Organisation and Financing of the German Health Insurance

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Abstract: *The author will try to explain the features of the German health insurance system, and to that end, proceed in two steps. The first consists of a rough overview of the system in general (chapter II.). The second step will lead to the main aspects of financing and organising the statutory health insurance (SHI), starting from the legal relations that have to be regulated and administered in order to make the SHI work (chapter III.).*

Key words: *health insurance, social security, Germany*

Organizacija in financiranje nemškega zdravstvenega zavarovanja

Povzetek: *V prispevku avtor skuša v dveh korakih razložiti značilnosti nemškega obveznega zdravstvenega zavarovanja. Najprej predstavi splošen pregled sistema (poglavje II), v nadaljevanju pa razlaga glavna načela financiranja in organizacije obveznega zdravstvenega zavarovanja, začenši s pravnimi razmerji, ki morajo biti ustrezno regulirana in upravljana, da sistem obveznega zdravstvenega zavarovanja lahko deluje (poglavje III).*

Ključne besede*: zdravstveno zavarovanje, socialna varnost, Nemčija*

1. INTRODUCTION

1. Health is one of the most valuable human commodities. And health care belongs to the most fundamental goods, and also most fundamental needs, of human beings. Health is a prerequisite for the pursuance of nearly all activities, be it participation in the labour market, be it education, or the simple exchange with other members of society. Consequently, health and health care are subjects of human rights provisions in practically all jurisdictions. It suffices to name the right

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to physical and mental health according to Art. 12 of the International Covenant on Economic, Social and Cultural Rights[1], the right to the protection of health according to Art. 11 of the European Social Charter[2] or the many national social rights such as Art. 51 of the Slovenian Constitution[3].

Whereas the actual function of such provisions as a basis for individual subjective rights may be questionable,[4] a state certainly has a legal duty to provide health care to the people living on its territory. The EU Charter of Fundamental Rights mentions the 'access to preventive health care and the right to benefit from medical treatment' as well as 'a high level of human health protection', and one might assume that this describes a legal responsibility of all public powers in Europe.

The fulfilment of this governmental task is anything but easy. Health care services are benefits in kind which have to be provided in an effective and efficient way. Manifold activities of health care professionals, hospitals and other medical entities have to be regulated; legislators and administration have to find the right balance between cost-effectiveness, sufficient quality, accessibility and innovative health care. It is not by chance that in most European states a considerable amount of money is being spent in order to finance health care.[5]

2. The organisation of health care systems is – even in Europe and the ongoing process of European integration – a matter of national powers,[6] and we can ob-

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1 Of 16 December 1966 (http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx); see also CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) (http://www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf).

2 Of 18 October 1961 (ETS No. 035), revised ESC of 3 May 1996 (ETS No. 163) (http://www.coe.int/en/web/turin-european-social-charter/charter-texts).

3 Of 23 December 1991 (see English version under: http://www.us-rs.si/en/about-the-court/legal-basis/).

4 See *Iliopoulos-Strangas* (ed.), La protection des droits sociaux fondamentaux dans les Etats membres de l'Union européenne: étude de droit comparé, 2000; *Iliopoulos-Strangas* (ed.), Soziale Grundrechte in Europa nach Lissabon, 2010; *Iliopoulos-Strangas*, Die Rechtsfigur des sogenannten sozialen Besitzstandes im europäischen Grundrechtsschutzsystem, in: Müller-Graff/Schmahl/Skouris (ed.), Europäisches Recht zwischen Bewährungund Wandel - Festschrift für Dieter H. Scheuing, p. 555 et seq; for a short overview *Becker,* Der europäische soziale Rechtsstaat: Entstehung, Entwicklung und Perspektiven, in: *Iliopoulos-Strangas* (ed.), Die Zukunft des Sozialen Rechtsstaates in Europa. The Future of the Constitutional Welfare State in Europe. L'Avenir de l'État de Droit Social en Europe, 2015, p. 101, 119.

5 See OECD Health Statistics 2016 (http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT).

6 See ECJ of 16 March 2004, Joined Cases C-264/01, C-306/01, C-354/01 and

serve different types of systems within the European Union. Generally speaking, there are two models: the insurance model, with health care financed from the contributions of insured persons,[7] and the national health service model,[8] with health care for all financed from taxes. In reality, there are considerable deviations from the blueprints of these models in most countries, and we can also observe mixed systems, such as in Poland.[9] I shall try to introduce to you the German health care system. Its history starts in 1883[10] when it was introduced as the first branch of Bismarck's social security legislation.[11] In its core, it still follows the traditional Bismarckian insurance architecture, and, especially due to the historical roots, it has some features that are rather unique in the whole world.[12]

I will try to explain these features, and to that end, proceed in two steps. The first consists of a rough overview of the system in general (below, II.). The second step will lead to the main aspects of financing and organising the statutory health insurance (SHI), starting from the legal relations that have to be regulated and administered in order to make the SHI work (below, III.).

