea that all members of society, even those who are financially not in a position to pay public or private insurance premiums, should have access to the health care system.

For many years only white-collar employees with an income above a certain threshold were allowed to opt out of social health insurance, but under the Health Care Reform Act of 1989 this option was extended to all employees with an income above the annually adjusted social security contribution ceiling (46,800 € per annum in 2005). Thus, the group of persons paying compulsory social health insurance contributions has been reduced, while the group with the right to subscribe exclusively to a private health insurance has been enlarged. While in the 1970s social health insurance was opened up to include low-income and/or high-risk groups, in the 1990s certain high-income and low-risk groups were given an exit option. Apart from high-income employees, the self-employed are also not compulsorily covered by social health insurance, but may opt to become voluntary members. The health expenses of civil servants are partly directly covered by a publicly financed scheme, while for the remaining costs the civil servants usually subscribe to a supplementary private insurance themselves. As a percentage of total population, however, the coverage rate of the social health insurance has remained relatively constant. From 1970 to 1980 it increased from 89% to 92%, followed by a decrease until 1989/90 to the 1970 level and a slight increase to 91% in 2002 (OECD Health Data 2004). Today, about 9% of the population possesses an exclusive and a

further 9% a supplementary private insurance.⁶ While for many years public coverage was increased by state legislation, the Health Care Reform Act of 1989 widened the scope for private health insurance.

5.2 System of financing

The analysis of the financing dimension has shown that four sources of financing are of importance in the German health care system (tax revenue, social insurance, private health insurance, and private out-of-pocket payments). These means of financing are regulated to different degrees at the national level by state actors/institutions, and are also delegated to different degrees to the self-regulatory system.

In the *in-patient sector*, for instance, the Länder (and until 1984 the federal government) have to cover investment costs. Since the Länder control the capacity planning of the hospital sector they also influence the quantity of hospital care, and thus greatly influence overall costs. The legal framework for in-patient health care is (besides the SGB V) provided on the national level by the Hospital Financing Act (KHG) and the respective executive order law, the Federal Hospital Remuneration Bye-Law. Since health care legislation that includes changes for the hospital sector must be approved by the Federal Council of Germany, the Länder have a strong influence on all regulations concerning in-patient health care provision. The Länder are also responsible for guaranteeing that in-patient services meet the demands of the population. They are therefore not only in control of investment costs, but also control the development of running costs for in-patient health care provision. The current introduction of a diagnosis related groups (DRG) system (see 5.3 *remuneration*), however, might strengthen the self-regulatory negotiation system in the area of hospital financing.

The *out-patient health care* budget, by contrast, is mainly defined by negotiations between associations of health insurance funds and panel doctors' associations. The partners in the mutual self-government system agree at sub-national level upon overall reimbursement for out-patient health care (§ 82, 1 SGB V). Social insurance funds transfer the overall budget to the panel doctors' associations, which are responsible for guaranteeing adequate out-patient health care provision (§ 85, 1, 2 SGB V). "Stability of contribution rates" was introduced as a target under the Health Insurance Cost Containment Act of 1977, and from 1985 onwards the "Advisory Council for Concerted Action in Health Care Systems" (now "Advisory Council on the Assessment of Devel-

⁶ The share of persons with exclusive private insurance, however, decreased from 9.5% in 1970 to 7.0% in 1976, followed by an increase to 10.5% in 1990. While for West Germany the share increased only slightly from 9.6% (in 1991) to 10.3% (in 2000), in East Germany private insurance was only introduced after the reunification, leading to a growth from 0.9% in 1990 to 4.1% in 2000. For the whole of Germany therefore, the share rose from 7.9% in 1991 to 9.2% in 2000 (Bundesministerium für Gesundheit 2001: 22, 365).

opments in the Health Care System”) became responsible for publishing annual reports on the development of the German health care system, taking the stability of contribution rates into account. But only under the Health Care Structure Act of 1993 was the stability of contribution rates established as a serious maxim of health policy, not only for out-patient health care but also for the in-patient and the pharmaceutical sectors. The introduction of sectoral budgets by the state can be considered as one (and by far the strongest) regulatory instrument for achieving that goal. Although this form of direct state intervention has been temporarily suspended, out-patient health care financing is still controlled by a sectoral budget.

Apart from direct state intervention, the self-regulatory system has also been influenced by a state-induced strengthening of the negotiation power of the social insurance funds. First, the act of 1977 prescribed that remuneration was no longer negotiable between the individual health insurance funds and the panel doctors’ associations, but by associations of insurance funds, organised at Länder level. Secondly, differences between health insurance funds (especially between statutory sickness funds and funds for white-collar employees) were evened out, making sickness fund associations more homogeneous and more powerful than before. These state interventions strengthened social insurance funds, whose priority interest are assumed to be steady contribution rates.⁷

