CHAPTER 8

The Public-Private Mix in Health Care: Reflections on the Interplay between Social and Private Insurance in Germany

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As Canadian courts consider *Charter* challenges to restrictions on private finance in health care, they will look to the experiences of other countries to attempt to gage the prospective impact of allowing a greater role for the private sector. In this chapter, we explore the interplay between Germany's public *social health insurance* (SHI) scheme, and its *substitutive private health insurance* (SPHI) scheme. In contrast to the predominantly tax-financed, single-payer system found in Canada, the German health care system is an SHI system.[1] Historically rooted in the Bismarckian welfare state and legally enshrined in *Sozialgesetzbuch V* (*SGB V*; the German social code, vol. 5), the German system—even in its current form, over a hundred years later—is said to represent a prototypical social-insurance

1 The SHI system is characterized by self-regulation of collective actors representing sickness funds and providers. The system is mainly financed by social-insurance contributions and includes a mandate to insure, as well as a definition of contribution rates irrespective of the individual's health risk. Providers of health services are typically private actors contracted by sickness funds. Hence, the dominant actors in the regulation and financing of the health care system are rather societal than state actors, while market actors prevail as providers. See Katharina Böhm et al, "Five Types of OECD Healthcare Systems: Empirical Results of a Deductive Classification" (2013) 113:3 Health Pol'y 258. See also Claus Wendt, Lorraine Frisina & Heinz Rothgang, "Healthcare System Types: A Conceptual Framework for Comparison" (2009) 43:1 Soc Pol'y & Admin 70

system.[2] It covers the overwhelming share of the population through what are currently 109 "sickness funds" (Krankenkassen).[3] Still, despite the predominance of this scheme, Germany stands out among OECD countries in its incorporation of SPHI[4] for around 11 per cent of the population.[5] Indeed, since the convergence of SHI and SPHI in the Netherlands in 2006, Germany is the only OECD country where a substantial share of the population is given the opportunity to opt out of compulsory SHI into the SPHI market.[6] Germany also has a role for "supplementary private insurance," but again its role is different from that called for in the *Cambie* claim, being primarily for the purposes of covering services not covered in the SHI scheme; for example, copayments for dental service.

The German system represents an insurance dualism that collectively achieves near to full coverage of the population. While it may be described as two-tier, a critical insight is that German SPHI is a fundamentally different type of private insurance than the applicants in *Cambie* are pursuing. In the former, it is only available as an option if one is in a high-income bracket or a member of certain professional groups, and, critically, one cannot then rely on the SHI (public) plan at all. Moreover, if one opts out of the SHI scheme (the public scheme), one must then buy SPHI. Both in *Chaoulli* and in *Cambie*, in Canada, the applicants sought/seek a form of private health insurance where everyone maintains public insurance coverage but wherein one may use private health insurance to pay for faster access. Thus Canadian courts, in examining the respective performances of the German and Canadian systems, need to understand the fundamentally different roles private health insurance can serve across different countries, and ensure that any lessons or insights from other countries are carefully calibrated to the Canadian context.

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2 Wendt, *supra* note 1.

3 GKV-Spitzenverband, *Kennzahlen der gesetzlichen Krankenversicherung* (Berlin: GKV-Spitzenverband, 2019).

4 Basic regulations for private insurance can be found in the German *Insurance Contract Act* (VVG).

5 "Der Datenservice der PKV" (2018), online: *PKV-Verband, Verband der privaten Krankenversicherung* www.pkv-zahlenportal.de/werte/2007/2017/12 [*PKV-Verband*].

6 Francesca Colombo & Nicole Tapay, "Private Health Insurance in OECD Countries: The Benefits and Costs for Individuals and Health Systems" (2004) OECD Health Working Papers; Ralf Götze, *Ende der Dualität? Krankenversicherungsreformen in Deutschland und den Niederlanden* (Frankfurt: Campus Verlag, 2016).

We would note at the outset that notwithstanding its success and remarkable longevity, the German version of a two-tiered health care system has not been immune to criticism or reform, especially since 2003, when proposals to merge both systems (into the so-called citizens insurance scheme) first entered the political agenda.[7] Calls for reform have been grounded in a concern for *equity* in financing and access, particularly as regards advantages enjoyed by the privately insured, such as shorter wait times and access to chiefs of staff within hospitals. Moreover, given that SPHI is a funded rather than a pay-as-you-go scheme, low interest rates have led to financial difficulties within the private system that support a case for convergence.[8]

In what follows, we do not specifically address the viability of the citizens' insurance model but do explore the strength of the claims made in its name. We ask what evidence can be found concerning the effects of Germany's mixed system of SHI and SPHI on patients and providers in Germany? We begin by offering an overview of the basic features and organization of both insurance schemes, particularly with a view to the regulatory frameworks surrounding matters of *coverage*, *financing*, and the *provision of services*, including timely access to care. We also address the regulatory incentives in place concerning the remuneration of doctors and the obligation to treat patients. In a final section, we reflect on lessons to be learned from Germany regarding the ongoing interplay between SHI and SPHI, as well as the consequences for equity, quality, and financial sustainability.

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7 Wissenschaftlicher Dienst des Deutschen Bundestags, *Argumente für und gegen eine "Bürgerversicherung"* (Berlin: Deutscher Bundestag, 2018); Jochen Pimpertz, "Bürgerversicherung—kein Heilmittel gegen grundlegende Fehlsteuerungen. Argumente zur Orientierung in einer komplexen Reformdiskussion" (2013), online: *Köln: Institut der deutschen Wirtschaft* <www.iwkoeln.de/studien/iw-policy-papers/beitrag/jochen-pimpertz-buergerversicherung-kein-heilmittel-gegen-grundlegende-fehlsteuerungen-123776.html>; Heinz Rothgang et al, *The State and Healthcare: Comparing OECD Countries* (Basingstoke, UK: Palgrave Macmillan, 2010).

8 Stefan Greß & Markus Lüngen, "Die Einführung einer Bürgerversicherung: Überwindung des ineffizienten Systemwettbewerbs zwischen GKV und PKV" (2017) 71:3 Gesundheits- und Sozialpolitik 68; Hartmut Reiners, "Nebelkerzen und alte Kamellen: Der Streit um die Bürgerversicherung" (2017), online: *Makroskop* <makroskop.eu/2017/12/nebelkerzen-und-alte-kamellen-der-streit-um-die-buergerversicherung/>.

