Current Themes in UK Health Care: How are They Approached in Germany?

Conference Report

2003

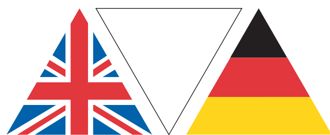
Current Themes in UK Health Care: How are They Approached in Germany?

London

12 March 2003

Conference Report

April 2003



Anglo-German Foundation for the Study of Industrial Society

King's Fund

The King's Fund

Anglo-German Foundation

For thirty years the Foundation has contributed to policy-making in Britain and Germany by funding bilateral research and discussion of economic and social issues which challenge both countries, and by making the results of this work available to decision-makers, practitioners and their advisers.

The King's Fund

The King's Fund is an independent charitable Foundation whose goal is to improve health, especially in London. It focuses on: tackling health inequalities and social injustice, enabling health and social care staff and organisations to work in partnership, across traditional boundaries, promoting cultural diversity in health, encouraging patient and wider public involvement in health and health care.

© 2003 Anglo-German Foundation and The King's Fund

Report compiled by Christopher Pick

Anglo-German Foundation for the
Study of Industrial Society/
Deutsch-Britische Stiftung für das
Studium der Industriegesellschaft
34 Belgrave Square, London SW1X 8DZ
Tel: +44 (0)20 7823 1123
Fax: + 44 (0)20 7823 2324
E-mail: info@agf.org.uk
Website: www.agf.org.uk

The King's Fund
11–13 Cavendish Square
London
W1G 0AN
Tel: 020 7307 2400
Fax: 020 7307 2801
E-mail: Libweb@kingsfund.org.uk
Website: www.kingsfund.org.uk

Contents

Introduction 1

The German political context 2

The German health system in a nutshell 4

Themes for discussion 7

  Panel and plenary discussion 7

Conclusion 11

Research themes 12

Introduction

Every government in the developed world is trying to meet the challenge – simple to express but highly complex to achieve – of providing high-quality health services at a reasonable cost. This seminar, organised jointly by the Anglo-German Foundation and the King's Fund, brought together specialists from higher education, the media, think-tanks, the civil service, politics, medicine, and health planning and management in both the public and private sectors to discuss how current issues in UK health care are being approached in Germany. The seminar builds on the Foundation's publication in 2002 of a major comparative study of the health care systems in Britain and Germany.

The very different health care systems of the two countries reflect strongly contrasting governance cultures. The German system holds together, through a complex system of accountability, a large number of different stakeholders (providers, purchasers, consumers), mostly regionally based; Britain's centralised National Health Service reflects the 'top-down' nature of much of British politics and society. The German system is gradually moving towards a greater degree of national involvement in pursuit of stronger strategic management and more consistent application of evidence-based medicine. In Britain, however, the government is seeking ways of decentralising health care in order to introduce a greater element of competition so as to improve performance.

The seminar focused on examining how the German experience can inform three live themes in current health care policy debate and development in the UK:

- national efforts to improve quality
- decentralising power to local communities *and*
- encouraging market forces in order to improve performance.

Lively debate and discussion produced many illuminating insights into positive ways in which Britain might benefit from the German experience. Thus, for example, in Germany the citizen's legal entitlement to health care leads to a better doctor–patient relationship; and the greater public confidence in the health care system in Germany may be a result of the greater delegation of control and decision-making.

The seminar made an important contribution to the Anglo-German Foundation's aim of developing comparative research on the British and German health care systems designed to be of positive use to policy-makers and managers in both countries.

The German political context

Dr Richard Freeman (Senior Lecturer in Politics at Edinburgh University) launched the morning's discussion with a concise assessment of the organisation of the German health care system and the way it reflects wider themes in German governance. He identified two main organisational characteristics:

- health care is structured around a financing system funded by compulsory social insurance. Broadly speaking, employers and employees pay into statutory but independent, self-governing sickness funds; this money is used to pay for services to patients delivered by a mix of public, not-for-profit and commercial providers.