The guiding idea behind the health reforms from the early 1990s onwards, however, was not to fix contribution rates through state intervention, but to trust the regulatory power of the market. In 1997, a free choice of sickness funds was introduced for almost the whole population, and since the level of contribution rates is currently the main incentive for insured persons to change their sickness fund, these funds now have an increasing interest in low contribution rates (Höppner et al. 2005). The free choice of sickness funds was combined with the introduction of risk structure compensation, whereby “risks” were calculated with respect to gender, age, income level and the number of co-insured persons. The result was a strong convergence of contribution rates among different sickness funds and branches of sickness funds.⁸ In sum, the financing

⁷ Traditionally, contribution rates have always been fixed by each health insurance fund individually, but within a legal framework defined by state regulation. The Ministry of Health sets the compulsory insurance income ceiling as well as the contribution ceiling by decree. So even without defining contribution rates at national level, the Ministry of Health has some influence on the assessable income and therefore on the level of contributions received by the sickness funds. For some groups of the population, contribution rates are even regulated at the national level.

⁸ Since the criteria for risk structure compensation only include estimated health risks and not “real” health risks, sickness funds still have an incentive to compete for “good” risks rather than for the most effective use of re-

of health care through social insurance contributions is still of major importance. However, within the self-regulatory system those actors have been strengthened who have an interest in stable health care costs and whose concern for low contribution rates has been raised by the introduction of competitive elements. The introduction of competition and other market principles can be considered to be the most influential change of the 1990s, and presumably had a path-breaking effect (see as well *Sections 5.3 and 5.4*). Sectoral budgets, on the other hand, are currently the main areas of direct state intervention. This temporary solution will presumably be abolished, however, as soon as the effects of market principles are in line with health policy goals.

The third source of financing, *private health insurance*, generally follows different principles than social insurance. In actual fact, however, this market is regulated by the state, too (Rothgang et al. 2005). From the 1990s, the German government not only increased direct intervention within the social insurance system, but also within the field of private insurance. Private health insurance companies were forced to offer a so-called “standard tariff” for the elderly (65+) comprising the standard benefit package of statutory health insurance combined with a premium rate no higher than the maximum premium paid under statutory health insurance (Wasem 1995). Moreover, private insurance companies were obliged to use profits exceeding the calculated interest rates to subsidise premiums for the elderly and to institutionalise a mutual finance equalisation scheme with other private insurers to this end. By and large, the state thus uses private insurance companies as a means to achieve public social policy goals.

Private out-of-pocket payments, finally, are highly regulated by the state at national level. Even though they partly compensate the reduced financial responsibility of social insurance funds, especially with respect to dental health care and pharmaceuticals, private out-of-pocket payments are regulated by the state and not by the system of mutual self-government. With the introduction of co-payments, the state primarily aims to open up new resources, and secondly to reduce the demand for certain health services. Under the Health Insurance Cost Containment Act of 1977, the former prescription charge was replaced by co-payments for each prescribed pharmaceutical that were gradually increased in 1981 and 1983. Since 1994, co-payments for pharmaceuticals have been set according to packaging size and stood at 4.00 Euro, 4.50 Euro and 5.00 Euro in 2003. In 2004 the co-payment method was changed again, and patients now have to pay 10% of the price of each pharmaceutical, with a minimum charge of 5.00 Euros and a maximum of 10.00 Euros. Additionally, social insurance financing for pharmaceuticals was budgeted from 1993 to 2000 through national state regulation. With respect to dental health

sources. Starting in 2007, risk structure compensation will directly take the different morbidity structures of sickness fund members into consideration so that fair competition will be improved in the near future.

care, co-payments were raised even further. The 1989 Health Care Reform Act introduced co-payments of 50% for dentures. If patients are able to give proof of regular dental care or regular dental examinations the social insurance allowance is generally raised by between 10% and 15% respectively.

5.3 Remuneration of service providers

Generally speaking, in the out-patient health care sector, service providers are remunerated by a salary, per-capita payments, fee-for-service payments etc., while in the in-patient sector remuneration for hospitals is generally based on a fixed budget per year, on a per diem basis, or on diagnosis related groups (DRGs). In reality, however, two or more of these remuneration methods are often combined. One major concern of out-patient doctors has been not to become state employees and receive a fixed salary, but to retain their autonomous status and keep their remuneration independent of state intervention.

The negotiation system between insurance funds associations and panel doctors' associations has already been described in *Section 5.2*. The overall reimbursement is distributed at *Länder* level by the respective panel doctors' associations to each individual doctor according to a fee distribution scale (§ 85, 4 SGB V). The bargaining power of sickness funds has been strengthened by appointing regional associations of insurance funds, instead of the individual sickness funds, as to negotiate with the regional panel doctors' associations. By balancing the power of sickness funds' and doctors' associations more evenly, state intervention has improved the process of equal and autonomous decision making within the system of mutual self-government. According to the fee distribution scale, the type and amount of services have to be taken into consideration when remunerating medical services (§ 85, 4 SGB V). The SGB V leaves no room for a remuneration method that is not in line with these criteria. Distribution is further based on a so-called common valuation standard giving relative prices. This standard is adjusted at federal level by a Valuation Board which was established in 1977. The Health Care Structure Act of 1993, however, changed the legislative framework as defined in SGB V at the national level, and these "guidelines" are fleshed out through negotiations between doctors and sickness funds. The Health Care Structure Act introduced lump-sum payments for typical standard and special health services, differentiated for general practitioners and (groups of) specialists. In 1999, the share of out-patient health care financed by lump-sum payments reached about 20%. This recalibration of remuneration methods is intended to strengthen primary health care at the expense of specialist health care and especially medical-technical services. In 1997, the still existing sectoral budget was supplemented by the introduction of a practice budget for each doctor. The aim of this move was to better control the still expanding out-patient health care services. The practice budget defines an upper limit for the total amount of chargeable health services

