



# Evolution of German Universal Health Coverage - Should Countries Follow the Steps?

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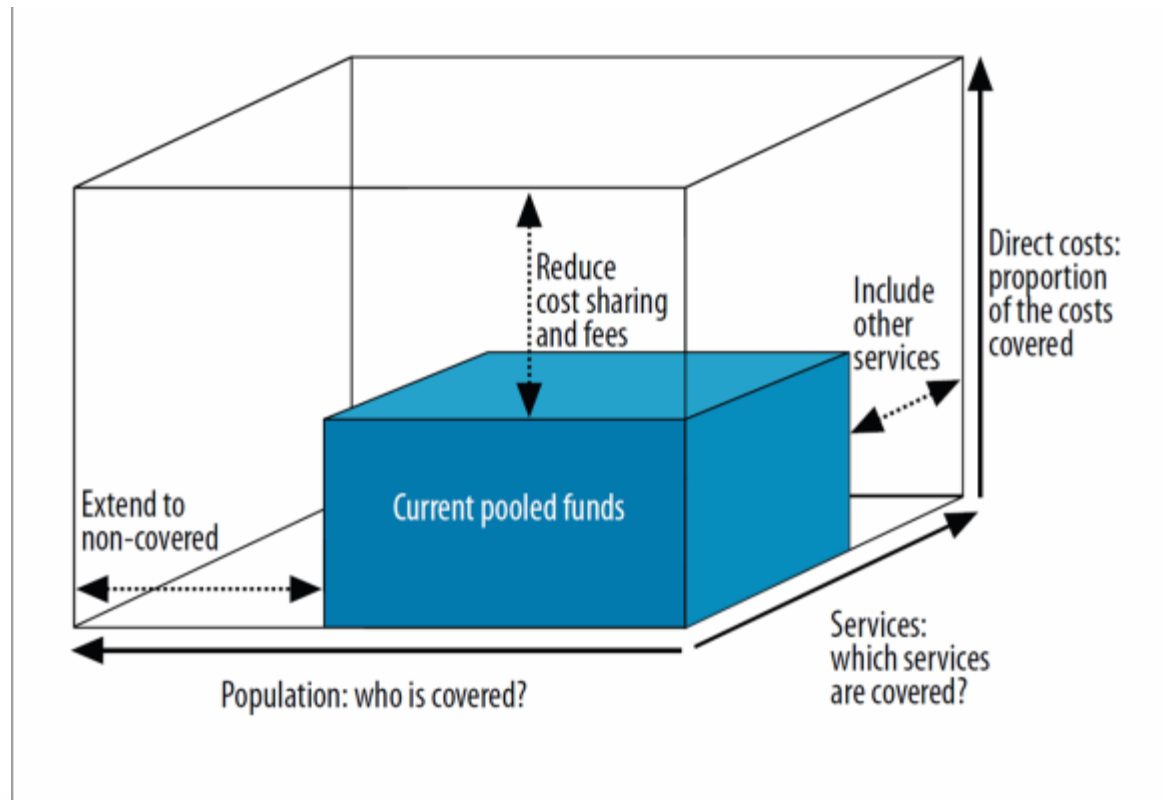
## The German health care system today

- Population: 82 million
- Health Care Expenditure: 11,3% of GDP
- 124 different sickness funds in Germany
- Benefits are granted based on medical needs
- Insured pay a %share of income as contributions
- Around 90% of population covered by statutory, 10% by private insurance
- Health care system is based on the principle of self-administration, government only provides for the legal foundation and framework





