View from Germany

Dr Bertram Häussler, director of the Institute for Health and Social Research describes developments in Germany's health care system since unification and the future of quality assurance.

Until October 1990 two German health care systems existed, which differed at least as much as the corresponding economic systems.

The eastern system was financed by a relatively low national budget distributed among the health services through several hierarchical levels. All services were provided by the state. Their use was free of charge and the public paid only token social security contributions. Physicians were public employees, like any other member of the national workforce, and were paid an average salary. The German Democratic Republic more or less followed a primary health care model. In urban areas primary and secondary care were organised in polyclinics – large units with up to fifty doctors, some hundred other health workers, and other staff.

Because of its considerably smaller economic power and the smaller share of the gross national product it allocated to the health care system, the republic had poor facilities compared with those of West Germany. Most hospitals were in poor condition, and technical equipment was either lacking or out of date. Pharmaceutical supplies were restricted to those that could be produced by the domestic sector or eastern bloc and were rarely of international standard. Waiting lists were considerable for scarce health services predominantly distributed to active members of the working force.

The health care system of former federal republic has become the uniform system for Germany as a whole. It is funded within a social security system which has remained essentially unaltered for over 100 years. More than 90 per cent of the population pay insurance premiums and employers pay half of the total premium of their employees. The premiums are a fixed percentage of the wages, and family members who are not employed have their insurance covered without extra charge. The use of services is generally free except for some user part charges – for example, for

medicines outside a list of free medicines.

Ambulatory services are generally provided by doctors in private offices. Most doctors are self employed. Patients have free access even to specialists. Ambulatory and hospital care are strictly separated. Physicians in private offices are paid on a fee for service basis whereas those in hospitals are employees.

Private offices, particularly those of specialists, are often equipped to a high technological standard. Long waiting lists are widely unknown even in hospitals, and expensive services are widely available, usually soon after their introduction.

Unifying the health care systems

The unification process meant an adoption of the principles of health care in West Germany in the unified country, and there was negligible discussion about the future shape of the health care system. In fact, there was little controversy about the principal ways of financing the system. Almost nobody campaigned for a tax-funded system like the NHS. Likewise, no opposition was encountered to raising the standards of the rundown system to those in the West.

Nevertheless, the process was not without conflict. Fierce controversy arose among experts and health care workers whose personal perspectives were affected by these changes. The key issue of the debate has been whether the polyclinics and the doctors employed by them can remain the basic structure for ambulatory services. The polyclinics came under fire not because of their failure in providing adequate services, nor their fundamental structural incompatibility, nor their uneconomic performance but rather that the organisations representing West German doctors feared them as a model that could undermine self employed physicians in private practice. Their political pressure and lobbying, together with many former East German doctors' expectations of prompt affluence, drove polyclinics into a defensive position and caused their widespread transformation into conglomerations of private practices. Only in the state of

Brandenburg did about 30 polyclinics reorganise themselves with the help of a government programme, into so called "health centres" in which employed and self employed physicians work together.

The unification of the German health care systems has hardly been guided by fundamental ideas of appropriateness or quality of care. In the short time between November 1989 and October 1990 there was neither time nor enough political will to find an optimal blend of Eastern and Western structures for maximal quality of care. Moreover, there were few hard data on effectiveness and appropriateness of health care services on which to base such considerations. However, unification took place just before deep structural changes within the West German system; therefore, it is regrettable that eastern options have not so far been considered.

Political reforms

Hardly two years after unification the political debate about substantial reforms of the health care system was back on the agenda. Since the last important legislative effort to contain costs, in January 1989, Germany has seen three ministers for health affairs.

Mr Seehofer, the present minister, started his job in April 1992 with some truly fundamental proposals. At least some of them will survive the onslaught of the contrary interests of various groups, as has been the usual pattern. The main objective of the reforms is to stop the constant increase in service utilisation characteristic of a health care system in which providers have a strong position.

This means not only quantitative cuts but that the range of services will be trimmed of services that are not crucial for medical care or that have proved ineffective. Furthermore new structures will be needed to increase the effectiveness and efficiency of the current system. The basic features of the reforms will be as follows.

- Negotiations between providers and health insurers will be increasingly shifted down from national and state levels to regional levels. It is widely acknowledged that the high

standards of medical equipment in metropolitan areas should not be subsidised by premium payments of rural populations who benefit little from it.

- The reimbursement system of hospital care will gradually be shifted towards a prospective payment system as in the United States. Therefore more hospitals will be run by private firms and managerial control will increase.
- The number of physicians will be limited and their salary increases will be pegged to those of the insured population. The fee for service system of reimbursement that has shown so many unfavourable effects on the quality of care will be replaced by some sort of capitation at least for family practitioners.
- Considerably fewer than the current total of 50 000 different drugs will be reimbursed by social health insurance. These drugs will have to have been accredited by the social health insurance and will be selected drugs considered to be effective and reasonably priced (for example, generic drugs).

Germany will also end its West German tradition of assigning blue collar and white collar employees different health insurance. Everybody will be free to choose their own health insurance, which will inevitably lead to more competition between insurers. Fortunately, mandatory financial compensation between different insurers, according to their different risk structures, will curb competition for "good risk" subjects.

Future prospects for quality assurance

According to the insurers, providers, and the government quality assurance will develop in the future, and there is at least some evidence that it will progress beyond its current status of pilot projects in most areas of health care.

In a few regions there are quality programmes that collect data on performance and aspects of quality, mainly for surgical procedures in hospitals. The data are processed in specific study centres and fed back to the hospitals. The results are generally not published, and even the participating hospitals know their own performance only in respect of explicitly defined standards. Little is known about what conclusions are drawn within the hospitals. A couple of hospitals in the country are experimenting with internal audit programmes.

In ambulatory care there is a long tradition of QA programmes for specific diagnostic procedures, mainly for checking blood testing regularly by including routine controls. More recently programmes for drug counselling have been established in many parts of the country to monitor doctors' prescribing habits and offer advice. Participating doctors reduce the number of drug prescriptions while increasing their niveau.

However, the way that physicians treat diseases or manage more general health problems is not yet subject to routine audit procedures. A series of pilot projects has led to a consensus that audit should take place in so called "quality circles." These

will probably not focus on physicians' behaviour in relation to well defined external standards but will emphasise communication aspects of the patient-doctor relationship. German doctors strongly insist that practice guidelines are secondary to the health needs arising from their patients' psychosocial situation.

Experiences in the United States show that efforts at economic control of the health care system are strongly linked to quality. Under the influence of increasing economic control German insurers will also develop an appetite for data that are sensitive to the economic performance of providers, and their interest will probably extend to aspects of appropriateness and quality of care. This will undoubtedly lead to an increase in external quality control. A few projects have already reviewed utilization of services on the basis of claims data from health insurances that also covered some aspects of quality. However, as long as insurers and providers are occupied with the forthcoming changes in the health care system there will be little remaining energy for quality assurance. Therefore, the federal health authorities have urged doctors and hospitals to take appropriate measures soon.

Despite all the obstacles, including strong requirements for confidentiality and data protection, Germany is facing interesting potential developments in quality assurance. It will be the task of all experts to ensure that these developments are realised.