Population Coverage under the Umbrella of Social and Private Insurances

The introduction of the *Health Insurance Act* of 1883 is generally regarded as the birth of the German SHI system, although the law had built upon earlier professional insurance schemes.[9] While in its early years SHI covered only 10 per cent of the population, mainly in the form of sick pay, it expanded gradually in terms of coverage and scope of benefits.[10] The main steps toward expanding coverage were the inclusion of workers in agriculture and forestry (1911), pensioners (1941), farmers (1972), the disabled (1975), students in higher education (1975), and artists (1983).[11] Nowadays, SHI provides coverage for some 87 per cent of the population, including compulsory insurance for all wage earners with incomes up to a ceiling set by the federal government (discussed below) and those claiming unemployment benefits.[12]

Those not covered by the SHI mandate include civil servants[13] and the self-employed, who are the major clients of SPHI. Alongside these two groups, employees with regular wages above €59,400 per year (approximately $89,000 Canadian), as of 2018, can *fully* opt out of SHI and choose to purchase SPHI.[14] It is required that those who

9 Götze, *supra* note 6 at 72.

10 Reinhard Busse et al, "Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition" (2017) 390:10097 The Lancet 882.

11 Jens Alber, "Bundesrepublik Deutschland" in Jens Alber & Brigitte Bernardi-Schenkluhn, eds, *Westeuropäische Gesundheitssysteme im Vergleich* (Frankfurt: Campus, 1992) 31.

12 For details, see s 5 *SGB V*.

13 As defined by the Federal Ministry of the Interior, the term "civil servant" refers to public employees "who stand in a relationship of service and loyalty defined by public law (art 33 (4) GG)," who are "intended to guarantee sound administration based on expertise, professional ability and loyal fulfilment of duties, and ensure that essential tasks are carried out without interruption." See Germany, Federal Ministry of the Interior, *The federal public service. An attractive and modern employer* (Berlin: Federal Ministry of the Interior, 2014) at 34. Civil servants typically take positions involving the exercise of sovereign authority: public administration, police forces, fire brigades, judges, professors, school-teachers, etc., as well as postal and telecommunication services before these were privatized. Alongside civil servants, there are public employees working on the basis of a contract under private law and, therefore, subject to the same regulations as employees in the private sector.

14 "Beitragsbemessungsgrenzen steigen 2018" (2018), online: *Bundesregierung* <www.bundesregierung.de/breg-de/aktuelles/beitragsbemessungsgrenzen-steigen-2018-452362 >.

do opt out must buy private health insurance and, further, that such plans meet minimum coverage conditions, preventing the possibility of under-insurance (what our Australian colleagues in chapter 10 refer to as "junk" policies) among the young and healthy. Thus, SPHI benefits must include reimbursement for outpatient and inpatient services, while copayments and deductibles must be limited to €5,000 per year.[15] Although all German citizens must now purchase either SHI or SPHI, applications for SPHI contracts can be declined (in which case the person must enroll under the SHI plan). Pre-existing conditions can be excluded, and risk-rating based on health status and age are allowed.[16] It is worth noting that the birth of German SPHI is generally dated to 1924, when the number of health insurance policies started to soar.[17] At this time, hyperinflation following the First World War had consumed the savings of the middle class, rendering out-of-pocket payments for health services unfeasible, making private health insurance an attractive option for large parts of the population excluded from the then-modest SHI scheme. Another milestone in the history of private health insurance in Germany was the introduction of the aforementioned upper-income threshold, at which employees no longer qualified for SHI. The income ceiling, however, now refers to an *option* to leave social insurance, rather than an obligation. This has been the subject of enormous political contest between the Christian Democrats and the Free Democratic Party on the one side and the Social Democratic Party on the other, as well as by the different health insurance lobby groups. Switching between SHI and SPHI has become increasingly difficult over time. Most

15 Klaus Jacobs, "Wettbewerb im dualen Krankenversicherungssystem in Deutschland. Fiktion und Realität" in Klaus Jacobs & Sabine Schulze, eds, *Die Krankenversicherung der Zukunft* (Berlin: KomPart Verlag, 2013) 47.

16 There are two exceptions to this rule. First, applications for newborn (or adopted) children of people already within SPHI plans must be accepted without individual risk adjustment of premiums. Second, since 2009, SPHI companies are obliged to provide a common basic tariff for all residents who are exempt from SHI and who had no private insurance contract by the end of 2008. Those with private insurance contracts before 2009 were allowed to opt into the basic tariff by the end of June 2009. Since then, it can only be taken up at age fifty-five or older, or, as a recipient of welfare benefits.

17 David Klingenberger, *Die Friedensgrenze zwischen gesetzlicher und privater Krankenversicherung: ökonomische und metaökonomische Kriterien einer optimierten Aufgabenabgrenzung zwischen Sozial- und Individualversicherung* (Regensburg: Transfer-Verlag, 2001) at 34.

significantly, since the *Statutory Health Insurance Reform Act* of 2000, those aged fifty-five and older have virtually no ability to switch back to the statutory SHI scheme;[18] this is to prevent free-riding upon the social scheme once one's health deteriorates in old age. Hence, choosing SPHI in Germany can be a decision for life.[19]

Table 8.1. Health care coverage in Germany

	Million	Percentage
Total population	82.8	100
Statutory health insurance (SHI)	72.3	87.3
Compulsory insurance	49.9	60.3
Voluntary insurance	6.0	7.3
Co-insured dependents (compulsory and voluntary)	16.3	19.7
Substitutive private health insurance (SPHI)	8.8	10.9
Supplementary private insurance	19.5	23.7

Source: Data on Federal Ministry of Health: KM 6-Statistik, online: *Gesundheitsberichterstattung des Bundes* <www.gbe-bund.de/>; number of private insurees extracted from *PKV-Verband, supra* note 5. Total population to calculate the percentages is based on the German census. See "Schätzung für 2018: Bevölkerungszahl auf 83,0 Millionen gestiegen" (2018), online: *Statistisches Bundesamt* <www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Bevoelkerung/Bevoelkerungsstand/_inhalt.html>.

As one can see from table 8.1, most people are covered by SHI, compulsorily (about 60 per cent of the population), as voluntary members (7.3 per cent), or co-insured dependents (about 20 per cent). Nearly 11 per cent of the population are covered by SPHI as the primary scheme.[20] As of 2017, about half of all persons with SPHI are active or retired civil servants who qualify for state grants, covering

18 Reinhard Busse & Miriam Blümel "Germany: Health System Review" (2014) 16:2 Health Systems in Transition 138.

19 Jacobs, *supra* note 15.

20 As opposed to other health care systems featuring a strong role for private insurance as the primary scheme (e.g., the United States), employer-based group insurance has no part. Those with SPHI choose individual health plans with a defined scope of benefits. The employer only supports the insured by paying a share of the premium. The latter is limited to the maximum employer's share payable to SHI contributions. By contrast, there are employer-based health-insurance funds within the SHI system. They follow the same rules as other SHI funds. Access to those funds may be restricted to the employees of the company running the fund. Moreover, employers are involved in the self-regulatory committees of SHI, where they aim to control cost increases.