for a single practice (Gerlinger 1997). Under the self-regulatory system, furthermore, panel doctors' associations were obliged to intervene if the volume of treatment in their respective region increased by more than 5 percent. Six months later, the second Statutory Health Insurance Reorganisation Act suspended the sectoral budget. In 2003 the practice budgets were also abolished by the Valuation Board and sectoral budgets became effective again. It had already been decided that for the future morbidity-oriented standard benefit volumes will be introduced.

While the principle of fee-for-service remuneration is still in force, it is increasingly defined by sectoral budgets, practice budgets (later: standard benefit volume) and lump-sum payments. These changes are partly the result of increasing state hierarchy, with the effect that negotiations within the self-regulatory system are increasingly in line with health policy goals. Moreover, the second Statutory Health Insurance Reorganisation Act of 1997 and the Health Care Modernisation Act of 2004 improved the potential for pilot projects (§§ 63 ff SGB V) and structural contracts (§ 73a SGB V), whereby partly the individual insurance funds (and not the federal or state insurance funds associations) are responsible for negotiating with doctors or groups of doctors. These new forms of negotiations, some of which take place at the local level, may even open the door for new models of remuneration.

The remuneration of in-patient health care is regulated at national level much more stringently than is the case with out-patient health care. Since 1972, hospitals have been reimbursed on the basis of standardised hospital per-diem allowances. This means that hospitals receive a fixed amount per patient and day, irrespective of the costs for different health care services. Since the Länder are responsible for developing "hospital plans", they have a major influence on the resources that are allocated to hospitals. Negotiations over hospital budgets, however, take place between the individual hospitals and the sickness funds associations. Starting with the Health Care Structure Act in 1993, a radical transformation of the hospital payment system has taken place. In 1996, a mixed payment system was introduced which combined hospital per-diem allowances with case-based lump-sum payments and special payments. Only about 25% of the total in-patient budget, however, was remunerated on the basis of the new system, while 75% was still paid on the basis of hospital per-diem allowances. The Social Insurance Health Reform Act of 2000 introduced a "universal, efficiency-based, lump-sum remuneration system" (§ 17b, 1 KHG), modelled on the Australian diagnosis related groups (DRG) system. The development of the specific design of the DRG system was assigned to the negotiations between the Federal Association of Hospitals and the sickness funds associations at federal level. However, since the contracting partners were not able to agree on the valuation and accounting of DRGs, the Ministry of Health regulated the introduc-

tion of the DRG system by decree (KFPV – BGBl. I: 3674). From 2007 onwards the hospital remuneration system will be completely DRG-based.

5.4 Access of service providers to the health care market

As already outlined above, in 1960 the German Constitutional Court overruled the restriction of access for medical doctors to the German health care market.⁹ Thus, within the self-regulatory system there was only an indirect control over the number and location of general practitioners and specialists. And since not only general practitioners but also specialists have the right to offer services in private practices, the German “health care market” can be considered comparatively open for access by medical doctors. Non-medical service providers, however, are dependent on the referral of patients by a medical doctor, and therefore their chances of entering the health care market are more restricted and subject to the doctors’ referral behaviour. The Federal Commission of Physicians and Sickness Funds controls the number of non-medical personnel in Germany (§ 92, 1, 6 SGB V). The access of non-medical service providers is therefore strictly controlled by doctors as well as doctors’ associations (Döhler 1997: 93ff).

The Health Care Structure Act also tightened the conditions for physicians to enter the health care market. The Federal Commission of Physicians and Sickness Funds was also assigned the task of developing guidelines for drawing up need plans (§ 92, 1 SGB V). If such schedules are exceeded by more than 10 per cent, admission commissions have the power to refuse new doctors permission to open a medical practice in districts judged to be oversupplied with self-employed doctors (§§ 96 and 101, 2 SGB V). Since 2003, the admission of physicians for the out-patient sector has been regulated by legally defined ratios for different groups of doctors (§ 102 SGB V); and for the first time, the percentage of general practitioners and specialists has been defined at a ratio of 60 to 40 (Rosenbrock and Gerlinger 2004: 116).