2. OVERVIEW

My overview has to start with the observation that there is not only one health insurance system in Germany. We can find both public and private health insurance. Whereas this is not at all remarkable as such, the interplay of the two forms of insurance is very special indeed. Private insurance is not restricted to supplementing public health care as in most other developed countries.[13] It is

C-355/01, (AOK Bundesverband and others); for a general overview *Becker*, Nationale Sozialleistungssysteme im europäischen Systemwettbewerb, in: *Becker/Schön* (Hrsg.), Steuer- und Sozialstaat im europäischen Systemwettbewerb, 2005, p. 1 et seq.

7 The so-called 'Bismarckian' Model.

8 Which became part of the famous Beveridge Report (Social Insurance and Allied Services, 1942).

9 See *Lach*, Organisation Akteure und Verhältnisse im polnischen System der Gesundheitsfürsorge, ZIAS 2016 (forthcoming).

10 Gesetz, betreffend die Krankenversicherung der Arbeite (RGBl. 1993, p. 73). The Statute came into force in 1884.

11 See for the background of this legislation *Ritter*, Sozialversicherung in Deutschland und England – Entstehung der Grundzüge im Vergleich, 1983.

12 Its most important legal basis today is the *Sozialgesetzbuch V* (Social Code Book V, in the following SGB V).

13 Where benefits from the public system can be supplemented by additional benefits from private

also used as a substitute of the statutory insurance, one might say as an independent pillar of health care in Germany, and that is why we can speak of a 'dual insurance system'.[14]

This special function of private insurance and the 'two pillar approach' is due to the historical evolution and two facts. First, civil servants, judges and soldiers are taken care of by the state and not the SHI.[15] We may call that an internalised system of social benefits[16] with the basic idea – also relevant for old age security and industrial injuries – that those public servants have a special and comprehensive legal relation to the government, and that it is therefore a duty of government also to provide social benefits.[17] Yet, as the government does not cover all costs of health care treatments, but as a rule not more than 50 %, civil servants need to partially cover their costs by private insurance contracts (= PHI-CS). Second, from the beginning on, the *Bismarckian* social insurance did not include all persons in dependent employment in the mandatory scheme.[18] It concentrated on the neediest workers, and although its personal scope of application was extended over time, statutory health insurance still today sets an upper limit for compulsory coverage. This is referred to as the gross annual earnings limit: persons whose salaries exceed this limit are exempt from the obligation to insure.[19] They used to be free to choose between voluntary affiliation to the public system if they fulfill rather restrictive conditions, or to enter into a private insurance contract, or not to have a contract at all. It was not before 2009, that Germany introduced a compulsory insurance for all in order to guarantee

insurance. In France, health mutual ('mutuelles') cover co-payments of the insured (see https://www.service-public.fr/particuliers/vosdroits/F20314, and *Kessler*, Droit de la protection sociale, 5th ed. 2014, p. 717 et seq.).

14 See *Becker*, German Health and Long-Term Care Insurance – Legal Aspects, in: The Role of Private Actors in Social Security, MPISoc Working Paper 1/2005, p. 3 et seq.(under www.mpisoc.mpg.de).

15 Art. 6 par. 1 No. 2 SGB V.

16 See *Zacher*, Grundtypen des Sozialrechts, in Festschrfit für Zeidler, vol. 1, 1987, p. 571 et seq.

17 See – with regard to old age security – *Körtek*, Die Beamtenversorgung in der Bundesrepublik Deutschland, in: *Becker/Köhler/Körtek* (Hrsg.), Die Alterssicherung von Beamten und ihre Reformen im Rechtsvergleich, 2010, p. 47 et seq.

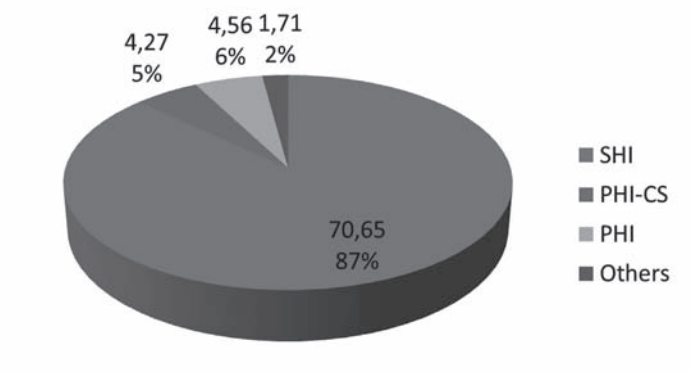
18 See *Becker*, Normative Grundlagen im deutschen Sozialstaat, Sozialpolitische Geschichte, in: *Carigiet/Mäder/Opielka/Schulz-Nieswandt* (Hrsg.), Wohlstand durch Gerechtigkeit, Deutschland und die Schweiz im sozialpolitischen Vergleich, 2006, p. 59 et seq.