50 per cent (70 per cent for the retired) of health care costs, including costs for dependents (70–80 per cent).[21] Those without a state grant (some 4.4 million private insurees) mainly include the self-employed and salaried employees who have opted out of SHI.

As it is neither a unique nor central feature of the German two-tiered system, *supplementary* private insurance is not the focus of the present study. However, it may be worth noting that more than a fifth of the population—that is, nearly 27 per cent of SHI beneficiaries—have purchased supplementary insurance. The lion's share of insurance policies is aimed at additional dental-care benefits, but supplemental plans also exist for select outpatient and inpatient services not included in SHI. These typically refer to added amenities (e.g., private versus shared hospital rooms), as opposed to quicker access to care. In theory, the combination of SHI-reimbursement tariffs[22] and supplementary private insurance can be used to jump queues and access higher-quality GP and specialist care. However, this approach is rarely taken.[23] People with an income to purchase such health plans instead opt out of SHI and into SPHI.

Financing across the Two Tiers

In 2017, the OECD estimated total current spending on health at nearly €368 billion and approximately 11.3 per cent of GDP, which is comparable to other high-spending nations such as France (11.5 per cent) and Switzerland (12.3 per cent), though considerably less than the United States (17.2 per cent). At the same time, Canada spent only 10.4 per cent of GDP on health, according to OECD figures. Health care in Germany is mainly financed by social insurance (70.3 per cent), that is, SHI, and, to a minor extent, social long-term care, pension, and accident insurance. SHI contribution rates are determined by the government and currently amount to 14.6 per cent of earned

21 *PKV-Verband, supra* note 5.

22 Reimbursement tariffs (s 13 *SGB V* and s 53 at para 4 *SGB V*) deviate from benefits in kind usually provided by SHI. Patients are charged according to the medical fee schedule similar to patients with SPHI. Their statutory sickness fund will reimburse the costs at the level spent for benefits in-kind minus a lump sum for extra administration costs and minus any rebates negotiated between the SHI fund and providers. Those with SHI who choose the reimbursement option can contract supplementary insurance to cover the extra costs.

23 Stefan Greß et al, "Kostenerstattung in der Gesetzlichen Krankenversicherung" (2011) Hochschule Fulda Working Paper No 01.

income up to an annual income ceiling of €53,100, divided equally between employees and employers. Private insurance financing amounted to 8.8 per cent of health expenditure, including SPHI and supplementary health insurance. Further, German households contributed 12.4 per cent of total health expenditure as out-of-pocket (OOP) spending, somewhat less than OOP spending in Canada (14.8 per cent).[24]

An important aspect not captured by OECD financing statistics on Germany is the role played by transfers from federal tax revenues to statutory health and pension funds—a topic which Fiona McDonald and Stephen Duckett also explore in their analysis of the Australian system in chapter 10. In Germany, the federal government subsidizes SHI funds to compensate for expenditures on areas perceived as more of a societal responsibility, such as the free co-insurance of children. Subsidies to the SHI health care fund (€14 billion) and statutory pension insurance (about €737 million) added up to around 4.2 per cent of total spending on health care in 2016.[25] Moreover, contributions to SHI, as well as the core part of SPHI premiums, are exempt from income taxes. By contrast, payments for supplementary insurance, sick pay, and SPHI for services falling outside the scope of social-insurance benefits are not tax deductible.[26] Further, there are tax reductions for providers of health care services. Public inpatient health care and nursing facilities are exempt from local business tax. For private facilities, tax exemptions kick in if they provide at least 40 per cent of their services for SHI schemes. Curative treatments and health care provided in hospitals accredited by federal states are also exempt from value-added tax.

Private health insurance premiums are regulated and may be risk-adjusted according to the age of the applicant, the design of the

24 All figures extracted from "OECD Health Statistics 2018" (2019), online: *OECD* <stats.oecd.org/> [OECD]. Figures refer to 2017 or the latest available year.

25 "Current Health Expenditure in millions of Euro (year, provider, function, financing agent)" (2018), online: *Gesundheitsberichterstattung des Bundes* <www.gbe-bund.de/>; "Einnahmen und Ausgaben der gesetzlichen Rentenversicherung (Geschäfts- und Rechnungsergebnisse der gesetzlichen Rentenversicherung)" (2018), online: *Gesundheitsberichterstattung des Bundes* <www.gbe-bund.de/>.

26 Theresa Grün, "Die Absetzbarkeit von Vorsorgeaufwendungen nach dem Bürgerentlastungsgesetz Krankenversicherung" (2009) Deutsches Steuerrecht 1457.

benefit package (range of services, deductibles), and health status at the point of underwriting. Due to a European Court of Justice decision,[27] gender differences may not influence premium calculation.[28] In contrast to SHI, family members are not automatically included under SPHI and must negotiate separate contracts of insurance. Employees holding SPHI[29] can claim a grant from their employer of 50 per cent of the premium but this cannot exceed the highest contribution paid for SHI.

The SPHI sector is also regulated to prevent the offering of low initial premiums to lure subscribers in, only to see rapid increases subsequently, or to prevent insurers from pricing subscribers out of the market as they age. Premiums for new entrants may not differ from premiums for those already insured if both share equal conditions, and SPHI must accrue reserves to cushion premium increases in old age.

Provision of Care and Definition of Benefits

Inpatient and Outpatient Providers

Among OECD countries, the German health care system stands out for its quantity of hospital beds per capita. By way of comparison, curative acute-care beds in Germany amounted to 6.1 per 1,000 of population in 2016, whereas the OECD average was nearly 40 per cent lower, at 3.7 beds per 1,000 people,[30] and by the same measure in Canada the average was only 2.0 beds. Nearly half of all beds are public, while a third are owned by charitable organizations, and about 18 per cent are owned by private for-profit companies, having grown from only 4 per cent in the early 1990s.[31] The advisory council of the health care system estimates that 95 per cent of the population can reach a hospital by car within twenty minutes.[32] Similarly,

27 01.03.2011—case C-236/09

28 Helge Sodan & Jörg Adam, *Handbuch des Krankenversicherungsrechts* (München: Beck, 2014).

29 Civil servants cannot claim support for premiums since they already receive state grants to meet at least half of their health costs.

30 OECD, *supra* note 24.

31 "Krankenhausstatistik. Grunddaten der Krankenhäuser und Vorsorge- oder Rehabilitationseinrichtungen" (2018), online: *Statistisches Bundesamt* <www.destatis.de/DE/Themen/Gesellschaft-Umwelt/Gesundheit/Krankenhaeuser/_inhalt.html> [*Statistisches Bundesamt*].