In the hospital sector, the Länder have always been in control of capacity planning. They are responsible for developing hospital requirement schedules in which the number of hospitals and hospital beds is defined. Hospitals that are included in the schedule have the right to contract with the sickness funds associations. Even though hospitals

⁹ Due to the decision of the Constitutional Court, the regulation of access for medical students to University has for many years been an important mechanism for controlling the number of doctors. Since 1973, the number of medical students is controlled by the Centre for Allocation of University Places (ZVS). A second instrument for regulating the number of doctors is the “condition of approbation”. Both instruments reduced the number of medical students at university by 20% in 1990/91 (Alber 1992: 94). These indirect measures for controlling the number of doctors were supplemented by the Panel Doctors’ Requirements Planning Act in 1987. A restriction on entry was only possible, however, if the number of doctors in a district exceeded a certain level by more than 50 percent (Alber 1992: 95).

have formally contracted with sickness funds since 1989, de facto “requirement schedules” are still decisive. Up to now, all attempts to strip the Länder of this power have failed. The introduction of diagnosis related groups, however, will presumably influence the access of hospitals to the health care market. The DRG system is expected to intensify competition between hospitals, and in-patient health care provision will increasingly be regulated by the price.¹⁰ Furthermore, the rights of the Medical Review Board of sickness funds (MDK) have been extended in order to monitor hospital beds to avoid an oversupply.

5.5 Access of patients to health care services

Under the German health insurance system, access to health services and the right of patients to choose their own doctor (general practitioner and specialist) has always been an important feature. Patients have free and direct access to general practitioners and specialists. In 1995, the free choice of doctors was further improved when the existing health insurance forms were replaced by health insurance cards that even allow “parallel” consultations with different specialists about the same ailment or condition (Beske and Hallauer 2001). Since previous examinations are not recorded on the health insurance card, the actual potential for “doctor hopping” increased during this period. In the second half of the 1990s, however, sickness funds attempted to implement gate-keeping mechanisms, and in the latest legislation (Statutory Health Insurance Modernisation Act 2004) insurance funds are even encouraged to do so. They are now obliged to offer a gate-keeping plan to all of their insurants. Thus, sickness funds and the federal government have made attempts to impose more control on the access of patients to health care services.¹¹ Access to non-medical service providers in the out-patient sector as well as access to hospitals, on the other hand, is highly restricted since for these health services in general a referral by a self-employed doctor is necessary.

¹⁰ Linked to the introduction of DRGs, the Federal Associations of Sickness Funds, the Association of Private Health Insurers, the German Federal Association of Hospitals and further actors have to agree on minimum standards for the quality and quantity of in-patient health services (§ 137, 1 SGB V). Hospitals that are not able to fulfil these standards (for example a certain number of operations per doctor and/or hospital) lose their right to provide these services.

¹¹ Since 2004 patients have to pay 10 Euros when visiting the doctor (general practitioners and specialists), but they are charged only once per quarter, while other contacts are free if they get a referral from their first contact doctor (in general their family doctor). Therefore a financial incentive has been introduced not to visit various general practitioners and specialists directly, but to decide on one first contact doctor and thus opt for a kind of gate-keeping model.

5.6 Content of the benefit package

In Germany, cuts in benefits have constantly been used as a cost-containment measure. During the 1970s and 1980s, numerous deductibles and co-payments were introduced through legislation. Though there was some rhetoric claiming that they were being introduced in order to limit moral-hazard behaviour, in fact they were just aiming at cost-containment. Only in the 1990s did efficiency considerations become more prominent, and the design of the benefits package started to follow the methods of evidence-based medicine and health technology assessment (HTA). Under the Health Care Reform Act of 1997, the Federal Committee of Physicians and Sickness Funds was given the power to evaluate existing and new technologies and services with respect to service effectiveness and cost-efficiency, and to decide whether they should be part of the publicly financed benefit package (Greß et al. 2004). In the most recent health care reform, which took effect in January 2004, these powers were consolidated and formalised in the new Joint Federal Committee, representing doctors, hospitals, and sickness funds. In its decision-making on benefit catalogues the Committee is advised by the newly-founded independent German Institute for Quality and Efficiency in Health Care. Thus, once again, the state has intervened in order to strengthen corporatist self-government following publicly decreed goals.

6 DISCUSSION

With respect to health care *financing*, a reduced role of the state can be detected. The reduction in tax financing is especially striking in the in-patient health care sector, where the state traditionally has the strongest role. Social insurance financing, on the other hand, has increased during the period under consideration. In the financing dimension the social insurance principle is thus even stronger than in 1970. For specific health services, however, private financing is becoming more and more important. Especially private out-of-pocket payments for dentures are increasing at a high rate, and are today even more important than social insurance payments. Pharmaceuticals, too, are increasingly financed privately out of the patients' pockets.

Our analysis of the *service provision* dimension shows inconsistent developments with respect to monetary and non-monetary resource flows. Monetary resource flows show a decrease in terms of out-patient service provision as a percentage of total health expenditure. And since the out-patient sector (including dental and pharmaceutical health care) can arguably be defined as “private”, from 1970 to 1998 a reduction in “purely” private service provision took place. Monetary resources spent on in-patient service provision, on the other hand, have increased. Since this sector has always been made up of a mixture of public, private non-profit and private for-profit hospitals, whether the increase of resources for in-patient health care can be assessed as “public”

or “private” depends on the relative importance of these hospital agencies. When analysing the development of health employment, however, we see a growing proportion of “private” out-patient health care personnel. Since OECD data as well as recent national data suggest a growth in private in-patient health care provision one can conclude that there has been an increase in private non-monetary service provision.