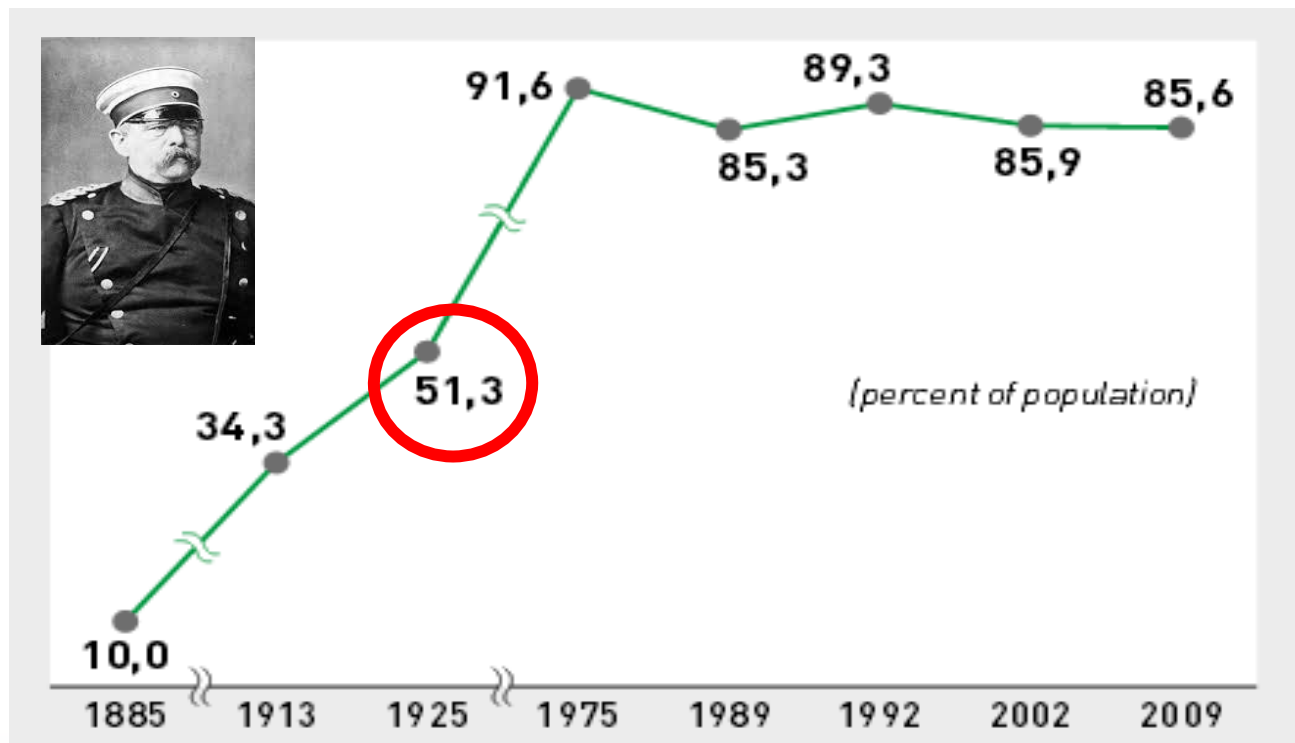
## UHC - the three dimensions





## German Social Health Insurance – A long path to population coverage

- Over 130 years old now, only since 2007 coverage for everybody





## Gradual Coverage Expansion (German examples)

Year	Creation of components of social security	Population coverage of social health insurance	Scale and scope of the mandated benefit package of social health insurance
1854		Miners	
1883	Statutory health insurance	Blue collar workers (in saltworks, processing plants, factories, metallurgical plants, railway companies, shipping companies, shipyards, building companies, trade companies, power plants) Craftsmen Persons employed by lawyers, notaries, bailiffs, industrial cooperatives, insurance funds	Minimum benefit package: Sickpay (63% of all benefits) Restricted in- and outpatient care free pharmaceuticals medical aid devices deathpay maternity support
1911		Agricultural and forestry workers Domestic servants Itinerant workers	Increase in maternity support Increase in sickpay of high-wage workers
1914		Civil servants	Earlier start of sickpay Family support for spouses and children
1917/18		The unemployed	Midwife services Obstetric services Pregnancy allowance Nursing mother's allowance
1975		Students All disabled	



## Made in Germany - Some features and lessons learned

- I. Governance**
- II. Benefit package design**
- III. Cost containment and budget control in provider payment**



## I. Governance - Self-administration

- **Principle:** State entrusts SHI with tasks that serve the public interest (health care provision for citizens).
- Legal supervision of regulatory bodies, but within their remit free to administer own affairs
- **Rationale:** self-administered organization can respond to changing needs and challenges more rapidly and flexibly than the State
- **Stakeholders have a voice.** Every six years composition of the Administrative Boards newly elected.
- 50% elected by the employers, 50% by members. The Administrative Board accountable for the fund's budget and its general political course. It also elects and oversees the Management Board.