32 Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen SVR Gesundheit, *Gutachten 2014 des Sachverständigenrates zur Begutachtung der*

Germany maintains 4.2 practicing physicians per 1,000 of population, outnumbered only by Austria (5.1), Lithuania (4.5), Norway (4.5), and Switzerland (4.3), while being considerably higher than those in Canada (2.6), the United States (2.6), and the United Kingdom (2.8). Approximately 78 per cent of practicing physicians are specialists, somewhat above the OECD average (68.8 per cent), as specialists are not only concentrated in hospitals but are often situated in outpatient practices. Contrary to physician density, the number of practicing nurses is low by international standards. The OECD counts only 3.25 nurses per 1,000 of population for Germany, whereas the OECD average is 8.9, almost three times higher.[33]

Irrespective of ownership structure, most hospitals offer services to patients insured in the SHI and SPHI alike. In 2016, only 343 of 1,607 German hospitals[34] exclusively served SPHI patients or those paying out of pocket, and these tend to be small hospitals, representing only 2 per cent of beds.[35] With respect to the outpatient sector, the German Medical Association registered around 154,400 practicing physicians (i.e., about 1.8 per 1,000 of population) in 2017.[36] Only about 7,000 physicians (4.6 per cent) opt to provide services exclusively to private patients, underscoring the predominance of SHI over SPHI. With nearly 90 per cent of the population covered by SHI, physicians would be remiss to ignore this market. This said, SHI physicians are free to offer services to SPHI patients.

In terms of what providers are obliged to offer SHI versus SPHI patients, different benefit rules apply. While the scope of health care benefits for SHI is listed in *SGB V*, detailed benefits are regularly negotiated in light of medical-technological progress. By contrast, SPHI benefits packages are defined by private insurance companies that are then chosen by insurees within regulations set by law.

Entwicklung im Gesundheitswesen: Bedarfsgerechte Versorgung. Perspektiven für ländliche Regionen und ausgewählte Leistungsbereiche (Berlin: Deutscher Bundestag, 2014) [*SVR Gesundheit*].

33 *Ibid.*

34 Note that this does not include psychiatric clinics.

35 *Statistisches Bundesamt, supra* note 31.

36 "Montgomery: Es ist höchste Zeit, den Ärztemangel ernsthaft zu bekämpfen Bundesärztekammer" (2018), online: *Bundesaerztekammer* <www.bundesaerztekammer.de/ueber-uns/aerztestatistik/aerztestatistik-2017/>.

Definition of SHI Benefit Package

In contrast to the protections of the *Canada Health Act*,[37] which is limited to hospital and physician services, German SHI benefits include prevention and health-screening measures, outpatient health care, some dental care, dental prostheses, pharmaceuticals, physiotherapy rehabilitation, orthopedic and prosthetic devices, hospital care, and rehabilitative care. According to section 12 of *SGB V*, benefits must be adequate, appropriate, and cost-effective. The details are regulated by the Federal Joint Committee,[38] Germany's highest decision-making body in health care issues, which may decide to exclude services from the basket of services insured by SHI if they fail to satisfy metrics for clinical effectiveness, medical necessity, cost-effectiveness, or pharmaceuticals if they are inexpedient or if more cost-effective alternatives exist.[39]

Each sickness fund can augment the benefit catalogue for its members. The general categories of benefits which may be expanded are defined in *SGB V*. They include preventive and rehabilitative care, care by midwives, in vitro fertilization, dental services (excluding dental prostheses), non-prescription drugs, remedies, home care, home help for the ill, and services by non-medical or alternative-care practitioners (sec. 11 at para 6, *SGB V*). Variations in the benefit catalogue are often designed to attract groups with low health risks, yet, thus far, discretionary benefits remain marginal. Expenditures related to the augmentation of SHI core plans amount to only €337.8 million, compared to total expenditures of €202 billion.[40]

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37 *Canada Health Act*, RSC 1985, c C-6.

38 The committee, known as the G-BA (Gemeinsamer Bundesausschuss), consists of thirteen members entitled to vote: an impartial chair and two impartial representatives proposed by the federal health ministry. Five members represent the sickness funds appointed by the National Association of Statutory Health Insurance Funds (GKV-Spitzenverband). Five members represent provider interests: the federal associations of SHI physicians (2), dentists (1), and the German Hospital Association (2). Further, accredited patient organizations and, depending on the topics under review, other stakeholders join the committee as advisors.

39 Katharina Böhm & Claudia Landwehr, "Strategic Institutional Design: Two Case Studies of Non-Majoritarian Agencies in Health Care Priority-Setting" (2015) 51:4 Gov & Opposition 632 at 650.

40 Bundesministerium für Gesundheit, *Gesetzliche Krankenversicherung* (Berlin: Bundesministerium für Gesundheit, 2016).

Definition of Benefits in SPHI

In 2009, concurrent with the introduction of a mandate to insure for all citizens (either SHI or SPHI), the *Insurance Contract Act* began to set a floor for the content of SPHI contracts. The benefit package must include reimbursement for comprehensive outpatient and inpatient health care, while copayments and deductibles are limited to maximum of €5,000 per year.[41] Beyond these regulations, benefits provided by SPHI insurance are a matter of individual contracts between the insurance company and the insured and, generally speaking, SPHI tends to be more comprehensive and provides remuneration at a more generous level than in the SHI scheme.

Regulating Providers of Health Care

Regulation in the German health care system is characterized by complex structures, but the main governing instruments are collective agreements between the sickness funds and provider associations, which govern the organization of health care delivery and the remuneration of providers. Concerning hospital services, collective agreements also include the Association of Private Health Insurers. Further, the German Medical Association (which all physicians must join) and the Associations of Statutory Health Insurance Physicians and Dentists have a mandate to improve professional education, guarantee professional ethics, and supervise professional practice.

In what follows, we describe the conditions set within this regulatory landscape for the main providers of health care services; namely, outpatient and inpatient physicians. We focus especially on the differences in provider remuneration between the two insurance tiers, as well as the regulatory incentives in place for private practice and the limits on private billing.