- the system's stability. The basic structure of the system introduced by Bismarck in 1883 remains in place today, having survived regime changes, world wars, and national division and reunification.

The largely self-governing health care system, operating through multiple organisations and at arm's length from government, reflects important characteristics of the German state established after 1945:

- *Corporatism*. The independent role of all the main participants – the funds (which purchase services) and doctors' associations and hospitals (the service-providers) – is guaranteed under public law. In effect, the system operates on the basis of negotiations between associations of payers and providers, regulated by government.

- *Regionalism*. Much of the business of health policy making, including corporatist negotiations between purchasers and providers (see above), takes place at regional *(Land)* level. The *Länder* (regional states) themselves hold some key responsibilities, such as those for hospital planning and investment. Through their representation in the upper house of parliament (the *Bundesrat*) the *Länder* can veto legislation proposed by the national government.

- *Legalism*. The system is closely regulated by constitutional law. Intense legislative activity over the last twenty-five years testifies to a 'search for control' over the system by government.

Richard Freeman concluded with observations designed to signpost the discussion and debate during the rest of the morning:

- *Reunification* of East and West Germany in 1990 brought increased costs (of infrastructure investment and extending insurance rights to unemployed workers in the east), and shifted the axis of redistribution among states from south–north to west–east.

- *Fragmentation* of government (governments at both national and regional levels are usually coalitions, and lower and upper houses of parliament may be controlled

by different parties) both in general and specifically in respect of health care can make for 'reform blockade'; in practice, government relies heavily on expert commissions and committees representing a range of interests at national level. Sectoral strategic management is hard to develop, and 'who's in charge' is often unclear.

- *Structural reform* at national level is not always as radical as it seems, and more often amounts to a redistribution of cost burdens among existing actors. The legislation and regulation of the German system creates the conditions required for its successful administration, but does not foster the leadership and strategic management essential in circumstances that require radical action and change.

- All this raises interesting questions for the NHS about the *role of* (and even need for) *government in the health sector*. In Germany, for reasons set out here, the state is often described as 'semi-sovereign'. In health care, multiple actors and interests, independent but with clearly defined responsibilities, negotiate with each other according to strong cultural norms of solidarity as well as subsidiarity – and produce a system that seems to work.

The German health system in a nutshell

Reinhard Busse (author of the AGF report comparing British and German health care systems, Professor of Health Care Management at Berlin University of Technology and Associate Research Director with the European Observatory on Health Care Systems) echoed Richard Freeman's comments. Professor Busse emphasised regionalism as the key to the German political system – the *Länder* hold all powers not explicitly passed to the national government, in contrast with the UK where the administrations in Scotland and Wales have been granted devolved powers. In addition, through the *Bundesrat* the *Länder* have a strong influence on national policies. He went on to delineate the main features of the German health care system and draw illuminating comparisons with its British counterpart.

- The German statutory system covers 89 per cent of the population and is responsible for 60 per cent of all health care expenditure. 75 per cent of the population are required by law to belong; the remaining 14 per cent, although entitled to opt for private health care, have chosen to remain in the statutory system. This is larger than the proportion that opts for private care, which means that the statutory system has to be good enough to retain them.

- Payments to the funds are income-related, not risk-related – which makes the system one of social insurance, rather than a profit-making enterprise. Balancing payments are made between the sickness funds to take account of the varying risk-profiles of their members.

- Ambulatory care (roughly the equivalent of UK primary care plus the out-patient services provided by hospitals) is provided by physicians, who must belong to a self-governing regional physicians' association. Hospital-based care (the equivalent of in-patient care in the UK) is provided by public, not-for-profit and commercial hospitals. Because they are all contracted with sickness funds, each hospital provides similar services, and the status of a particular hospital is not an issue.

- The two sectors are totally separate financially. Sickness funds contract with providers in each sector (i.e. the regional associations of physicians and hospital associations) to provide services to their members.