## I. Governance - Self-administration

- Self-administration enacted by the non-profit payer and provider organizations
- **Triple role:**
  - Interest representation of their members
  - Self-administration of service provision
  - Steering function within the health care financing system





## I. Governance - The benefits of self-administration

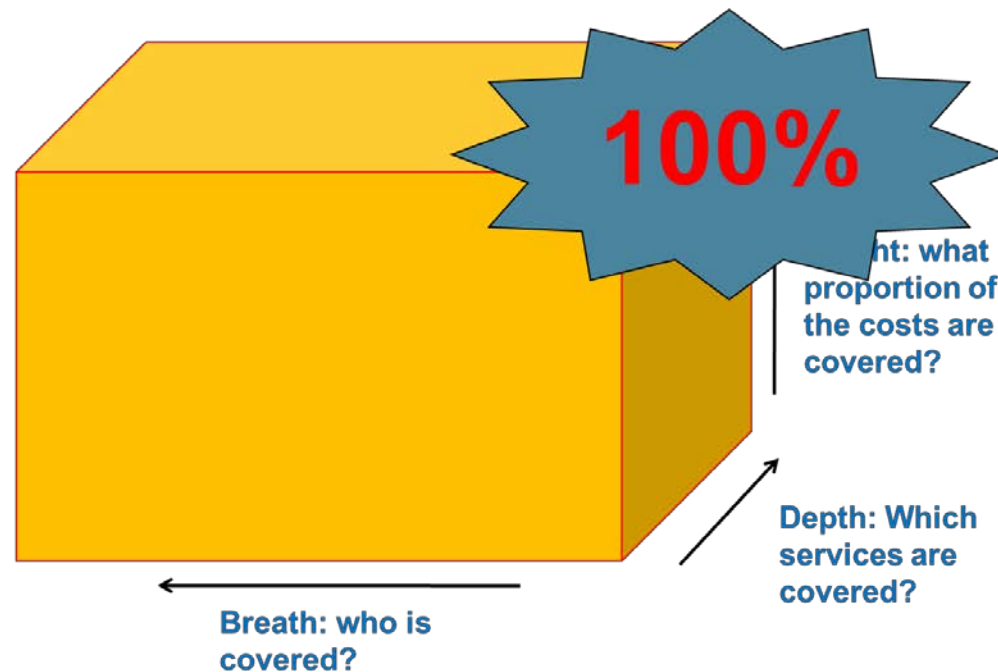
- Compared to a central state-controlled system, regional provider and payer associations **decentralized** decision-making
- Also considered as an expression of **democracy**, as representatives in the associations are elected
- **Stability, sustainability** and **balance** of interests

→ **Alternative to both state and market regulation of a health care financing system**



## II. Benefit Design – Comprehensive package

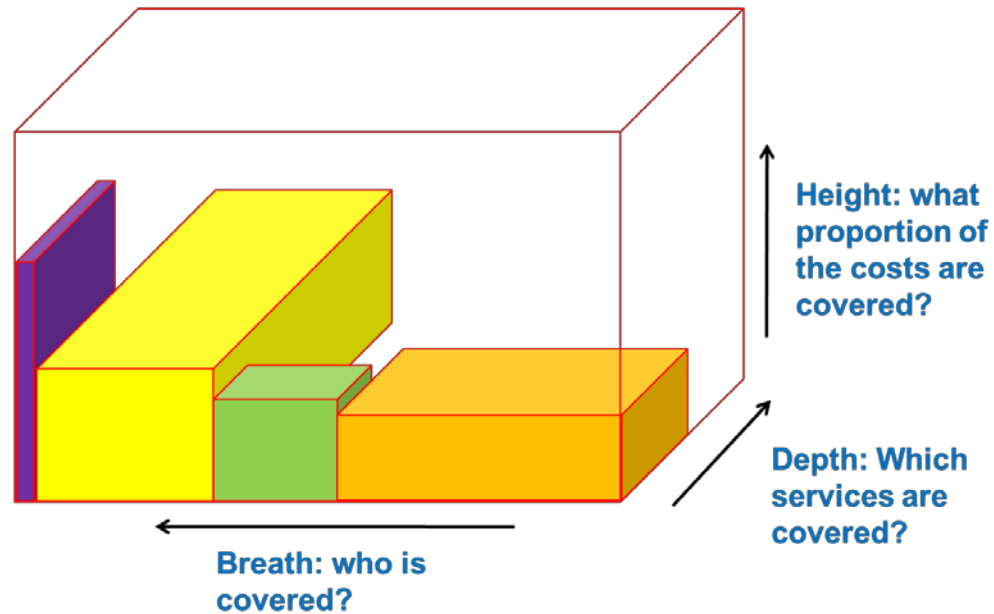
In a perfect world...