Remuneration and Regulatory Incentives in the Outpatient Sector

Physicians in the outpatient sector are usually self-employed. About 95 per cent own a license issued by the regional association of SHI physicians and offer services under a collective contract funded by SHI. At the same time, they deliver health care for close to 11 per cent of the population that are privately insured. As in Canada, physicians are free to offer services not included in the benefit package of the

41 Jacobs, *supra* note 15 at 50.

SHI and financed OOP or through supplementary private insurance. Hence, public and private domains are not separated on the delivery side. As mentioned earlier, about 5 per cent of physicians are not part of SHI and work on a private basis only. The remuneration of outpatient practice under SPHI differs substantially from SHI rules. Private billing is based on the medical-fee schedule decreed by the government as a result of negotiations between the German Medical Association and SPHI carriers. A similar fee schedule is in place for dental services. Physicians can bill up to 3.5 times the base rate of services depending on their time and effort, for which SPHI guarantees coverage. Around 85 per cent of physician services are billed by a factor of 2.3 times the base rates.[42] Since the schedule is outdated, physicians can create their own fees for new and innovative treatments not addressed in the fee schedule. The SPHI funds will reimburse all medically required physician services without any volume limits. By contrast, remuneration within SHI involves a combination of flat rates and fee-for-service remuneration based on a Uniform Value Scale up to a maximum volume.[43] A series of studies have found that remuneration for similar services in the outpatient sector paid by SPHI is, on average, 2.25 to 3.9 times higher than SHI payments.[44]

Special rules apply to the social tariffs that SPHI carriers are required to offer for the elderly who can no longer afford their health plan (standard tariff) and SPHI insured who become dependent on welfare benefits (basic tariff; see n16 above), and for those patients,

42 Frank Niehaus, *Ein Vergleich der ärztlichen Vergütung nach GOÄ und EBM* (2009) Wissenschaftliches Institut der PKV Discussion Paper No 7 at 16.

43 The remuneration of outpatient physicians for SHI services is a complex multilevel procedure. First, based on earlier expenditures the federal representatives of SHI funds and SHI physicians negotiate orientation values for prices and morbidity-oriented volumes, which are, in a second step, translated into regional prices and volumes by the regional bodies of the negotiation partners. The associations of SHI physicians are responsible for allocating the volumes to the different groups of physicians. About 70 per cent of outpatient physician services are remunerated according to this procedure and subject to volume limits. Physician services beyond these limits will be remunerated with a reduced price or not paid at all. The remaining 30 per cent of services (e.g., outpatient surgery, vaccination, prevention, or specific cancer treatment) are remunerated according to the negotiated prices without limits. See Busse & Blümel, *supra* note 18 at 268.

44 Niehaus, *supra* note 42 at 30.

physicians are not permitted to bill more than 1.8 times (standard tariff) and 1.2 times (basic tariff) the base rate. Reduced rates also apply for technical services and laboratory work.[45]

In 2015, the average physician practice received 70.4 per cent of total revenue from SHI and 26.3 per cent from private practice.[46] Private sources included private insurance (mainly SPHI, while supplementary insurance is only a relevant source for dental service), as well as OOP spending by SHI patients for extra services. Revenue from private practice increased by 4.1 per cent between 2003 and 2015.[47] Revenue from private practice also varies by specialty. The average general practice earns only 17.5 per cent through private billing, while the average private share for specialist practice such as radiology or orthopedics can increase to around 45 per cent. The income of dentists is composed almost evenly of SHI and private sources, reflecting the stronger role of cost sharing in this sector.[48] Data also show that the higher the revenue per practice, the more the income derives from private practice.[49]

Since the different remuneration schemes generate incentives that favour private billing by physicians, regulations are necessary to protect SHI patients. Among the responsibilities of SHI physicians, for example, is an obligation to be present for consultation at least twenty hours per week. The regional associations of SHI physicians (known as Kassenärztliche Vereinigungen, or KVs) have a mandate to guarantee state of the art, timely outpatient care. In agreement with the associations of sickness funds, KVs are responsible for needs- and demand-based planning according to the decrees of the Federal Joint Committee. Benchmarks for physician density are set for each district, and specific groups of physicians qualified by types of regions. In the case of oversupply, licenses for the respective district are restricted. Responses to undersupply mainly include

45 PKV-Verband, Sozialtarife in der PKV (Köln: PKV-Verband, 2009).

46 "Unternehmen und Arbeitsstätten. Kostenstruktur bei Arzt- und Zahnarztpraxen sowie Praxen von psychologischen Psychotherapeuten" (2015), online: *Statistisches Bundesamt* <www.destatis.de/DE/Themen/Branchen-Unternehmen/Dienstleistungen/Publikationen/Downloads-Dienstleistungen-Kostenstruktur/kostenstruktur-aerzte-2020161159004.pdf?__blob=publicationFile&v=3> at 13.

47 *Ibid* at 15.

48 *Ibid* at 16.

49 *Ibid* at 32.

economic incentives, such as subsidies or loans, for taking over an existing practice or investment costs.[50] A new decree for needs- and demand-based planning initiated with the *Statutory Health Insurance Care Structures Act* of 2012 allows for the adjustment of benchmarks in response to regional demographic and morbidity characteristics.[51] The associations of SHI physicians and dentists are also responsible for guaranteeing service provision for those in SPHI who are entitled to pay basic or standard tariffs (i.e., the elderly or welfare recipients who cannot switch to SHI).

Of crucial importance in the protection of those within the SHI scheme is the prohibition of extra-billing for SHI services, as defined in the collective agreement between SHI doctors and the sickness funds.[52] By the same token, it is unlawful to bill SHI patients for shorter waiting times. There are, however, media reports about such practices, and consumer-protection advocates criticize weak control mechanisms by KVs.[53] Although there are specific regulations preventing SHI physicians from pushing patients to private care when they are entitled to care under the SHI scheme,[54] examples of abuse can be found. One reported example, found in the 20 March 2014, issue of a physicians' journal, involved an eye specialist who offered swift access to private consultation for SHI patients, instead of regular waiting times of several months.[55] Professional sanctions include a reprimand, fines, or the temporal/permanent revocation of the license to treat SHI patients.

If the KV fails to guarantee service provision for SHI, the responsibility falls on sickness funds, who are then allowed to contract physicians selectively, authorize hospital doctors to provide outpatient practice, or obligate physicians to serve SHI. As an

50 Michael Simon, *Das Gesundheitssystem in Deutschland. Eine Einführung in Struktur und Funktionsweise* (Bern: Hans Huber, 2010) at 196.

51 *SVR Gesundheit*, *supra* note 32 at 444.

52 "Bundesmantelvertrag—Ärzte" (2019), online: *Kassenärztliche Bundesvereinigung* <www.kbv.de/media/sp/BMV_Aerzte.pdf>.

53 Anette Dowideit & Anja Ettel, "So kaufen sich Kassenpatienten einen Privat-Termin" (2016), online: *Die Welt* <www.welt.de/152760917>.

54 The respective rules can be found in s 128 paragraph 5a *SGB V* and s 18 paragraph 8 of the collective agreement BMV-Ä.