The most important changes, however, have taken place with respect to regulation. The frequency of state interventions in the self-regulatory health care system in Germany increased from the early 1990s onwards. The rise in direct state intervention becomes especially evident with respect to the implementation of sectoral budgets. Further state interventions aimed to strengthen the bargaining power of sickness funds associations, and thus of those actors with the greatest interest in stable contribution rates. Since the state has always been an important actor, these and further state interventions did not result in a structural change of the German health care system. The introduction of market principles in the 1990s (by state regulation), however, can be considered as a structural change with the path-breaking effect of narrowing down the scope for negotiations within the self-regulatory system. Market principles such as competition between sickness funds, for instance, have the tendency to spread to other areas of regulation. The Health Care Modernisation Act of 2004 allowed (to a limited extent) individual insurance funds to negotiate directly with doctors or group of doctors, which may open the door for new models of remuneration. Moreover, in the hospital sector, the DRG system was introduced. These changes have been primarily driven by state actors on the national level. The DRG system will undoubtedly influence the access of hospitals to the health care market and will intensify competition between hospitals. Since it is still considered to be the responsibility of the state to guarantee access to the health care system for all sections of the population, state control and therefore the “shadow of state hierarchy” has to be broadened to ensure that the results of these competitive elements are still in line with public health policy goals.