## II. Benefit Design

In the real world...



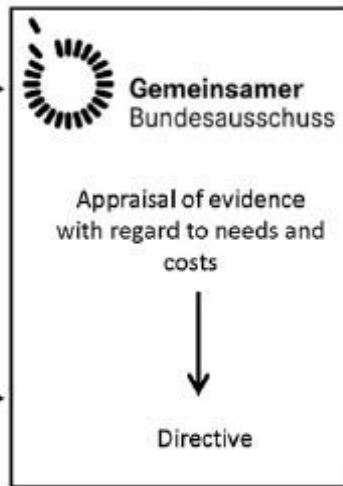


## II. Benefit Design - Decision Makers

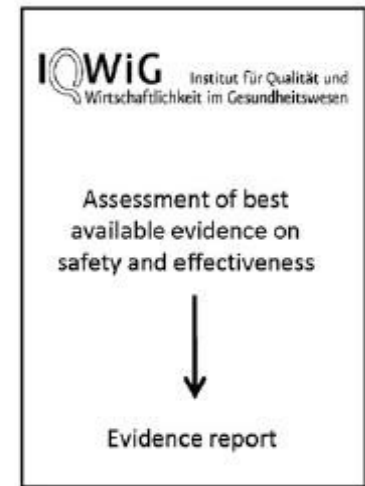
### Federal MOH



### Joint Federal Committee



### Institute for Quality and Efficiency in Health Care