- The German system is based on the individual's legal entitlement to receive the best care for their condition. Physicians and hospitals are obliged to treat patients; patients have freedom to select a particular physician or hospital.

- Legal entitlement can lead to doctors offering treatment whose efficacy has not been proved but which the patient feels they require. Equally it avoids constraints on treatment for budgetary reasons – i.e. the UK's 'postcode rationing'. In the UK, by contrast, there is no legal entitlement to a specific form of care or treatment.

The contrast with the UK system – in methods of planning, regulating and financing – is huge:

- In Germany over half all health-related expenditure comes from sickness funds, while in the UK most health care is funded directly by the government from tax revenues.

- The German system is based on strong delegation of control and decision-making, which rests largely with the sickness funds, the hospital organisations and the physicians' associations. Government (especially at the national level) has limited control. One consequence is that political involvement is minimal – there is no public expectation (in contrast with the UK) that politicians will carry the can for, or be expected to intervene directly in, individual cases or in detailed health care planning. Equally, strategic planning (at regional or national level) is more difficult to achieve.

- In Germany attempts to establish national good practice founded on evidence-based medicine (see below) are at a much more rudimentary stage than in the UK.

Since the late 1980s, German governments have been struggling with three dilemmas:

- The *rapidly increasing cost of health insurance contributions*. A number of measures to reduce the costs of health care have been tried (not wholly successfully). Most recently attention has focused on the income side. Since payments to sickness funds are income-related, two factors have a threatening impact on the funds' income. These are demography – in an ageing population a greater proportion of people receive pensions, which are lower than wages – and the increasing number of unemployed people, whose income (in the form of welfare benefits) is lower than wages.

- The *quality and cost-effectiveness of health care*. The 'benefit catalogue' – the services offered by sickness funds to their members – is generous and includes services of unproven effectiveness. Doctors and hospitals have a financial incentive (albeit small) to prescribe. This, combined with inadequate knowledge about the efficacy of particular treatments, leads to inappropriate services being offered. In relation to the rest of Europe, German health care is expensive and of average quality – and thus its cost-effectiveness is low. Government is attempting to improve cost-effectiveness through guidelines and 'disease management programmes', but implementing these in law and then getting them adopted by the organisations concerned is a lengthy process.

- The *tension between equality of care and competition*. Recent legislation has ironed out differing levels of health care provision and contribution rates between the sickness funds, leaving a dilemma: how can the different funds compete when they offer an (almost) identical benefits catalogue, an (almost) identical system of health-care provision, and similar contribution rates?

Legislation proposed for 2003 – the Health Care System Modernisation Act – is designed to resolve some of these issues. This legislation will

- limit collective contracting by the sickness funds to family medicine and in-patient hospital care and will introduce selective contracting to ambulatory specialist care (i.e. specialist out-patient services provided by physicians)
- use disease management programmes to introduce integrated care of patients across the ambulatory and hospital sectors
- create a new German Centre for Quality in Medicine, modelled on the UK's National Institute for Clinical Excellence, which will increase pressure on physicians and hospitals to adopt treatments of proven efficacy.

Themes for discussion

Before the seminar broke into small groups for a short burst of intensive discussion, Jennifer Dixon (Director of Health Care Policy at the King's Fund) highlighted three themes of current UK health policy. The main objective is

- *quality improvement* – through national systems such as standards, performance indicators, inspection, performance management and performance development

which will be achieved through

- *decentralising power* – through greater budgetary control by Primary Care Trusts, new freedoms for Foundation Hospitals, greater public involvement

and

- *increased market signals* – largely on the provider side, e.g. diversity of providers (hospitals, pharmacies), patient choice (e.g. for elective care), fixed-price competition between hospitals.

Panel and plenary discussion

The morning's final session produced brisk and thought-provoking debate around and beyond the themes suggested by Jennifer Dixon. Alongside Reinhard Busse, Jennifer Dixon and Richard Freeman on the panel were Anna Dixon, lecturer in European Health Policy at the London School of Economics, and Martin McKee, Professor of European Public Health and Co-Director of the European Centre on Health of Societies in Transition at the London School of Hygiene and Tropical Medicine. For ease of reading, the ebb and flow of discussion between the panel and the floor is reproduced in note form. As is to be expected in a discussion, many contributors made overlapping points; such repetitions have been ignored here.