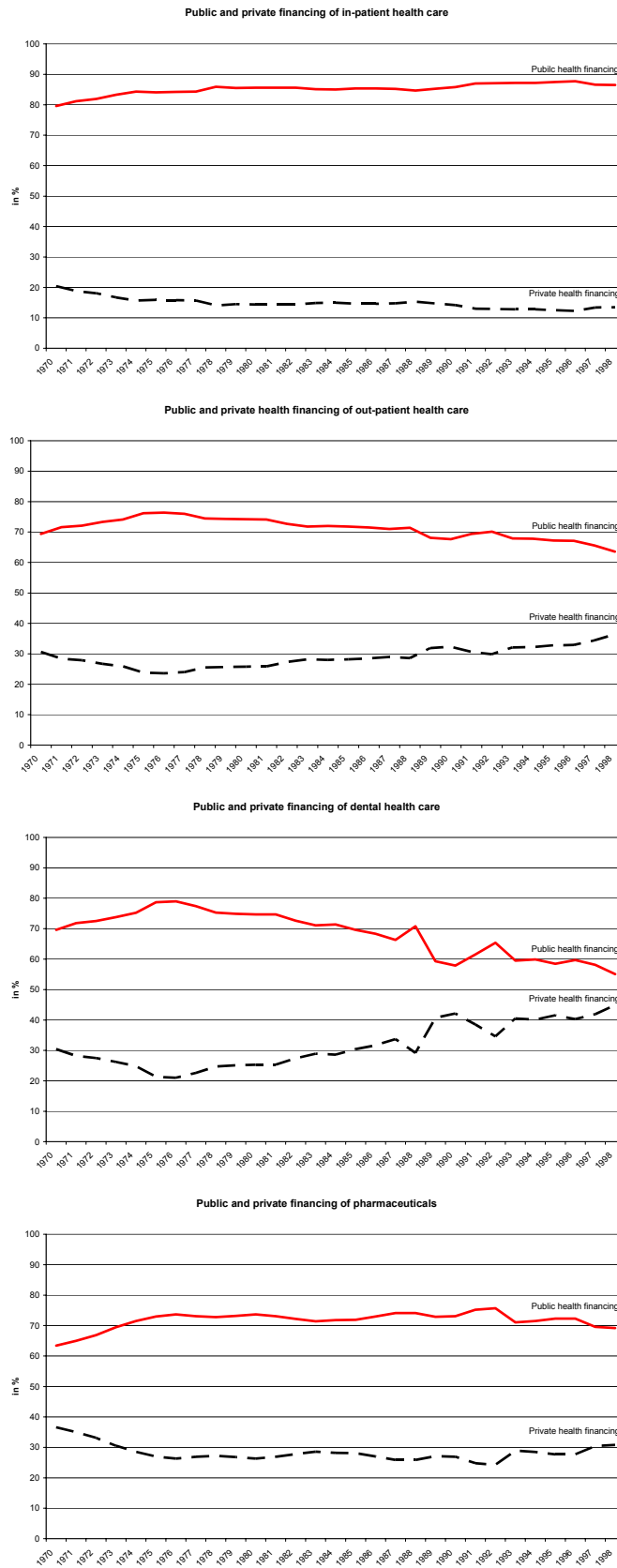
REFERENCES

- Alber, Jens (1992): Das Gesundheitswesen der Bundesrepublik Deutschland. Entwicklung, Struktur und Funktionsweise. Frankfurt a. M., Campus
- Beske, Fritz; Hallauer, Johannes F. (2001): Das Gesundheitswesen in Deutschland. Struktur – Leistung – Weiterentwicklung. 3. Auflage, Köln, Deutscher Ärzte-Verlag
- Bundesministerium für Gesundheit (2001): Daten des Gesundheitswesens – Ausgabe 2001. Baden-Baden, Nomos
- Castles, Francis G. (2004). The Future of the Welfare State: Crisis Myths and Crisis Realities. Oxford, Oxford University Press
- Comas-Herrera, Adelina (1999): Is there Convergence in the Health Expenditures of the EU Member States? In: Mossialos, Elias; Le Grand, Julian (eds): Health Care and Cost Containment in the European Union. Aldershot, Ashgate, 197-218
- Döhler, Marian (1997): Die Regulierung von Professionsgrenzen. Struktur und Entwicklungsdynamik von Gesundheitsberufen im internationalen Vergleich. Frankfurt a. M., Campus
- Döhler, Marian; Manow, Philip (1995): Staatliche Reformpolitik und die Rolle der Verbände im Gesundheitssektor. In: Mayntz, Renate (ed): Gesellschaftliche Selbstregulierung und Politische Steuerung. Frankfurt a. M., Campus, 140-168
- Farny, Dieter (1995): Versicherungsbetriebslehre. Karlsruhe, VVW
- Gerlinger, Thomas (1997): Wettbewerbsordnung und Honorarpolitik. Die Neugestaltung der kassenärztlichen Vergütung zwischen Gesundheitsstrukturgesetz und ‚dritter Stufe‘ der Gesundheitsreform. Frankfurt a. M., Mabuse-Verlag
- Greß, Stefan; Niebuhr, Dea; Rothgang, Heinz; Wasem, Jürgen (2005): Benefit Decisions in German Social Health Insurance. In: Jost, Timothy S. (ed): Health Care Coverage Determinations: An International Comparative Study. Maidenhead, Open University Press, 115-131
- Höppner, Karin; Greß, Stefan; Rothgang, Heinz; Wasem, Jürgen (2005): Grenzen und Dysfunktionalitäten des Kassenwettbewerbs in der GKV: Theorie und Empirie der Risikoselektion in Deutschland. ZeS-Arbeitspapier, University of Bremen, forthcoming
- Jost, Timothy S. (1998): German Health Care Reform: The Next Steps. *Journal of Health Politics, Policy and Law*, Vol. 23, No. 4, 697-711
- Leidl, Reiner (2001): Konvergenz der Gesundheitssysteme in der Europäischen Union. *Gesundheitsökonomie und Qualitätsmanagement*, 6, 2, 44-53
- OECD (1994): Health: Quality and Choice. OECD Health Policy Studies No. 4, Paris, OECD
- OECD (1995): New Directions in Health Care Policy. OECD Health Policy Studies No. 7, Paris, OECD
- OECD (1996): Health Care Reform. The Will to Change. OECD Health Policy Studies No. 8, Paris, OECD
- OECD Health Data (2002): OECD Health Data 2002. Comparative Analysis of 30 Countries. Paris, OECD

- OECD Health Data (2004): OECD Health Data 2004. Comparative Analysis of 30 Countries. Paris, OECD
- Rosenbrock, Rolf; Gerlinger, Thomas (2004): Gesundheitspolitik. Eine systematische Einführung. Bern, Verlag Hans Huber
- Rosewitz, Bernd; Webber, Douglas (1990): Reformversuche und Reformblockaden im deutschen Gesundheitswesen. Frankfurt a. M., Campus
- Rothgang, Heinz (1994): Der Einfluß der Finanzierungssysteme und Entscheidungsregeln auf Beschäftigungsstrukturen und -volumina englischer und deutscher Krankenhäuser. Dissertation. Köln
- Rothgang, Heinz; Dräther, Hendrik (2003): Ökonomische Aspekte gesundheitlicher Prävention. *Zeitschrift für Sozialreform*, Heft 3: 531-549
- Rothgang, Heinz; Glaeske, Gerd; Hoepfner, Karin; Borchert, Lars; Becker, Roland (2005): Differenzierung privater Krankenversicherungstarife nach Geschlecht: Bestandsaufnahme, Probleme, Optionen. Gutachten für das Bundesministerium für Familie, Senioren, Frauen und Jugend.
- Scharpf, Fritz W. (1991): Die Handlungsfähigkeit des Staates am Ende des zwanzigsten Jahrhunderts. *Politische Vierteljahresschrift*, 32. Heft 4, S. 621-634
- Statistisches Bundesamt (2001): Gesundheitswesen, Ausgaben für Gesundheit, Fachserie 12, Wiesbaden, Metzler Poeschl
- Statistisches Bundesamt (various issues): Grunddaten der Krankenhäuser und Vorsorge- oder Rehabilitationseinrichtungen, Fachserie 12, Reihe 6.1, Wiesbaden, Metzler Poeschl
- Wasem, Jürgen (1995): Gesetzliche und private Krankenversicherung – auf dem Weg in die Konvergenz? *Sozialer Fortschritt*, 44, 4, 89-96
- Wendt, Claus; Grimmeisen, Simone; Rothgang, Heinz (2005): Convergence or Divergence in OECD Health Care Systems? In: Cantillon, Bea; Marx, Ive (eds): International Cooperation in Social Security. How to cope with globalisation? Antwerpen/Oxford, Intersentia, 15-45