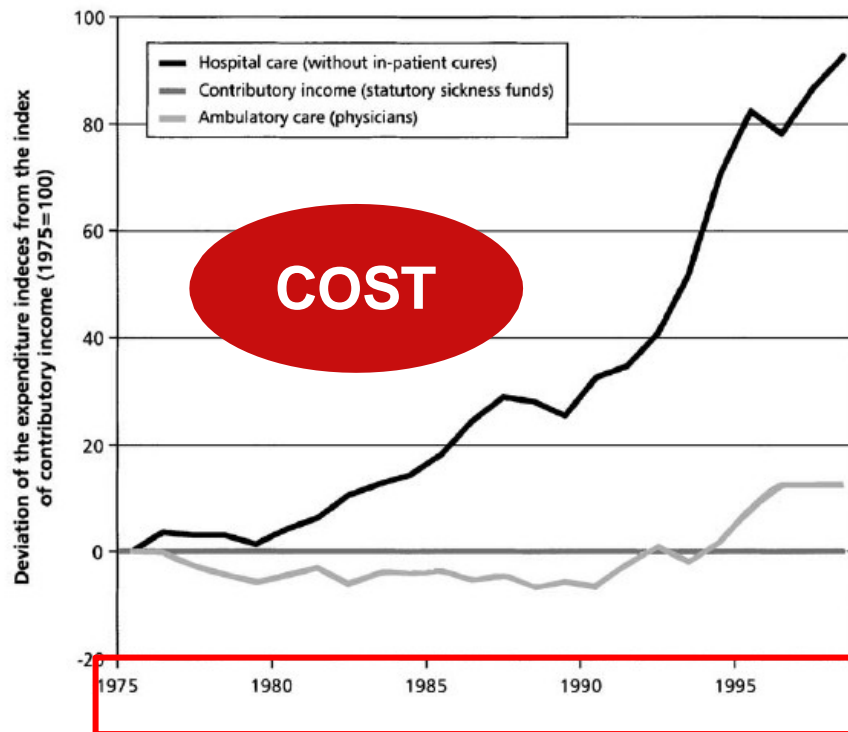


### MEMBERS

- 5 medical representatives
- 5 SHI representatives
- 5 patient representatives

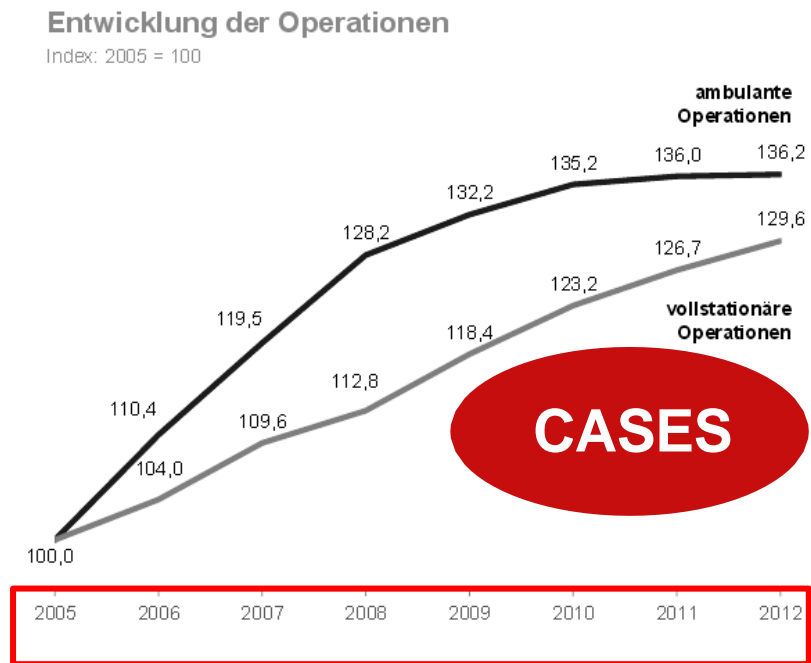


### III. Cost containment and budget control - challenges



**COST**

**Fee For Service**

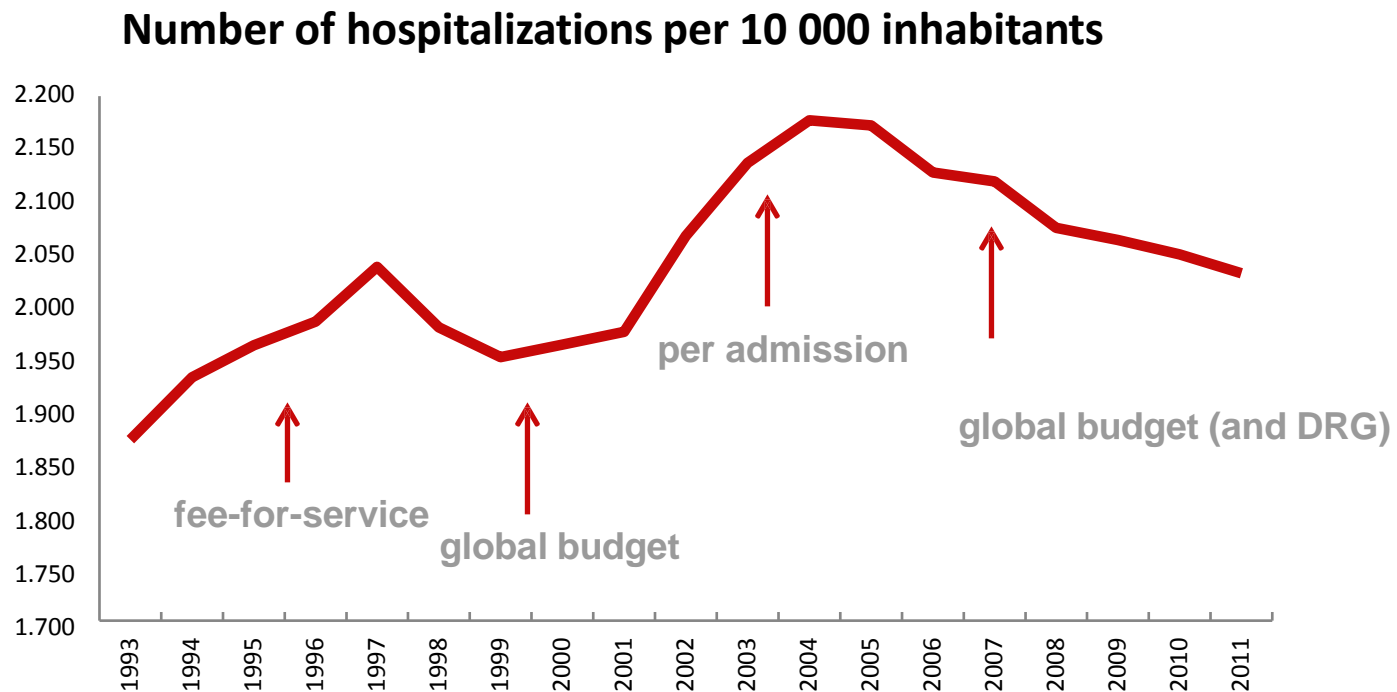