19 Art. 6 par. 1 No. 1, par. 6 SGB V.

universal access to health care.[20] Since then, all those who are not eligible for the public system have to be affiliated to a private sickness fund, and insurance companies offering such funds are obliged to accept all offers for coverage.[21]

The situation leads to some competition between private and public health insurance, yet in a marginal[22] and questionable way.[23] As the figures show,[24] private insurance covers only a relatively small share of the German health care market. This is one reason why I will, in the next steps, concentrate on the public insurance and the so-called German SHI.

3. STATUTORY HEALTH INSURANCE



[20] Law on strengthening competition in the SHI (Gesetz zur Stärkung des Wettbewerbs in der GKV) of 26. March 2007 (BGBl. I, p. 378).

[21] Including 'basic insurance'; see for the constitutionality of these provisions German Federal Constitutional Court, dec. of 10 June 2009, 1 BvR 706/08, 1 BvR 814/08, 1 BvR 819/08, 1 BvR 832/08, 1 BvR 837/08.

[22] See *Becker/Schweitzer*, Wettbewerb im Gesundheitswesen – Welche gesetzlichen Regelungen empfehlen sich zur Verbesserung eines Wettbewerbs der Versicherer und Leistungserbringer im Gesundheitswesen?, Gutachten B zum 69. Deutschen Juristentag, 2012, p. B 142 et seq.

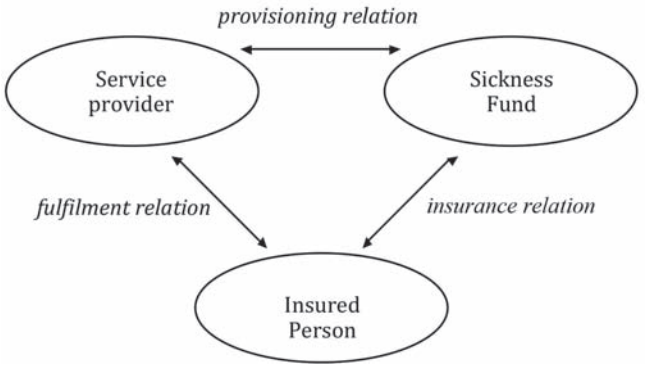
[23] See for further discussions *Kingreen/Kühling*, Monistische Einwohnerversicherung, 2013, on the one hand and *Steiner*, Verfassungsfragen der dualen Krankenversicherung, 2015, on the other.

[24] Source: Statistisches Bundesamt, Amtliche Statistik KM 1 Dezember 2014, retrieved from: http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/GKV/Mitglieder_Versicherte/KM1_Januar_bis_Dezember_2014.pdf, accessed September 14, 2016; Verband der Privaten Krankenversicherung, Zahlenbericht der PKV 2014, retrieved from: https://www.pkv.de/service/zahlen-und-fakten/archiv-pkv-zahlenbericht/zahlenbericht-2014.pdf, accessed September 14, 2016.

3.1. Legal Relations and Corporatism

a) Within SHI, we can distinguish between different actors and different legal relations that bind these actors together. I have to admit that such an approach is very much derived from German legal doctrine, but it is also very helpful in order to explain governmental responsibility for the system in general and its organisation in particular.

First of all, we have the insured, a person who is, mandatorily or voluntarily part of the SHI,[25] entitled to health care benefits – and who also has to pay contributions, even if benefits and contributions do not constitute a relation of mutual exchange in the proper sense. Second, we have the administrative authorities which are competent to implement the system. These are the sickness funds (*Krankenkassen*). In a way, they have to ensure that every insured person will get the necessary benefits according to the statutes in force. Therefore, we may call the relation between the insured and the sickness fund an 'insurance relation' or a 'social benefits relation'. Yet, German sickness funds do not own the necessary institutions or personnel for providing health care services. Therefore, they have to make some sort of arrangement in order to ensure that a third actor, a private health care provider, will take over the duty to fulfil the right. Usually, sickness funds do not purchase services from a provider in a stricter sense, but merely create a legal basis for service provision ('provisioning relation').[26] The actual fulfilment of the social right will take place on the basis of a legal relation between the service provider and the insured person ('fulfilment relation').



[25] For mandatory insurance see Art. 5 SGB V; for voluntary affiliation Art. 9 SGB V.
[26] Art. 69 et seq. SGB V.

b) In order to understand the German SHI, it is essential to stress two aspects. First, sickness funds (SF) do not form part of governmental administration. They are autonomous administrative bodies following the principle of so-called self-government or self-administration (*Körperschaften mit Selbstverwaltung*). This is a heritage of *Bismarck*,[27] as all social insurance authorities have been organised according to this principle from the beginning on.[28] The idea was to take up societal processes and to directly involve trade unions and employers' associations in the organisation of social insurance. As a result, we still have, today, different types of sickness funds:[29] local funds (*Allgemeine Ortskrankenkassen* – AOK), company funds (*Betriebskrankenkassen* – BKK), guild funds (*Innungskrankenkassen* – IKK) and so-called reserve funds (*Ersatzkassen*). And we also have two particular funds, one for the agricultural sector[30] and one for the K-B-S (*Knappschaft-Bahn-See*, the social insurance body for miners, railway employees and seamen). It is important to stress that every single fund still has its own legal personality and is supervised by governmental authorities[31].