55 Ärzte Zeitung, "Disziplinarverfahren gegen Cottbuser Ärztin" (2014), online: Ärzte Zeitung <www.aerztezeitung.de/praxis_wirtschaft/vertragsarztrecht/article/857363/verdachtsfall-termin-geld-disziplinarverfahren-cottbuser-aerztin.html>.

example, some dentists refused to treat SHI patients and cancelled their SHI license to protest against the *Statutory Health Insurance Modernization Act* of 2004.[56] The dentists who participated in the collective action were banned for six years and could not participate in the SHI system. The *Social Court* of Stuttgart of First Instance confirmed disciplinary measures by the regional KV in response to the striking SHI physicians[57] but granted permission for a direct appeal at the Federal Constitutional Court, where the issue is still under review.[58]

Remuneration and Regulatory Incentives in the Inpatient Sector

The core regulatory framework for the provision of hospital care can be found in the *Hospital Financing Act*. The federal states are responsible for guaranteeing needs-based health care delivery in hospitals. This translates to a key role in the infrastructural development and accreditation of hospitals. The federal states bear the investment costs of accredited hospitals while operating costs are financed by patients and their insurance. At the same time, accredited hospitals have a mandate to provide specific, pre-defined services, as well as a license to provide services for members of SHI. The sickness funds, however, are responsible for contracting with hospitals directly and negotiating individual budgets.[59] Hospital plans are mostly developed according to current use, while the estimation of future needs based around general demographic developments rather than detailed medical needs.[60]

Running costs for hospital services are mainly financed in line with a diagnosis-related groups (DRG) system, that is, fixed prices for defined groups of diagnoses, which share similar expected costs.[61] Hospitals receive additional funding for patients whose medical condition force much longer stays than to be expected from their diagnosis. They receive less for discharging patients too early,

56 See BSG, Federal Social Court decision, 17.06.2009: B 6 KA 16/08 R, online: <https://openjur.de/u/169475.html>.

57 Social Court Stuttgart AZ.: S 4 KA 3147/13

58 Ärzte Zeitung, "Streikrecht für Vertragsärzte: Karlsruhe ist jetzt am Zug" (2017), online: Ärzte Zeitung <www.aerztezeitung.de/politik_gesellschaft/berufspolitik/article/942007/streikrecht-vertragsaerzte-karlsruhe-jetzt-zug.html>.

59 Simon, *supra* note 50 at 262.

60 *SVR Gesundheit*, *supra* note 32.

61 Simon, *supra* note 50.

thereby causing medical problems. Moreover, there are extra funds for innovative treatments and several activities not adequately covered through the DRG system.[62] In terms of two-tier care, at this stage there is no difference between SHI and private insurance. However, hospitals can generate additional revenue through providing amenities such as private rooms and other related amenities. Moreover, private patients can choose treatment by more experienced doctors and selected specialists—generally, chief-of-staff physicians entitled to issue a private invoice. Such services are billed according to the medical-fee schedule discussed earlier. Here, physicians and hospitals profit from private patients, and this can motivate preferential treatment of the privately insured.[63]

Generally, and in contrast to Canada, hospital doctors are primarily salaried employees. However, in recent years, hospitals have increasingly made use of independent physicians who are contracted to provide fee-based services.[64] Meanwhile, chiefs of staff have a standard salary, which they can augment by treating private patients on a fee-for-service basis. Recently defined standard contracts issued and recommended by the German Hospital Association place new emphasis on activity-based wage-components rather than the right to bill patients.[65] Still, the mode of remunerating chief-of-staff physicians tends to incentivize the treatment of privately insured patients.[66]

Effects of German Two-Tiered System on Patient Access to Services

Generally, the German health care system scores well in terms of access to family doctors and specialists, and is considered "one of

62 *Ibid* at 298; "Zu- und Abschläge" (2016), online: *GKV-Spitzenverband* <www.gkv-spitzenverband.de/krankenversicherung/krankenhaeuser/krankenhaeuser_abrechnung/zu_abschlaege/zu_abschlaege.jsp>.

63 Christoph Schwierz et al, "Discrimination in waiting times by insurance type and financial soundness of German acute care hospitals" (2011) 12:5 Eur J of Health Economics 405.

64 Kassenärztliche Bundesvereinigung & Bundesärztekammer, *Honorarärztliche Tätigkeit in Deutschland* (Berlin: Kassenärztliche Bundesvereinigung und Bundesärztekammer, 2011).

65 Kienbaum, *Vergütungsreport: Ärzte, Führungskräfte und Spezialisten in Krankenhäusern* (Köln: Kienbaum, 2016).

66 Busse & Blümel, *supra* note 18.

the consumer-friendliest health systems in Europe."[67] Reibling[68] classifies Germany as having a health care system with a very high provider density, with few constraints on patient access to providers. Neither cost sharing nor gate-keeping instruments establish access restrictions. In what follows, we first examine the role of financial barriers, as well as the timeliness and quality of care specific to the two-tiers. We then proceed, in a final section, to reflect on the fairness and the sustainability of the German health care system in light of its effects on providers and patients, as well as with a view to future challenges. We conclude by offering some tentative lessons to be learned from the German case for other health care systems.

Financial Barriers

Copayments in SHI make up for only a small share of OOP spending. They mainly arise in the case of prescribed pharmaceuticals for which the patient pays 10 per cent of the price, but a minimum of €5 and maximum of €10 per prescription. Drugs for which the sickness fund of the insured has negotiated rebates are free of charge. For hospital stays, preventive spa, or rehabilitative inpatient care, patients are charged €10 per day for up to twenty-eight days per year. Inpatient stay for childbirth is free of charge. Total SHI copayments may not exceed 2 per cent of income or 1 per cent of income for people with chronic disease.

OOP spending amounted to €43.5 billion in 2016, and expenditures on over-the-counter remedies accounted for 37.2 per cent of that, since non-prescription drugs have been broadly excluded from the SHI benefit package since 2004. Medical services of physicians and dentists accounted for roughly another third of OOP spending (32.5 per cent), and mainly refer to services not included in the SHI benefit package. Only a minor share of OOP spending (3.4 per cent) was spent in hospitals.[69] Surveys by the Commonwealth Fund show that relatively few people had problems accessing health care due to financial barriers in Germany. Combining different indicators of cost-related access problems, Germany was ranked fourth among

67 *Ibid* at 266.

68 Nadine Reibling, "Healthcare systems in Europe: towards an incorporation of patient access" (2010) 20:1 J Eur Social Pol'y 5.

69 "Co-payments of private households in the Statutory Health Insurance" (2018), online Gesundheitsberichterstattung des Bundes <www.gbe-bund.de>.

eleven high-spending OECD countries in terms of easy access.[70] Still, the study finds that between 7 per cent and 21 per cent of survey respondents encountered problems with paying medical bills. There is no information about the insurance status of these people. Cost sharing in private insurance is defined by the individual contract and may vary within the limits of the insurance contract act, that is, the maximum deductible of €5,000 per year. The insurance contracts of civil servants are generally designed without any deductibles since the plans only insure the part of the health costs not covered by the government allowance for civil servants.[71] The German SOEP household survey shows that deductibles tend to increase with age.[72] Since premiums increase in old age, SPHI-insurees often choose higher deductibles in exchange for reduced monthly premiums. While private insurance is generally regarded as advantageous, it also causes problems for a growing share of the insured; namely, the self-employed and civil servants with low incomes, dependents of civil servants who lose entitlements for public subsidies after family breakup, and the elderly.[73] These groups have problems bearing the costs incurred due to premium increases, and have to accept higher deductibles or reduced benefits.