**CASES**

**DRG**

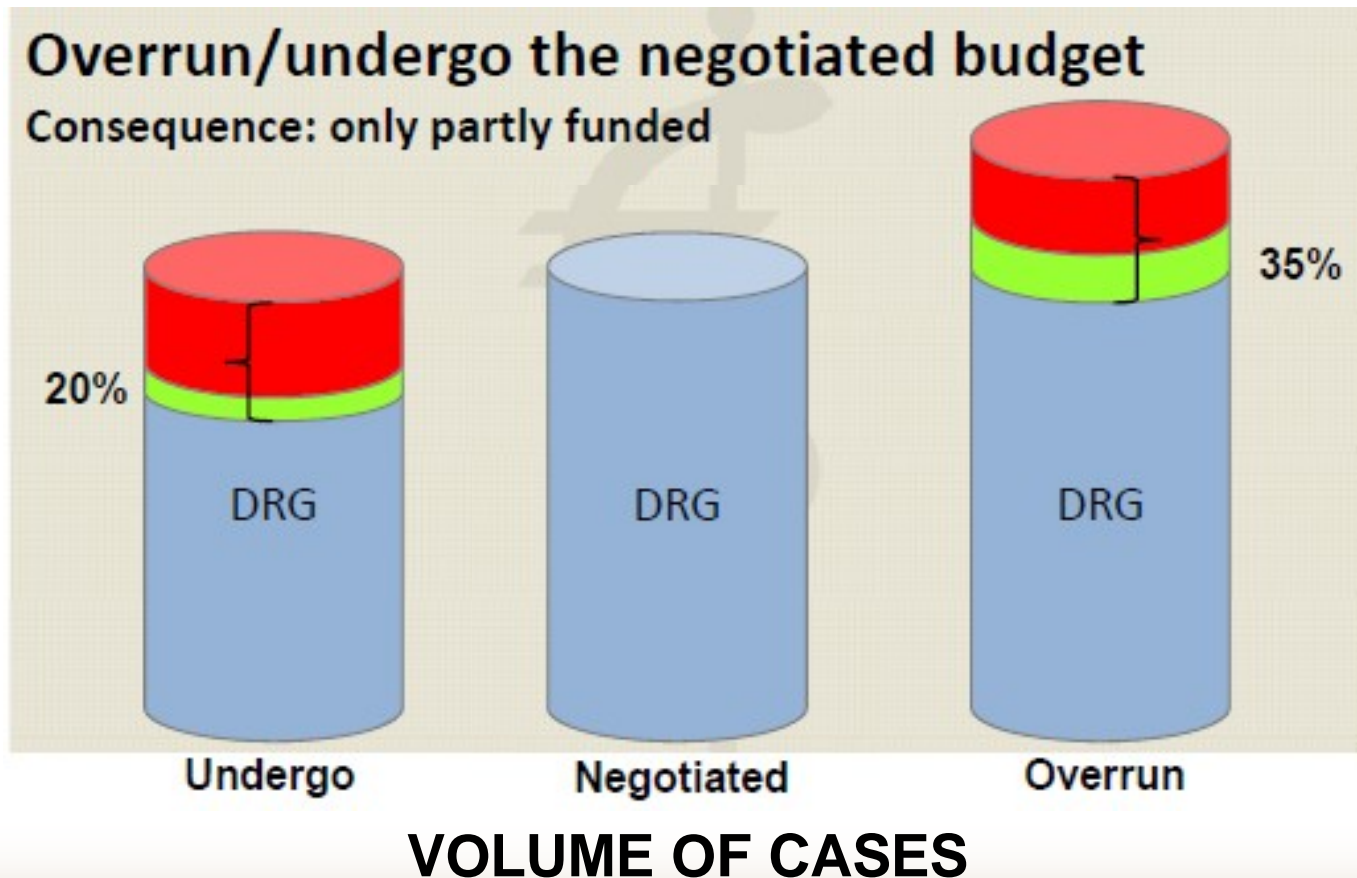


### III. Impact of remuneration mechanism on behaviour of hospitals (from Czech Republic)





### III. DRG - Contracting: case mix and volume agreements





TERIMA KASIH!