Second, these authorities, or their associations respectively, are part of a corporatist arrangement[32] that has been set up for the regulation of what I have called the provision relation. In order to make the whole SHI work, it is important to decide on the access to service providers, to fix prices by fixing appropriate tariffs, and to ensure quality assessment.[33] Most of these tasks are not pursued by the government, but are subject to negotiations and agreements made between sickness fund associations (on the federal level *Spitzenverband Bund der Krankenkassen*, also called *GKV-Spitzenverband* – SpVbBund,

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[27] And of the traditional German way of organising administrative authorities; see *Lorenz von Stein*, Handbuch der Verwaltungslehre, 2nd ed. 1876, p. 33 et seq.

[28] See *Stolleis*, Geschichte des Sozialrechts in Deutschland, 2003, p. 71 et seq. See for a detailed overview on the hostorical background *Stier-Somlo*, Sozialgesetzgebung. Geschichtliche Grundlagen und Krankenversicherungsrecht, 1906, p. 16 et seq.

[29] Art. 143 et seq. SGB V.

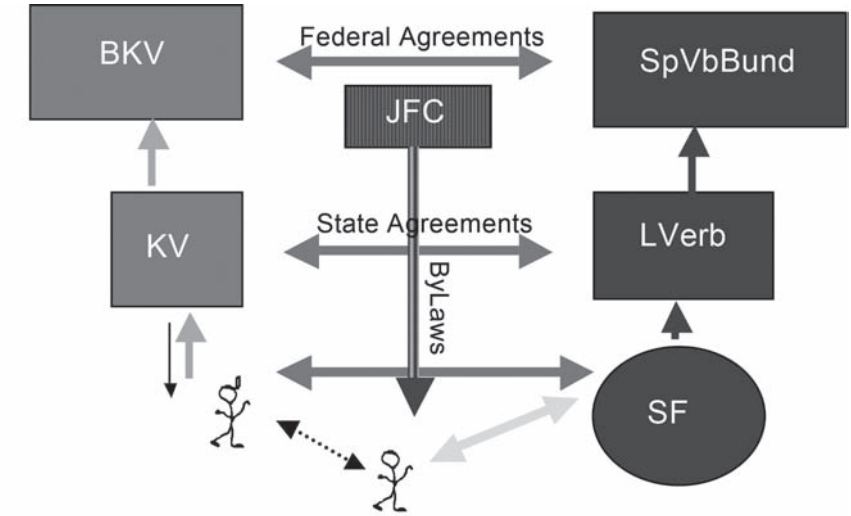
[30] Since 1 January 2013 *Sozialversicherung für Landwirtschaft, Forsten und Gartenbau*.

[31] Either a federal agency, the Federal Insurance Office (*Bundesversicherungsamt*) or state authorities (the state health ministries), dependent on the territorial scope of competences of the respective sickness fund. See Art. 87 par 2 of the Basic Law (*Grundgesetz*).

[32] See for the background *Becker*, Hat die gemeinsame Selbstverwaltung noch eine Zukunft?, in: Gesetzliche Krankenversicherung in der Krise - Von der staatlichen Regulierung zur solidarischen Wettbewerbsordnung, 2002, p. 122 et seq.

[33] For a comprehensive analysis see *Becker/Meeßen/Neueder/Schlegelmilch/Schön/Vilaclara*, Strukturen und Prinzipien der Leistungserbringung im Sozialrecht, part 1 in VSSR 2011, S. 323 et seq., part 2 and 3 in VSSR 2012, p. 1 et seq. and 103 et seq.

and on state level *Landesverbände* - LVerb)[34] and the service providers. In order to make that work, physicians (or medical doctors) as the most important group of such providers,[35] are also organised in a 'pillar' of autonomous administrative bodies following the principle of self-government (on the federal level *Bundeskassenärztliche Vereinigung* – BKV).[36] All physicians inscribed with the statutory health insurance have to be members of such a public entity (*Kassenärztliche Vereinigung* – KV).



This architecture, including the Joint Federal Committee (*Gemeinsamer Bundesausschuss*) as a very important institutional connecting link, serves as a basis for the German corporatist model. Its actual importance cannot be overestimated. The advantage of corporatism is that running the SHI is, to a wide extent, not dependent on day-to-day political influence; this is seen as an important factor for the stabilisation of the system – although it is very clear that this system could not work without permanent legal adjustments made by

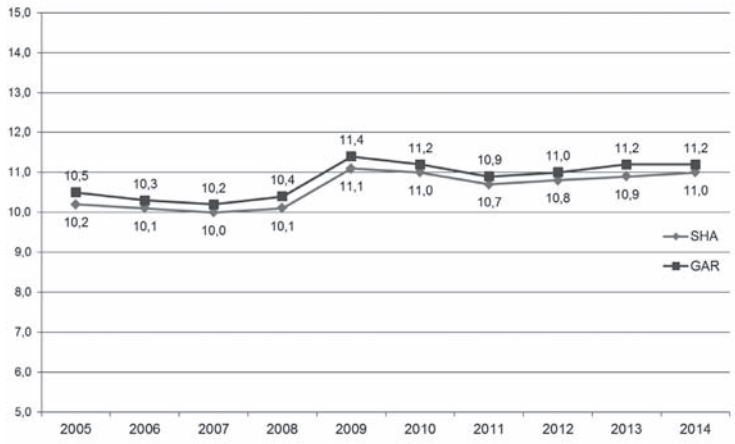
[34] Art. 217a et seq. and Art. 207 et seq. SGB V.