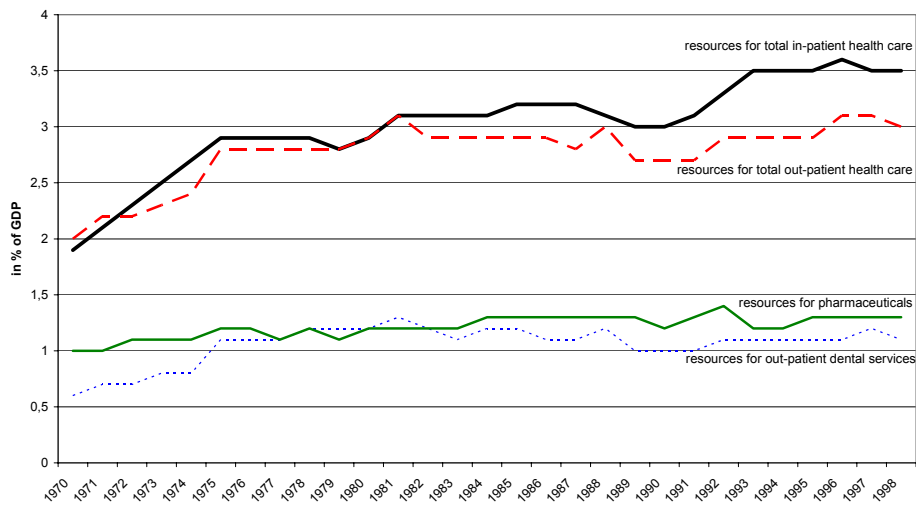
APPENDIX

Figure A1: Public and private health care financing according to health care sectors



Sources: OECD Health Data 2002

Figure A2: Allocation of monetary resources among health care sectors in % of GDP



Sources: OECD Health Data 2002

Table A1: Sources of financing across health care sectors

Year	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98
<i>In-patient care</i>																													
General government in % of total in-patient health expenditure	28.1	27.8	25.5	26.1	20.9	18.5	17.1	16.7	19.0	16.8	17.3	16.8	16.9	16.0	14.0	14.9	13.8	12.2	12.2	13.0	12.3	13.5	13.3	12.2	10.2	10.4	11.4	9.5	8.3
Social insurance in % of total in-patient health expenditure	55.5	57.1	59.7	60.3	66.2	68.1	69.7	70.1	68.8	70.6	70.1	70.4	70.4	71.1	72.8	72.1	73.2	73.9	73.3	72.3	73.4	73.9	74.2	75.2	77.2	76.9	76.8	78.7	79.8
Private insurance in % of total in-patient health expenditure	7.7	7.0	7.0	6.5	6.4	6.5	6.4	6.4	6.3	6.6	6.7	7.1	7.2	7.2	7.4	7.3	7.4	7.6	7.9	8.1	8.2	7.1	7.1	7.1	7.1	7.1	6.4	6.4	6.4
Out-of-pocket payments in % of total in-patient health expenditure	3.6	3.1	2.7	2.2	1.8	1.5	1.7	1.8	0.9	0.9	0.9	0.7	0.6	0.8	0.8	0.8	0.7	0.6	0.7	0.5	0.5	0.8	0.9	1.0	1.0	0.9	1.2	1.4	1.5
All other funds	5.1	5.0	5.1	4.9	4.8	5.4	5.1	5.1	4.9	5.0	4.9	5.0	5.0	4.9	5.0	4.8	5.0	5.8	5.9	6.2	5.6	4.7	4.6	4.5	4.5	4.7	4.2	4.1	4.0
<i>Out-patient care</i>																													
General government in % of total out-patient health expenditure	4.4	4.2	4.2	4.2	4.3	4.4	4.3	4.2	4.4	4.1	4.1	4.1	4.3	4.1	3.9	3.8	4.0	4.2	4.0	3.8	3.8	3.6	3.8	4.0	3.3	3.1	3.4	3.7	4.0
Social insurance in % of total out-patient health expenditure	68.5	70.4	70.6	71.6	72.2	73.0	72.8	72.7	71.3	71.2	70.8	70.6	69.9	69.0	69.4	69.0	69.1	68.8	68.2	67.5	67.5	69.0	69.0	68.1	68.6	69.0	68.4	66.6	65.2
Private insurance in % of total out-patient health expenditure	5.4	5.0	4.8	4.5	5.0	4.6	4.7	4.6	4.8	5.0	5.3	5.5	5.7	5.2	5.1	5.5	5.4	5.7	5.7	6.9	7.3	6.6	6.3	6.7	6.8	6.9	7.1	7.3	7.6
Out-of-pocket payments in % of total out-patient health expenditure	16.9	15.7	15.7	15.1	13.5	13.0	13.3	13.7	14.6	14.6	14.6	14.4	14.7	16.7	16.8	16.7	16.4	15.9	17.0	15.5	15.5	15.5	15.9	16.3	16.4	15.7	15.7	17.0	17.7
All other funds	4.8	4.7	4.6	4.6	5.0	5.1	4.9	4.8	5.0	5.1	5.2	5.4	5.5	4.9	4.7	4.9	5.0	5.3	5.2	6.3	6.0	5.2	5.1	5.0	5.0	5.3	5.4	5.4	5.5

