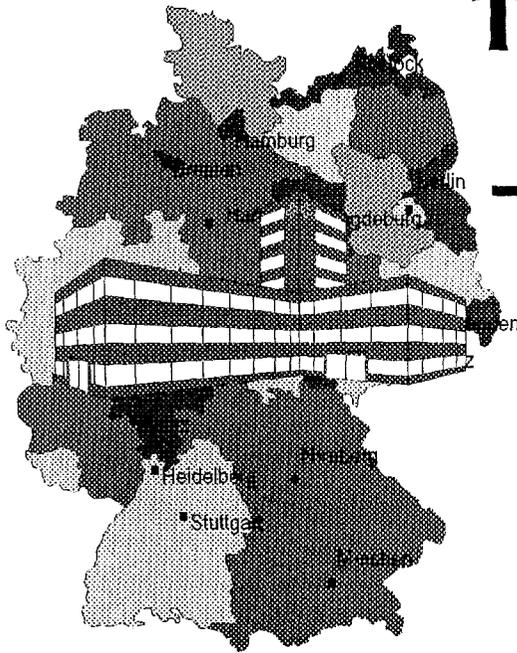




Technical Brief

No. 5 - January 1995



The German Health Insurance System

Impressions and lessons to be learned for the Philippines

Juan R. Nañagas, MD

Undersecretary of Health
Health Facilities, Standards and Regulations

learned from this tour may prove valuable in formulating the implementing rules and regulations if the bill is enacted into law.

Although the German social health insurance system is considered by many as one of the most efficient in the world in terms of coverage, quality of care, and equity, a country cannot just adopt its principles and organization. Certainly, a lot can be said for a system that covers 90% of the population, paying for any health care intervention that is deemed necessary. But there are historical, cultural, demographic, and economic differences that have to be considered in the study of why the German system is where it is today. It will also be worthwhile to remember that the system is in a state of flux and is presently addressing issues that may affect, or are affecting it.

This paper is by no means a comprehensive study of the German social health insurance system, but will try to deal with issues that the author feels may relate, either because of its absence or similarity, to Philippine conditions.

A team composed of representatives from the Department of Health (DOH) central office and one from the Region 10 Health Office, an officer of the Federation of HAMIS (Health and Management Information System) winners, and HAMIS staff representing the Visayas and Mindanao, went on a study tour (September 1994) of the German health care system with particular interest in its system of health insurance. This was made possible through an invitation from the German Agency for Technical Cooperation (GTZ), and was arranged and conducted by Professor Dr. Detlef Schwefel, the Project Manager of the GTZ-funded HAMIS Project of the DOH. The tour came at a time when a bill on National Health Insurance for the Philippines is pending at both the Lower and Upper Houses of Congress. Hopefully, lessons



"Technical Brief" reports on the findings of research studies and their interpretations of implications for health policy. They also highlight information regarding

important aspects of health policy based on conferences, research, policy speeches, demonstration and pilot project results, consultations, and public discussions.

"Technical Brief" draws attention to recent factual findings that have significant policy implications. It is meant to disseminate factual information and expressions of opinion bearing on policy and policy related issues to provide important information and to encourage the exchange of ideas, interpretation of facts and expressions of opinion among those interested in development and formulation of health policy in the Philippines.

This publication is issued under the general stewardship of the Health Finance Development Project (HFDP), Office of the Undersecretary, Chief of Staff, Department of Health under a Cooperative Agreement (contract no. 492-0446-C-00-2114-00) with US Agency for International Development. To assure uniform quality and appropriateness of content, the HFDP is assisted by the Editorial Committee of the HPDP, the HFDP Communication Committee, and technical editors as appropriate. The views, expressions, and opinions contained in this publication are those of the authors' and are not necessarily endorsed by the USAID and the Department of Health.

Gloria Gilda V. Custodio
Issue Editor

Inquiries may be sent to:
Health Policy Development Staff (HPDS)
Department of Health
San Lazaro Compound
Manila, Philippines
TN: (632) 711-6744
Fax No: (632) 711-6812

Health Finance Development Project
(HFDP)
20/F Pacific Bank Bldg.
Ayala Avenue, Makati
Philippines
TN: (632) 817-4433
(632) 817-6297
Fax No: (632) 810-1761

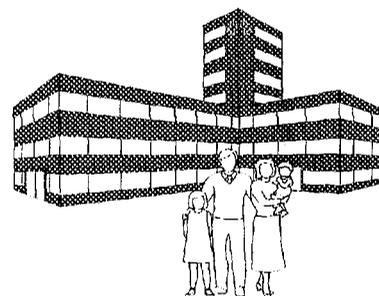
I. BRIEF HISTORY AND OVERVIEW OF THE GERMAN HEALTH INSURANCE SYSTEM

History

In 1883 Otto von Bismarck established what was to become the present German health insurance system. At that time, Germany was rapidly industrializing, a situation that can be likened to that of the Philippines today. The segment of the population covered was those of the industrial workers, and the health insurance law of 1883 mandated compulsory coverage, providing cash and medical services to those who became ill. Statutory health insurance is thus the oldest of the social insurance systems, and from it, the present social insurance system developed.