[35] A rather similar arrangements exists for hospitals although planning competences of the states (*Länder*) have to be observed. For other areas, in particular medical products, there are different arrangements with a much less compley structure of direct sontracts between service providers abd sickness funds.

[36] Art. 77 et seq. SGB V. Analogous entities exist for dentist (*Kassenzahnärztliche Vereinigungen*).

the legislator. The most important and difficult task is to find the right balance between room for self-administration on the one hand, and a detailed statutory basis on the other. This is also very significant in legal terms, as German health corporatism has been heavily criticised as suffering from a lack of democratic legitimacy.[37] Last November, the German Federal Constitutional Court offered some indications but did not have to decide in the merits of the case.[38] In so far, the system still works in its traditional way.

3.2. Financing the System



a) The overall spending on health in Germany amounts to about 322 billion Euros. This is more or less the same figure as the General German Federal Budget (of 317 bill. €) and amounts to 11 % of the GDP.[39] These numbers are calculated according to the OECD's 'System of Health Accounts' (SHA) and include the ex-

[37] See e.g. *Kingreen*, Knappheit und Verteilungsgerechtigkeit im Gesundheitswesen, VVDStRL 70 (2011), p. 152, 176 et seq.; *Heinig*, Der Sozialstaat im Dienste der Freiheit. Zur Formel vom sozialen Staat in Art. 20 Abs. 1 GG, 2008, p. 475 et seq.

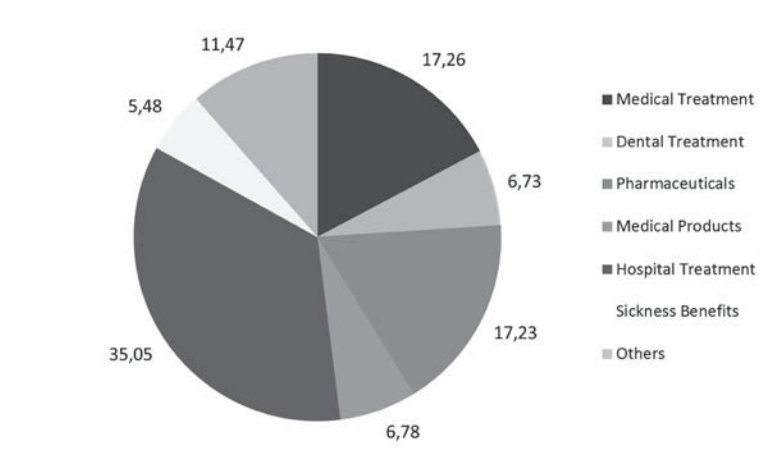
[38] Case 1 BvR 2056/12 of 10 November 2015 (German version under: http://www.bundesverfassungsgericht.de/SharedDocs/Entscheidungen/DE/2015/11/rs20151110_1bvr205612.html).

[39] Source: Gesundheitsausgaben in Deutschland als Anteil am BIP und in Mio. € (primary source: Statistisches Bundesamt, Gesundheitsausgabenrechnung), retrieved from: www.gbe-bund.de, accessed September 14, 2016; OECD.Stat, Health Expenditure and financing, retrieved from: http://stats.oecd.org/, accessed September 14, 2016.

penditure of the SHI as well as of the PHI, of public entities and private households for prevention, health care and investments (blue line); the alternatively used German approach (*Deutsche Gesundheitsausgabenrechnung* – GAR, red line) also includes the expenditure on research.[40]

The biggest share of this number is made up by the expenditures of the SHI. These have increased over the years and now reach more than 193 billion Euros for benefits. If we also take the administrative costs into account, which amount to about 5 % of the expenditures for benefits, the sum is more than 200 billion Euros.[41]

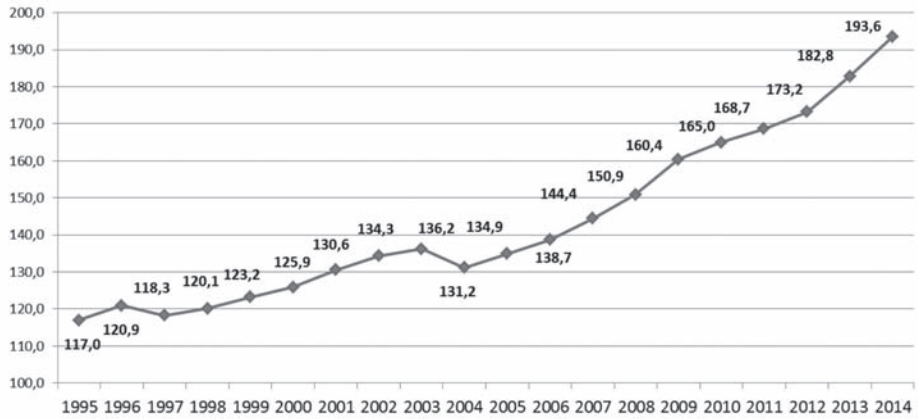
If we look at the different kinds of benefits, we can see that more than a third is spent on hospital treatment, approximately a fourth on medical and dental treatment and another fourth on pharmaceuticals and medical products.[42]