Comparative patient experience

Comment

Is the greater dissatisfaction expressed by UK patients related to objective performance measures or because of cultural differences resulting from the UK's top-down approach?

Responses

- Satisfaction ratings are shaped by expectations – and recent political discourse has talked down the NHS. In addition, the UK is suffering the consequences of massive underinvestment over the past 30 years.

- Good patient experiences depend on good communication and involvement in decision-making – at the doctor–patient level, not at the policy level. Legal entitlement (as in Germany) makes for a better doctor–patient relationship.

- Evidence-based medicine enables doctors to consider the effectiveness of treatments, but can also impair the doctor–patient relationship, for the patient may not get the treatment they believe they require.

- Cultural attitudes (the top-down hierarchical approach) in the UK stifle innovation.

- Even though their professional status in Germany is lower than in the UK, nurses in Germany express greater satisfaction in their work because they are able to spend more time with individual patients.

- The new German Centre for Quality in Medicine, placed outside the traditional provider–purchaser structure, will challenge the current system of self-regulation and impose new cost-effectiveness constraints. Physicians are concerned that they will have to modify their treatment methods, and are suggesting to patients that their clinical freedom will be compromised.

Affordability of treatment

Comment

The key issue in the UK is who takes the decision that a particular treatment, although known to be clinically effective, is unaffordable. The government's drive to devolution will inevitably lead to local differentiation – to a 'postcode lottery'. Will there be a similar debate on affordability in Germany and who will make the decisions?

Responses

- Entitlement to a beneficial treatment exists throughout Germany – issues of local affordability cannot override legal entitlement.

- The inequity in the German system arises because different sickness funds impose different contribution levels on the same income bands.

Responsibility for health care

Comment

Who is responsible for health care in Germany at the level of national politics?

Responses

- In many respects, no one. There is no direct contact between the national health ministry and the CEO of an individual German hospital. Many German hospitals are independent organisations managed under private law – the German public would not expect the minister to take responsibility for a decision made by a German hospital, or for something that happens in it.

- The German health care system (as in many aspects of governance in Germany) operates through a complex system of interlocked accountability involving medical practitioners, hospitals, sickness funds (and thus the public as paying members of funds), national and *Land* ministries, and trade unions (through representation on company boards).

Does ownership matter – should we leave it to the markets to achieve quality?

Comment

The UK has a hang-up about ownership. We live in a consumerist society – why should the health service remain a state-run monopoly? The multiplicity of funding schemes and providers in Germany give the public enormous choice. We should rely on the market to improve quality.

Responses

- Although the German system is not market-based, it relies, admittedly to a limited extent, on market incentives for providers, for example by tying the level of reimbursement to the number of patients treated and the number and type of services provided.

- The German system is demand-led. People get what they want (and sometimes more than they need), and there is some over-supply of medical technology. However, Germany is now reaching a point at which, however much sickness association contributions rise each year, resources will have to be limited.

- The sickness funds operate in a limited 'market'. The risk compensation scheme (which balances risk between the different funds), the legally guaranteed benefits catalogue and the collective contracting system (under which all sickness funds contract the same providers under the same conditions) mean that contribution rates are very similar.

- Ownership is a more significant issue in the UK than in Germany. In the UK shareholder value is of great importance and companies are acquired for their assets. In Germany, by contrast, private enterprises operate in a different culture and are constrained by obligations to a range of stakeholders, including trade unions, that their British counterparts do not have to meet.

Control and supply of human resources

Comment

In the past the NHS has tried to control the supply of manpower – with the consequence that, as investment in the NHS increases, lack of qualified staff to provide new services is proving a bottleneck.