Timeliness and Quality of Care

Perhaps due to one of the largest hospital capacities in the OECD world, and also given a high number of practicing physicians, waiting periods for treatment are short and, therefore, are not high on the German political agenda.[74] Concerning the timeliness of care, Germany was also placed fourth among eleven nations by

70 Karen Davis et al, *Mirror, Mirror on the Wall. How the Performance of the US Health Care System Compares Internationally* (UK: The Commonwealth Fund, 2014).

71 Stefan Greß & Stefanie Heinemann, "Schwachstellen im Geschäftsmodell der privaten Krankenversicherung" in Klaus Jacobs & Sabine Schulze, eds, *Die Krankenversicherung der Zukunft* (Berlin: KomPart Verlag, 2013) 107.

72 The German SOEP (Socio-Economic Panel) household-survey results of 2001 pointed to average annual deductibles of €400 for the privately insured aged forty or younger, and €850 annually for those sixty years and over. More recent data on OOP spending related to deductibles for the privately insured is not available. See Markus Grabka, "Prämien in der PKV: deutlich stärkerer Anstieg als in der gesetzlichen Krankenversicherung" (2006) 73:46 Wochenbericht des DIW Berlin 653.

73 Jacobs, *supra* note 15 at 56.

74 Busse & Blümel, *supra* note 18 at 267.

the Commonwealth Fund. Thus, 72 per cent of respondents waited less than four weeks to see a specialist, and only 10 per cent had to wait longer than two months.[75] There is, however, some evidence of preferential treatment for patients with private insurance, which at times motivates reform discussions and media attention. Privately insured patients report fewer problems with wait times.[76] According to Busse and Blümel,[77] there are shorter wait times and more consultation time given to those covered by SPHI. The difference in wait times ranges between an average of about two to three days to twenty-three days, and refer mainly to specialist appointments, not GP care.[78] Schwierz et al and Sauerland et al have tested hospitals to ascertain the effect of insurance status on waiting times.[79] One in three[80] or four[81] hospitals, respectively, actively asked for the insurance status of the test patient before offering a wait time for a disease category that was not an emergency but required early treatment. PHI holders had significantly shorter waiting times. In particular, hospitals with a superior financial performance (and probably with higher utilization rates) tended to engage more in this kind of discriminatory practice.[82] However, the magnitude of effects found was unlikely to bear detrimental consequences for the health of SHI patients. On average, longer waits of 2.5 days[83] and 1.6 days[84] were estimated. A study by the Bertelsmann Foundation, with 5,618 respondents, identified shorter wait times in primary care for patients covered by SPHI. The difference in average wait

75 Cathy Schoen et al, "Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries" (2013) 32:12 Health Affairs 2205.

76 Klaus Zok, "GPV/PKV im Vergleich—die Wahrnehmung der Versicherten" in Klaus Jacobs & Sabine Schulze, eds, *Die Krankenversicherung der Zukunft* (Berlin: KomPart Verlag, 2013) 15.

77 Busse & Blümel, *supra* note 18 at 269.

78 *Ibid.*

79 Schwierz, *supra* note 63; Dirk Sauerland, Björn A Kuchinke & Ansgar Wübker, "Warten gesetzlich Versicherte länger? Zum Einfluss des Versichertenstatus auf den Zugang zu medizinischen Leistungen im stationären Sektor" (2009) 14:2 Gesundheitsökonomie und Qualitätsmanagement 86.

80 Schwierz, *supra* note 63;

81 Sauerland, Kuchinke & Ansgar, *supra* note 79.

82 Schwierz, *supra* note 63 at 413.

83 *Ibid.*

84 Sauerland, Kuchinke & Ansgar, *supra* note 79.

time was 3.3 days, compared to 4.0 days for those with SHI. Higher risks for excessive wait times, defined as ten days or more, were found for the elderly, as well as for those living in the eastern part of Germany.[85] These were attributed to a higher disease burden and larger areas with lower physician density in the east.[86]

As concerns other differences in access between the two tiers, it bears noting that physicians tend to prescribe fewer generics in favour of more patented and higher-priced pharmaceuticals for the privately insured.[87] Whether these differences actually contribute to health outcomes is not easy to measure. The risk profile of the privately insured differs from those within SHI. Members of SPHI are, on average, healthier, younger, and have higher socio-economic backgrounds.[88] A recent study indicates that superior health status among the SPHI population does not only result from a selection effect but is also related to access to better health services than those covered by SHI.[89] This said, there is also evidence for oversupply in SPHI.[90] That is, those covered by SPHI have more physician visits after first contact, indicating supplier-induced demand,[91] and they more frequently undergo unnecessary examinations.[92]

While Germany has high physician density on average, some problems arise due to regional disparities. The higher share of

85 Andres L Ramos, Falk Hoffmann & Ove Spreckelsen, "Waiting times in primary care depending on insurance scheme in Germany" (2018) 18:191 BMC Health Serv Res 18.

86 *Ibid.*

87 Dieter Ziegenhagen et al, "Arzneimittelversorgung von PKV-Versicherten im Vergleich zur GKV" (2004) 9:2 Gesundheitsökonomie und Qualitätsmanagement 108.

88 Dietmar Haun, "Quo vadis, GKV und PKV? Entwicklung der Erwerbs- und Einkommensstrukturen von Versicherten im dualen System" in Klaus Jacobs & Sabine Schulze, eds, *Die Krankenversicherung der Zukunft* (Berlin: KomPart Verlag, 2013) 75; Peter Kriwy & Andreas Mielck, "Versicherte in der Gesetzlichen Krankenversicherung (GKV) und der privaten Krankenversicherung (PKV): Unterschiede in Morbidität und Gesundheitsverhalten" (2006) 68:5 Das Gesundheitswesen 281.

89 Johannes Stauder & Tom Kossow, "Selektion oder bessere Leistungen. Warum sind Privatversicherte gesünder als gesetzlich Versicherte" (2016) 79:3 Das Gesundheitswesen.