[40] Source: Gesundheitsausgaben in Deutschland in Mio. € (primary source: Statistisches Bundesamt, Gesundheitsausgabenrechnung), retrieved from: www.gbe-bund.de, accessed September 14, 2016; Current Health Expenditure in millions of Euro (primary source: Statistisches Bundesamt, Gesundheitsausgabenrechnung), retrieved from: www.gbe-bund.de, accessed September 14, 2016.

[41] Source: Einnahmen und Ausgaben der gesetzlichen Krankenversicherung (primary source: Statistisches Bundesamt, Amtliche Statistik KJ 1), retrieved from: www.gbe-bund.de, accessed September 14, 2016.

[42] Source: Statistisches Bundesamt, Amtliche Statistik KJ 1 Jahresdurchschnitt 2014, retrieved from: http://www.bmg.bund.de/fileadmin/dateien/Downloads/Statistiken/GKV/Finanzergebnisse/KJ1_2014.pdf, accessed September 14, 2016.



b) What are the sources for the financing of SHI?

First of all and for more than 90 %, SHI is financed from contributions.[43] As for the biggest group of insured persons, the employees, they share the contributions with employers. Both shares are 7.3 % of the wages.[44] Yet, one has to take into account that there is also the possibility of so-called additional contributions which have to be paid by the employees only. In order to understand this, I will have to explain how the contributions are allocated to the sickness funds.

c) Every sickness fund collects contributions and has to pass the money on to the Federal Sickness Fund (*Gesundheitsfonds*), which is an account managed by the Federal Insurance Agency (*Bundesversicherungsamt*).[45] The Agency is responsible for the allocation to every single SF which – you have to remember – has its own legal personality and also its own budget.[46] This allocation takes into account the number, the age, the gender and the morbidity of the insured. It is based on the *Risikostrukturausgleich* (RSA),[47] i.e. a risk adjustment scheme which cannot be described in detail here.

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[43] See Art. 220 SGB V. See for compensations out of the general budget Art. 221 SGB V. Such payments were: in 2015 11,5 Bill. € ; in 2016 14,0 Bill. € , and planned for 2017 are 14,5 Bill.. € .

[44] Art. 241 and 249 SGB V.

[45] Art. 271 SGB V.

[46] Art. 266 SGB V.

[47] Art. 265 et seq. SGB V. See also *Becker*, Rechtliche Fragen im Zusammenhang mit dem Risikostrukturausgleich – unter Berücksichtigung der integrierten Versorgung, VSSR 2001, p. 277 et seq.

If a sickness fund is not in the position to cover its expenses from the money allocated by the Federal Agency, it has to raise additional contributions from the insured.[48] This rather complicated way of collecting and distributing contributions pursues two objectives. First, if the general contribution rate does not change but the SHI is in need of additional finances due to the medical-technical progress, then this necessary expansion of the overall budget has to be financed from additional contributions. This means at the same time that employees pay for medical improvements, whereas the cost of labour does not increase; the share of the employers remains stable. This is at least the theory. In practice, there might be growing political pressure if the additional contributions reach a comparatively high level, and as a result the legislator might increase the general contribution rate.

The second goal is to make sickness funds work efficiently. This brings us to the last point which is another particular feature of the German SHI: competition between sickness funds.

3.3. Competition between Sickness Funds

Up to 1996, Sickness Funds had the power to regulate the contribution rate. This led to very different rates, between different types of Sickness Funds as well as between single Sickness Funds of the same type. For example, the contribution rate of the local fund in Cologne was different from that of the local fund in Munich, and this again differed from a company fund situated in the same city. Such a system is hardly in line with the constitutional principle of equal treatment[49] if the insured were assigned to a specific Sickness Fund.[50]

In order to improve the situation, the legislator decided, in 1992,[51] to give the insured a comprehensive right to freely choose their Sickness Fund.[52] This leads,

[48] Art. 242 SGB V. Restructured by Law on sustainable and socially balanced financing of the SHI (Gesetz zur nachhaltigen und sozial ausgewogenen Finanzierung der Gesetzlichen Krankenversicherung) of 22 December 2010 (BGBl. I, p. 2309).

[49] According to Art. 3 par. 1 of the Basic Law.

[50] Although the German Federal Constitutional Court accepted the system as being 'not yet unconstitutional', dec. of 8 February 1994, 1 BvR 1237/85, BVerfGE 89, 365.