Response

- In Germany an individual has a constitutional right to choose their profession, which means that the only limit on the number of medical students is the capacity

of the institutions to train them. Forecasts of future requirements for physicians may not be used to restrict entry to medical school. Neither universities nor the health ministry can require a medical school to accept fewer students than their staff and patient capacity allows.

Patient involvement

Comment

Do patients want to be involved in developing the German health care system?

Response

- Until relatively recently, sickness funds were managed by elected members, who did the job on a part-time basis. Now professional management has been introduced, and elected members are taking a less active role. There is no evident public disquiet at this loss of influence. The government thinks that patient groups should be involved, but there is no obvious public demand for this.

Public health

Comment

What part does public health, a relatively neglected but cost-effective form of health care, play in Germany?

Responses

- Both Germany and the UK have low life expectancy rates in relation to the rest of Europe, which suggests that both countries have a long way to go in improving public health. The major issues in Germany are the failure to tackle smoking and alcohol consumption.

- Historical associations provide one reason for the reluctance of German governments to intervene proactively to improve public health – the Nazi regime was the last government to do this. (For example, health warnings on German cigarette packs come from EU health ministers, not from the German government.)

- Recent public health crises in the UK (e.g. immunisation) demonstrate the public's increasing reluctance to accept government direction on public health.

Conclusion

In her concluding comments, Jennifer Dixon of the King's Fund pointed to some important distinctions between the German and British health care systems.

- The corporate, inclusive nature of the German system is enlightening. A range of stakeholders – including purchasers (i.e. the sickness funds), providers (associations of doctors and hospitals), consumers, regional government, trade unions – are involved in decision-making.
- The British government is trying to remedy the unhealthy nature of the UK's binary system, with its strict purchaser–provider division, by strengthening the powers of the regulators and by decentralising power within the NHS to Primary Care Trusts and, as is now proposed, to Foundation Hospitals. However, it is difficult to be confident that true stakeholder involvement will develop: the powers of local government are restricted, the prospect of regional government is uncertain, and the trade unions are disregarded. The preference of the government seems to be for decentralisation based on a consumer model, with competition being created first on the supply side and subsequently on the demand side.
- Germany, by contrast, is moving towards a mixture of more centralised decision-making, designed to bring about stronger strategic management and to develop the practice of evidence-based health care, and increased competition among purchasers, achieved by greater selectivity in contracting providers. There are likely to be considerable difficulties when these two trends combine.

Research themes

The Anglo-German Foundation has set aside significant funds for future comparative research, binational seminars, workshops etc on the British and German health care systems. There follows an outline list of specific areas, identified in this seminar and in Reinhard Busse's comparative study of the two systems, in which further research and exchanges of experience would yield beneficial results for policy-makers and managers in both countries. Anyone wishing to take these ideas further should contact Keith Dobson, Director of the Foundation.

- A comparison of the different methods of resource allocation in the UK (population-based data) and Germany (individual data on age, sex and future morbidity).

- The organisation of providers of primary care – Primary Care Trusts in the UK and the German physicians' associations – especially the scope and nature of regulations relating to their accountability and governance.

- Hospital planning: how is the need for new hospital facilities, or for the closure of old ones, identified? How far is evidence on changing clinical practice taken into account? And what lessons can be learned from new types of hospital capital financing and operation?

- Hospital care: how do British and German hospitals differ in the latitude they enjoy for decision-making, and what are the implications for the delivery of health care? What is the impact of the different strategies in each country for promoting high-quality care, and how does each country ensure that the distribution of resources supports, rather than impedes, high-quality care?

- What are the implications of the very different relationships between in-patient and ambulatory care in the UK and Germany, and, as boundaries shift in each country, how can they learn from each other?

- The financing, regulation and delivery of social care.

- Detailed data on health care provision for different groups of patients so as to provide information on how typical patient pathways differ and the consequences of such differences.

- The outcomes of health care – seen in terms of both patient satisfaction with the care they have received and the effectiveness of the care, e.g. in terms of mortality or quality of life.