Even with a system that started a hundred years ago, and has been considered one of the most efficient in terms of cost-containment, laws have to be passed periodically for greater financial viability. In the last 100 years, the German health insurance system has undergone some changes and reforms to conform with the realities and needs of the changing times, such as cost containment reforms, financial viability, and adjustment

of its range of services. Some other concerns regarding the future center around three areas, (1) competition to increase efficiency, (2) cost containment without destroying the concept of solidarity, and (3) new foci of financing.



OVERVIEW

Funding and Principles

Funding: Today, after over a hundred years, more than 900 social health insurance funds which can be grouped into seven types according to the organization or foundation, support the system. These are: 1) local sick funds, 2) substitute funds, 3) business or industry insurance funds, 4) guild or trade insurance, 5) insurance for seamen, 6) insurance for miners, and 7) sick funds for farmers. Of these, the more important entities (to be further discussed elsewhere in the paper) are the local sick funds, the substitute

fund, and the funds provided by business. Together they account for 90% of social health insurance funds. Except for a very small minority farmers group, there is no government or Federal subsidy for the cost of personal health care. The number of members in these funds range from 500 to 7 million. These "sickness funds" are private, non-profit organizations but with a legal mandate ("public law corporations") and are governed by federal laws and regulations. They also must meet objectives

that are publicly determined. Thus, they differ from the Philippine concept of private insurance companies, although they may act as one in collecting premiums, negotiating rates with, and transferring funds to providers for services.

Membership in a sickness fund is compulsory. Only the self-employed who have never been employed, or people who exceed a certain level of income can use private insurance. Of those who qualify, approximately two-thirds choose to remain in the sickness funds. For this reason about 90% of the population is covered by the sickness funds (with the rest of the population, opting for private health insurance schemes). Many opt to do this because there are really few advantages in the private insurance system. These include: the right to choose a senior hospital physician, to use a non-local hospital, to stay in a single or double room instead of a ward. Because private insurance rates depend on the number of persons enrolled, and their health status; small families and healthy individuals would pay less under the private insurance scheme than in the sick fund where

"The health system in Germany is not administered as a service by the state, but by the cooperative efforts of health insurance funds, the medical profession, the hospitals, and all others providing health services. The state only provides a framework of regulations..."

premiums are deducted as a percentage of gross income or salary, a substantial 8-16.5% (average of 13-13.5%). However, those under a private insurance system first have to pay their medical bills for which they would be reimbursed (cost-recovery principle) in contrast to the benefit-in-kind principle of the statutory health insurance system. Also, once a person has opted for private insurance, transferring from one to another is difficult and one cannot revert to the statutory sickness fund

until a person's income falls below a level that has been determined.

Principles: The German health insurance system operates on several basic principles, like solidarity, subsidiarity, and service in kind, aside from the usual insurance principles. Solidarity as a principle is common in most European communities and works on the belief in the responsibility of the community to provide for one another through collective action. This ensures an adequate level of well-being for all, and lessens the burden of bearing adverse risk. On the other hand subsidiarity is characterized by self-administration. The health system in Germany is not administered as a service by the state, but by the cooperative efforts of health insurance funds, the medical profession, the hospitals, and all others providing health services. The state only provides a framework of regulations, not providing the services but specifying which services and how much to spend for them. Those availing of health insurance need not pay large amounts out-of-pocket. Vouchers are given to the provider who in turn gives it to the doctors association for billing.

II. THE SOCIAL HEALTH FUNDS

Local Sick Funds

By January 1, 1991, the health care system of Western Germany was also extended to the people of the Eastern states, the new Lander (there are sixteen Lander or federal states in Germany). The local statutory health insurance funds (local sick funds) are therefore in place all over the country. Accounting for 41% of all those enrolled in a

statutory health fund, these local sick funds provide health services in kind, so that the insured receive health care benefits without any direct payment. Contributions are equally shared between employee and employer. It is the fund that provides payment to the providers. These funds are independent entities and administration is without interference from the Federal government whose main function is to ensure that they abide by the law, encoded in the Fifth Book of the Social Security Code. Different sets of rules govern different services which are classified into five types: inpatient services, outpatient services, dental services, drugs, and medical devices. These local sick funds operate on the basis of regions (municipal and state), serving employees of a defined geographical area. There is a National Association of regional statutory health funds.