[51] Law on securing and structural improvement of the SHI (Gesetz zur Sicherung und Strukturverbesserung der gesetzlichen Krankenversicherung) of 21 December 1992 (BGBl. I, p. 2266).

[52] Art. 173 SGB V.

very obviously, to competition between sickness funds[53] – although these funds still are public law corporations, and although the health market keeps being strongly regulated.[54]

At the beginning of the competition,[55] sickness funds maintained the power to set their own contribution rates. Since 2009,[56] the allocation system has changed in the way we have already learnt of. From the start, a risk adjustment system had been installed in order to guarantee fair conditions. No Sickness Fund has the right to refuse any insured as its member, and all insured have the right to receive the same kind and amount of benefits as laid down by the legislation and the by-laws of the Federal Joint Committee. That means that there is actually only very little room for competition: Sickness Funds can offer some additional benefits,[57] but only if these are financed from extra money. Sickness Funds can make some arrangements with benefits providers,[58] but the by far biggest part of all relevant aspects is regulated by collective agreements. As a result, there are unified tariffs and the same obligations of benefits providers concerning availability and quality for all SF and all insured. In sum, competition mostly concerns services and the efficiency of the administration.[59]

What are the results of this very peculiar form of competition? First, it obviously leads to a concentration process in the organisation. The number of Sickness Funds – which amounted to more than 1200 in 1993 –, is now at around 120.[60] We have fewer and bigger sickness funds today. Second, competition quite presumably does not lead to savings in the overall costs. But thirdly and lastly,

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[53] See in general *Becker*, Funktionen und Steuerung von Wahlmöglichkeiten und Wettbewerb im Gesundheitswesen, in: *Becker/Ross/Sichert* (Hrsg.), Wahlmöglichkeiten und Wettbewerb in der Krankenhausversorgung, Steuerungsinstrumente in Deutschland, den Niederlanden, der Schweiz und den USA im Rechtsvergleich, 2010, p. 11 et seq.

[54] See *Becker/Kingreen*, Der Krankenkassenwettbewerb zwischen Sozial- und Wettbewerbsrecht – Zur geplanten Ausdehnung der Anwendung des GWB auf das Handeln der Krankenkassen (zusammen mit T. Kingreen), NZS 2010, p. 417 et seq.

[55] See for a first analysis *Becker*, Maßstäbe für den Wettbewerb unter den Kranken- und Pflegekassen, in: Soziale Sicherheit und Wettbewerb, SDSRV 48 (2001), p. 7 et seq.

[56] Law of 26. March 2007 (Fn. 20).

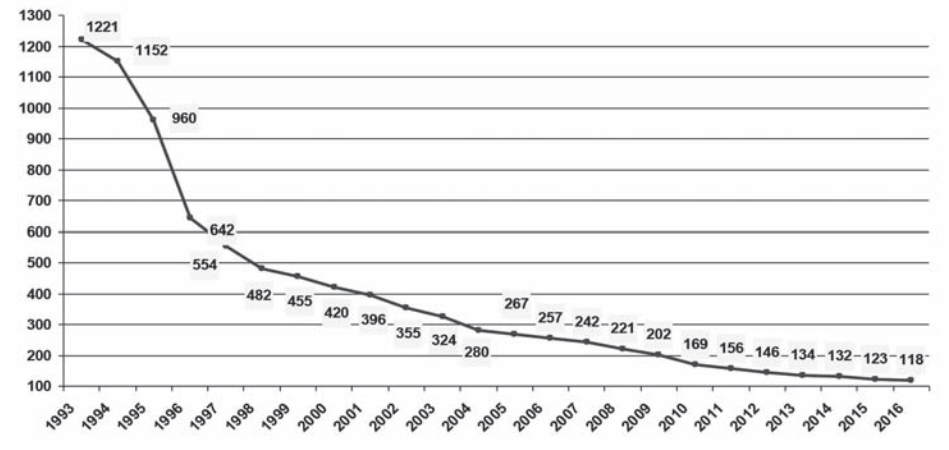
[57] On the basis of Art. 11 par. 6 and Art. 53 SGB V.

[58] In particular on the basis of Art. 140a SGB V.

[59] See for a comprehensive assessment *Becker/Schweitzer*, Gutachten B zum 69, DJT (fn. 22).

[60] Source: GKV-Spitzenverband, Entwicklung der Krankenkassenanzahl seit 1993, retrieved from: https://www.gkv-spitzenverband.de/presse/zahlen_und_grafiken/zahlen_und_grafiken.jsp#lightbox, accessed September 14, 2016.

it may help improve the service quality of Sickness Funds and it opens some room for experiments and flexibility.



4. FINAL REMARKS

Whether the way we organise and finance our health insurance is the right one, is subject to ongoing discussions in Germany. Especially the effectiveness of involving a plurality of Sickness Funds, and of the restricted competition between these funds, remains an open question. The same doubts concern the dual insurance system and the role of private insurance, as it implies that not all persons living in Germany are dealt with equally and belong to one big group of persons. However, equal treatment is key to a successful implementation of the principle of solidarity. The peculiarities of our health insurance can only be explained from the historical development.