90 Jacobs, *supra* note 15.

91 Hendrik Jürges, "Health Insurance Status and Physician Behavior in Germany" (2009) 129:2 Schmollers Jahrbuch 297.

92 Zok, *supra* note 76 at 23.

private patients in wealthy regions contributes to regional disparities.[93] Statistically, a 1 per cent higher share of SPHI coverage means three SHI physicians more per 100,000 of population. The correlation is stronger for specialists.[94] The concentration of physicians in wealthy urban regions and shortages found in rural areas can also be explained by the general attractiveness of the local labour market and cultural options. However, Vogt's[95] analysis of the regional variation of office-based physicians shows that 14 per cent of the variation in GP density, and between 2 per cent and 6 per cent of specialist density, can be explained by the share of the population with SPHI, when alternative motives are controlled for. Thus, the insurance dualism intensifies regional disparities in supply for both general practitioners and specialists.

Fairness, Sustainability, and Future Challenges for German Health Care

The German system, which fuses a large SHI system with a smaller SPHI one, separates its population into the more affluent and typically healthier (covered by SPHI) and the rest: the average income of those covered by SPHI is more than double the average income of those in SHI.[96] Hence, it is not surprising that many with the means to do so, opt out of SHI in favour of SPHI. For those, SPHI premiums even tend to be cheaper than the top contributions they would have to pay under SHI, unless they are responsible for many dependents or bear adverse health risks. Moreover, to attract enrollees, SPHI provides financial incentives to health care providers (higher prices) for the preferential treatment of the privately insured; although the effect of this is more pronounced in community-based settings than in hospitals. Does this kind of inequality have a negative effect on those within the SHI? There is some limited evidence of such ill effects but it is not determinative. Still, many on the political left criticize the opting out of high incomes and "good risks" as a two-tier system.[97] The German

93 *SVR Gesundheit, supra* note 32 at para 441.

94 *Ibid.*

95 Verena Vogt, "The contribution of locational factors to regional variations in office-based physicians in Germany" (2016) 120:2 Health Pol'y 198.

96 Haun, *supra* note 88.

97 Karl Lauterbach, *Der Zweiklassenstaat. Wie die Privilegierten Deutschland ruinieren* (Berlin: Rohwolt, 2008).

Council of Economic Experts has also criticized the segmented insurance system for risk selection and misallocation of scarce resources.[98] The council has repeatedly suggested the integration of both schemes into a system where private insurance and SHI funds both offer a comprehensive basic health insurance, preferably financed through flat-rate contributions, and compete on a level playing field—much as is now the case in the Netherlands.[99]

Efforts toward integrating SHI and SPHI into one system have been and will be strongly opposed by SPHI stakeholders, and it would certainly evoke claims about its unconstitutionality.[100] Incremental change might however lead to convergence. The city state of Hamburg has reformed the allowance system for civil servants to provide for a free choice of SHI, and other states are likely to follow. At the same time, SPHI has, since 2012, sustained a net loss of insurees to SHI.[101] Demographic ageing, lower numbers of self-employed and civil servants, particularly high increases of premiums, and declining net interest rates for old-age provisions have challenged the SPHI model.[102] Moreover, shifting adverse risks to SHI has been made more difficult and recent reforms oblige private

98 Jacobs, *supra* note 15 at 67; Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung SVR Wirtschaft, *Erfolge im Ausland - Herausforderungen im Inland* (Köln: Bundesanzeiger Verlagsgesellschaft, 2004) [*SVR Wirtschaft, 2004*].

99 *SVR Witschaft, supra* note 98; Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung SVR Wirtschaft, *Die Finanzkrise meistern -- Wachstumskräfte stärken* (Köln: Bundesanzeiger Verlagsgesellschaft, 2008) [*SVR Wirtschaft, 2008*].

100 Constitutional claims are raised concerning the legislative competence of the federal government (art 74 of the German Constitution (GG)), the professional freedom of the private insurance funds (based on arts 12 and 14 GG), property rights of the insured (art 14 GG), and the right to include civil servants into social insurance (art 33 at para 5 GG). While claims concerning federal legislative competences and the inclusion of civil servants are unlikely to succeed, professional freedom and property rights can be constitutional obstacles to reform. The integration of SPHI into SHI would affect 75 per cent of the business volume of private health insurance. Further, property rights of about 200 billion active life reserves which belong to the insurance community rather than the individual insured cannot easily be integrated into SHI. At least, grandfathering clauses will apply to existing insurance contracts. See Wissenschaftlicher Dienst, *supra* note 7 at 10.

101 *Ibid.*

102 Greß & Heinemann, *supra* note 71 at 116.

insurance to provide social tariffs that are akin to conditions in SHI. Hence, the gradual integration of private insurance and SHI is likely to become an issue of future health reforms.

Lessons to be Learned from German "Two-Tier" Health Care

From one lens, the German health care system appears to be a showcase for at least a particular version of two-tier health care. The coexistence of SHI with a SPHI for part of the population provides many economic incentives for physicians and hospitals to privilege private patients. Indeed, evidence clearly points to shorter waiting times and more comprehensive medical treatment for those covered by SPHI. However, the vast majority of patients (and providers) are served and engaged by the SHI system. As concerns the effects of the two-tier system on providers, despite financial incentives generated by SPHI, physicians in Germany remain largely rooted in the SHI system. This is made possible through a combination of legal restrictions on physicians that secure their boundedness to the public system (e.g., minimum consultation hours per week), as well as by virtue of the vastly dominant size of the SHI market in relation to SPHI—a relation that is itself secured by regulations that allow for only limited possibilities for individuals to opt out of SHI and very restricted possibilities for those with SPHI to opt back into SHI when their income falls or their health deteriorates.

What can be made of all this complexity in design within the German system? Of the various lessons to be drawn from the German health care system, it bears emphasis, first and foremost, that its dualism does not owe to intelligent design but, rather, emerges from a historical evolution involving social risks incurred by industrialization, war, and economic depression, as well as ongoing political struggles among interest groups. That said, in its present form, the system has been rather successful at balancing the competing interests of employers, employees, unions, doctors, patients, etc., across the two tiers, suggesting that corporatist regulatory bodies are, at least in this context, quite effective at keeping the system afloat. The German experience therefore testifies to the possibility of allowing space for the private market within a predominantly social-insurance welfare-state universe. However, it is clear that the two can only coexist when regulation assures the pre-eminence and survival of the latter. It is, therefore, crucial for those countries looking to adopt a mixed-insurance system similar to that of Germany's that, in order

for the advantages of SHI to come to the fore (e.g., timely and adequate access to care, expansive coverage, good hospital infrastructure, etc.), strong regulations must be in place to minimize access to SPHI, and also to control the effects of its incentives on providers; for example, regulation preventing extra-billing by SHI providers, regulation requiring SPHI carriers to carry the full risks of their insured population, and regulation requiring a certain amount of time and productivity devoted to SHI patients. Of course, this begs the question: In the absence of the particularities of German history, does such a two-tiered health care system even make sense given the high costs that regulation itself entails? This is a question, however, that can only be answered by future research.

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