Table A1 (continued): Sources of financing across health care sectors

Year	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98
Dental services: dental prosthesis																													
General government in % of total dental health expenditure																													
Social insurance in % of total dental health expenditure																													
	49,3	55,4	58,5	61,3	62,1	72,0	74,4	72,9	70,6	71,2	71,7	72,0	67,9	66,5	67,4	67,8	64,6	61,7	68,9	51,0	48,6	52,9	56,8	44,0	46,0	43,0	44,2	42,8	33,4
Private insurance in % of total dental health expenditure																													
	3,9	3,5	3,4	3,5	4,1	3,5	3,5	4,1	4,5	4,8	5,0	5,2	5,9	6,2	5,9	5,1	5,7	6,0	5,5	6,8	7,3	6,6	7,8	11,1	10,6	10,1	9,9	9,2	9,9
Out-of-pocket payments in % of total dental health expenditure																													
	43,8	38,2	35,3	32,1	30,3	21,1	19,2	19,4	20,8	19,9	19,1	18,5	21,4	22,3	22,0	23,2	25,2	27,5	21,3	36,7	38,8	35,9	29,0	37,4	36,2	39,7	39,1	41,8	50,2
All other funds																													
	2,9	2,8	2,8	3,0	3,5	3,5	3,0	3,6	4,1	4,2	4,2	4,2	4,8	5,0	4,6	3,9	4,5	4,8	4,3	5,5	5,3	4,6	6,4	7,5	7,1	7,1	6,9	6,2	6,5
Pharmaceuticals																													
General government in % of total expenditure on pharmaceuticals																													
	1,6	1,4	1,4	1,3	1,2	1,1	1,0	1,0	0,9	0,9	0,8	0,8	0,7	0,7	0,6	0,6	0,5	0,5	0,4	0,4	0,4	0,3	0,3	0,4	0,3	0,3	0,3	0,2	0,2
Social insurance in % of total expenditure on pharmaceuticals																													
	60,4	56,5	63,8	68,4	68,2	69,2	69,5	68,9	68,4	68,3	68,6	68,8	68,0	67,3	67,8	68,2	68,9	69,7	69,8	67,1	67,2	69,3	69,7	65,1	65,5	66,4	66,8	64,1	64,0
Private insurance in % of total expenditure on pharmaceuticals																													
	6,6	5,5	5,6	5,0	4,6	4,5	4,3	4,1	3,9	4,0	3,9	4,0	3,9	3,7	3,7	3,9	3,7	3,8	3,8	4,3	4,4	3,9	3,9	4,4	4,3	4,3	4,3	4,5	4,7
Out-of-pocket payments in % of total expenditure on pharmaceuticals																													
	26,4	23,3	24,8	24,1	22,2	21,2	21,3	22,4	23,3	23,4	23,4	23,2	24,1	25,3	25,0	24,5	23,9	22,9	22,9	24,7	24,9	23,7	23,3	27,1	27,1	26,1	25,7	28,0	28,1
All other funds																													
	5,0	13,3	4,5	1,2	3,8	4,1	3,9	3,7	3,5	3,4	3,3	3,3	3,2	3,0	2,9	3,0	3,0	3,1	3,1	3,5	3,2	2,8	2,7	3,0	2,9	3,0	3,0	3,1	3,0

Sources: Statistisches Bundesamt 2001: Fachserie 12, own calculation

BIOGRAPHICAL NOTE

Claus Wendt is research fellow at the „Mannheimer Zentrum für Europäische Sozialforschung (MZES)“, University of Mannheim.

Telephone: +49 621 181-2819

Fax: +49 621 181-2866

E-Mail: Claus.Wendt@mzes.uni-mannheim.de

Address: University of Mannheim, „Mannheimer Zentrum für Europäische Sozialforschung (MZES)“, L7,1, 68161 Mannheim

Heinz Rothgang is project manager at the Collaborative Research Center “Transformations of the State”, University of Bremen.

Telephone: +49 421 218-4132

Fax: +49 421 218-7540

E-Mail: rothgang@zes.uni-bremen.de

Address: Universität Bremen, Zentrum für Sozialpolitik (Zes), Parkallee 39, Barkhof, 28209 Bremen

Uwe Helmert is research fellow at the Collaborative Research Center “Transformations of the State”, University of Bremen.

Telephone: +49 421 218-4400

Fax: +49 421 218-7540

E-Mail: uhelmert@sfb597.uni-bremen.de

Address: Universität Bremen, Zentrum für Sozialpolitik (ZeS), Parkallee 39, Barkhof, 28209 Bremen