Nevertheless, the fact that Sichness Funds do not form an integral part of governmental administration as well as the system of corporatist negotiations lead to some independence from governmental health politics. And the variety of administrative bodies and insurance systems leaves room for some experiments. Both elements contribute to a health care system which is, although in need of ongoing adaptations by the legislator as every health care system all over the world, stable and well-accepted by the insured.

Organizacija in financiranje nemškega zdravstvenega zavarovanja

Ulrich Becker*

Povzetek

Uvodoma je izpostavljeno, da v Nemčiji ne obstaja le en sistem zdravstvenega zavarovanja, obstajata namreč javno in zasebno zdravstveno zavarovanje. Samo po sebi to ni nič posebnega, vendar je prepletanje obeh oblik zavarovanja v Nemčiji zelo specifično. Zasebno zavarovanje ni omejeno le na dopolnjevanje obveznega / javnega / zakonskega zavarovanja kot v večini drugih razvitih državah. Zasebno zavarovanje je možno skleniti namesto obveznega, zato bi lahko govorili o samostojnem stebru zdravstvenega varstva v Nemčiji in posledično o 'dualnem sistemu zavarovanja'.

Ta posebna funkcija zasebnega zdravstvenega zavarovanja in 'dvo-stebrni pristop' je posledica zgodovinskega razvoja in dveh dejstev. Prvič, za državne uradnike, sodnike in vojake skrbi država, ne sistem obveznega zdravstvenega zavarovanja. Lahko rečemo, da tak notranji sistem socialnih ugodnosti, ki temelji na ideji, da imajo javni uslužbenci poseben in vseobsegajoč pravni odnos do države – kar velja tudi za zavarovanje za starost in za poškodbe pri delu – od države zahteva, da zagotovi njihovo socialno varnost. Ker pa država ne krije vseh stroškov zdravljenja (praviloma ne več kot 50%), morajo javni uslužbenci sami pokrivati del stroškov preko zasebnih zavarovanj.

Drugič, že vse od svojega začetka v Bismarckovo obvezno socialno zavarovanje niso bile vključene vse osebe v odvisnih zaposlitvenih razmerjih. Namenjeno je bilo le tistim delavcem, ki so ga najbolj potrebovali in čeprav se je število vključenih oseb s časom širilo, obvezno zavarovanje še danes določa zgornjo mejo za obvezno vključitev vanj. Odvisno je od bruto letnega zaslužka: kdor zasluži več kot določeno vsoto, se ni dolžan vključiti v obvezno zdravstveno zavarovanje. Prej so se zaposleni lahko sami odločili za vključitev v javni sistem zavarovanja če so izpolnjevali dokaj stroge pogoje, za zasebno zavarovanje ali tudi zato, da se sploh ne zavarujejo. Nemčija je šele leta 2009 uvedla sistem, da se morajo

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vsi obvezno zdravstveno zavarovati in tako zagotovila univerzalni dostop do zdravstvenega varstva. Od takrat se morajo vsi tisti, ki niso upravičeni do vključitve v javni sistem zavarovanja zavarovati sami pri zasebnih zavarovalnicah, pri čemer slednje ne smejo zavrniti nikogar.

Tak položaj ustvarja določeno konkurenco med javnim in zasebnim zdravstvenim zavarovanjem, čeprav razmeroma skromno in na vprašljiv način. Zasebno zavarovanje pokriva razmeroma majhen delež nemškega trga zdravstvenih storitev. To je eden od razlogov, zaradi katerega je v prispevku temeljiteje analizirano javno zavarovanje in tako imenovan sistem obveznega zdravstvenega zavarovanja.

Trenutno v Nemčiji potekajo razprave o tem, ali je način organizacije in financiranja zdravstvenega zavarovanja ustrezen. Še posebej učinkovitost vključevanja številnih strukturnih skladov in omejevanje konkurence med njimi ostaja odprto vprašanje. Enaki pomisleki se nanašajo na dualni sistem zavarovanja in na vlogo zasebnega zavarovanja, saj to pomeni, da vse osebe, ki živijo v Nemčiji niso obravnavane enako, čeprav predstavljajo veliko skupino. Enako obravnavanje pa ključnega pomena za uspešno izvajanje načela solidarnosti. Posebnosti nemškega zdravstvenega zavarovanja je mogoče razlagati le s perspektive zgodovinskega razvoja.

Vendar pa dejstvo, da zdravstvene blagajne niso del neposredne državne uprave, kot tudi sistem korporativnih pogajanj predstavljata določeno neodvisnost od vladne zdravstvene politike. Raznolikost upravnih organov in zavarovalniških sistemov dopušča določen prostor za eksperimentiranje. Oba elementa prispevata k sistemu zdravstvenega varstva, ki je stabilen in ga zavarovanci dobro sprejemajo, vendar pa potrebuje stalno prilagajanje s strani zakonodajalca, kar velja tudi za druge sisteme zdravstvenega zavarovanja kjerkoli v svetu.