The governing body of the sick fund, the board of directors, is composed of employers and employees duly elected by the members for a period of 4 years. They in turn elect 'fund managers' who are tenured officials. The board decides the contribution rates and the budget of the insurance while the fund managers perform routine work like

"The local sick funds operate on the basis of regions (municipal and state), serving employees of a defined geographical area. There is a National Association of regional statutory health funds."

bargaining with the providers. The responsibility of cost development is also left by the Federal government to the hands of the partners, the employers and employees.

Substitute Funds

Another major group of insurance funds is the 'substitute fund'. This is traditionally for 'white collar' workers, offered as an option to local, company-based, or trade-based insurance funds. Unlike the statutory funds

which are regional, substitute funds are usually national. Most are open to all white-collar workers but some may be availed of only by certain professions. It accounts for 36% of people insured in statutory insurance funds.

Benefits offered are the same as those in the local sick funds, but premiums may be minimally less than the average for the local sick funds. Many say that the reason for opting into a substitute fund is basically prestige as the service received is the same as from the sickness funds. Those enrolled in the substitute funds claim that service is 'better,' and the fund approves more services. This is probably more of a perceived, rather than a real difference.

Industry or Company-based Funds

The third largest group of insurance funds in terms of membership are those provided by large companies. They account for 13% of all those enrolled in a statutory health fund. Again in contrast to the area-based local sick funds, some of the company-based funds are national in scope. Benefits are the same as the other sickness funds.

There were approximately 700 such funds in 1992. Employers chose to provide their own insurance funds (minimum membership - 450) because it may be more economical; a work force of low-risk individuals may mean lower costs than paying into a fund which services many higher risk persons.

III. PROVIDERS

There are over 300,000 physicians for 80 million people in Germany, giving it one of the highest per capita ratio of doctors. Aside from them, there are other health care providers like dentists, and a limited number of psychologists. Of the 300,000, approximately 98,000 are ambulatory care physicians; 124,000 are hospital based; 56,000 are pensioners; and 30,000 are non-health care providers such as epidemiologist, ministry of health doctors and others.

Physicians in Germany are classified either as ambulatory care, or hospital based, with a small percentage being allowed both. However, the sick funds envision an integrated fund for both in and out-patient care paid on a capitation format. This is part of a package of reforms that may be introduced as cost-cutting procedures including pre-stationary diagnostic services to avoid duplication of laboratory and diagnostic services in the hospitals. Another factor that has to be considered is the matter of out-patient surgery, like arthroscopy, which is being allowed in some out-patient clinics.

Ambulatory Care Physicians

To work within the system as an ambulatory physician one has to be a member of a physician's association of which there are 23 in the 16 Federal states. They have to "pay" to be in - approximately 3% of their billing goes to the association. Also, the risk of setting up their offices belongs to the physician.

There are requirements regarding training that must be met before a physician can become a member of the association. This includes special seminars to inform them about the system.

Organization



Physicians in a regional association elect a representative for 4 years to a "parliament" which in turn elects a board of directors for decision-making and negotiations. The national organization, composed of a representative from each regional parliament, sets the minimum coverage and are responsible for both economic and medical questions. The schema for fee negotiation is seen in Figure 1. The advantages of "bargaining" include

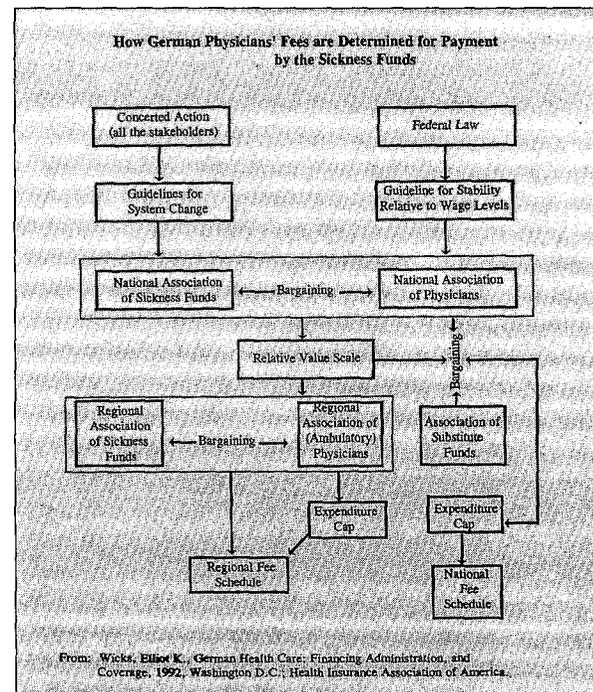


Figure 1

5

the equality of bargaining power whatever the size of the physician's association and the potential to respond quickly to improve service.

IV. PROVIDER PAYMENT MECHANISM

A fee-for-service arrangement based on a negotiated fee schedule is the mode of payment which is limited by a negotiated cap. However, as has been previously mentioned, the physician does not bill his patient but is given a voucher in which is noted all services to the patient for that quarter. This is sent to the physician's association which bills the sickness fund which in turn provides the money to the physician's association for redistribution to its members.

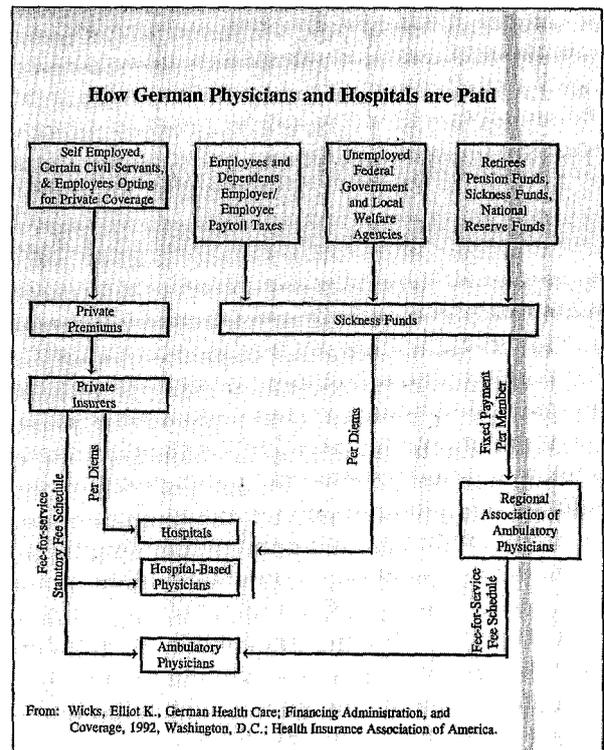
An information system provides control of physician's services. The system checks the validity of data on the vouchers; the plausibility of services per day or a profile of daily activities (5% of all physicians randomly checked per quarter); and monitoring of the economic aspect of their services.

V. HOSPITALS

Physicians in a hospital setting are considered employees of the hospital. Hospitals have separate sources for their operating and capital expenses. They are paid for their operations by the sickness funds on a per-diem basis which includes salaries for their health personnel. The per diem rate is also negotiated annually between the sickness funds and the individual hospital with the state reserving the right to intervene in case of non-agreement which is rare. The schema for payment to hospitals is shown in Figure 2. In 1992, the average rate was 408 DM per day, 5,670 DM per case. The per-diem mode probably accounts for the longer hospital stays of in-patients in Germany, averaging 14.6 days nationally for general hospitals in 1991. Salaries of hospital physicians are again negotiated nationally for civil service employees; the rate is

used even by private hospitals with some minor variations. Of the approximately 100 billion DM spent for hospitals, about 60% are for personnel expenses.

Capital expenses, on the other hand, are paid for by the government with funds from the state government. The local government determines if a hospital is part of its hospital plans and once approved, negotiations start. Capital investment plans of individual hospitals will only be reimbursed by the state if these are deemed consistent with the state plans. Capital spending for hospitals amounted to only .22% of GDP in 1989. However, the country probably does not need more hospital beds as 1991 statistics show that nationally, there are 100.9 beds per 10,000 population.



VI. BENEFITS

By law, Germans are entitled to any health service as long as it is considered 'necessary' and 'economical.' This means that unlimited hospital and out-patient services, maternity care, prescription drugs, medical supplies and devices, dental care, preventive medical care, family planning and rehabilitation services, even massage and stays in health spas are available as long as they are prescribed and considered necessary. As

has been mentioned, co-payments, if needed, are minimal and apply only to dentures, glasses, and prescription drugs for out-patient care (drugs are included in hospital charges).

"In the Philippines, contributions in terms of monetary value are maintained at a certain level after a certain income is reached, so much so, that the social nature of the insurance is lost since high-salaried employees pay only as much as the lower-salaried. There is no such level in Germany, but those earning above a certain level can opt for private insurance."

health, almost fifty percent of expenditures comes out-of-pocket, with health insurance (Medicare) accounting for 18% and government expenditures, 31%. Personal health care in Germany is paid almost purely from insurance funds, therefore only from contributions. We also have a situation in the Philippines where a large majority of the population (probably 30%) can be considered paupers. Will the contributions from those who can afford be able to 'subsidize' them along the lines of social

insurance, or will a large infusion of government funds be necessary?

VII. POSSIBLE LESSONS

As the Philippines struggles with its present form of social health insurance, Medicare, the success of social insurance systems of other countries like Germany, Korea, and Canada may provide valuable lessons. However, we also have to be reminded that there are many differences between these countries and the Philippines, and that we have to be sure that whatever form of health insurance that is crafted for our people will be acceptable culturally, economically, and demographically.

Obviously, the economic factor is most disturbing. The GDP of Germany and the Philippines are vastly different and on top of that, the level of health expenditures are even greater. Health expenditures in the Federal Republic of Germany accounts for less than 10% of GDP while that of the Philippines may be less than 3%. Also, for personal

Even if a compulsory health insurance bill is passed in the Philippines, its funds, unlike that of Germany, cannot pay for all health interventions even if deemed necessary. Even if contributions are raised to a level of percentage of gross income (average of 12.5%) as Germany's, the Peso is less than the Mark. Politically, it would be very difficult to increase contributions to Medicare from the present 2.5% (divided between employer and employee). In the Philippines, contributions in terms of monetary value are maintained at a certain level after a certain income is reached, so much so, that the social nature of the insurance is lost since high-salaried employees pay only as much as the lower-salaried. There is no such level in Germany, but those earning above a certain level, can opt for private insurance. Probably because the Germans have been used to paying for some type of social insurance through the 'dying funds' and the 'sickness funds' of the journeymen of the guilds even before Bismark's historic decree on social health insurance more than a hundred years ago. There is not much objection in Germany to paying a major percentage

of gross income for health insurance (the solidarity principle). There is none of the mentality prevalent here in the Philippines. What happens is if one contributes a certain amount, automatically one must try to get his money's worth through unnecessary consultations or even get a refund of contributions if the insurance is not availed of. A possible starting point for Filipinos can be the 'bayanihan' spirit we claim to have which motivates a community into action for one of its members in need. A

"Related to the amount that GSIS and SSS collects, is the amount of reserve funds. Unlike in the Philippines, in the German system, the whole health insurance fund is used for health benefits with a small percentage for administrative and other expenses."

frequent example given of 'bayanihan' is in moving a native hut to a new location through the collective efforts of everyone in the community without any remuneration asked for. But I feel, that this is limited to the village or 'barangay' level; how to harness and expand this mentality would be a challenge to social scientists and community leaders.

Related to the amount that GSIS and SSS collects, is the amount of reserve funds. Unlike in the Philippines, in the German system, the whole health insurance fund is used for health benefits with a small percentage for administrative and other expenses. The reserve level of a few months is not for investment purposes so the fund is truly a social health fund. In the Philippines the reserve funds that the SSS has built up from the health insurance funds is used for investments that are presently necessary to sustain the funds since it pays out more than it collects due to an inefficient and fraud-laden system.

There are other principles that can probably apply, one of which is subsidiarity. The situation where there are over nine hundred health insurance funds in Germany, yet all giving the same benefits, can hopefully be replicable in our country. Plurality would seem to be more in keeping with the Filipino

psyche. The fear of many private health insurance companies, HMO's, and community-based health insurance systems that they will be forced to stop operations can thus be allayed. A basic health package common to all insurance systems can be mandated by the bill. The subsidiarity principle should also work well in the devolved setting that we are in if the local governments can attain enough political maturity and social orientation to be able to embrace social insurance principles.

Lastly, we should emulate the foresight of the German government to think of possible factors and how they may affect the system in the future. However it presupposes a system where change is easily affected. In the Philippines, under the present set-up of Medicare, where GSIS and SSS control the funds, this may not be easily accomplished. Moreover there is no institution in the Philippines that studies the impact of similar factors.

VIII. CONCLUSION

The Philippines is at the threshold of an attempt to establish a national health insurance system. One version wants to build on the existing system, the other to completely reorganize it. To look at the experiences of countries with successful social health insurance schemes is logical but should be done with the caution that there are many differences between one country and another in terms of its economy, politics, and culture. But one should not consider these differences as absolute contraindications for taking a closer look at their systems. We Filipinos, are apt to say, that we easily adapt, that we are good improvisers. We hope we can prove this true with our national health insurance.

8