HEALTH CARE DELIVERY IN BRITAIN AND GERMANY: TOWARDS CONVERGENCE?

Background: Two different health care systems

Generally speaking, the British and the German health care systems differ not only with respect to their financing and service provision arrangements, but also with respect to the underlying governance mechanisms. For the most part, the British health care system and in particular its core, the National Health Service (NHS), is funded out of general taxation. The German health care system, by contrast, is funded through social insurance contributions, shared by employees and employers. While the NHS provides both primary and specialist care for all legal residents of the UK, Germany's health care system provides these services only to those residents who are insured either under the compulsory public health care scheme (GKV) or under the private health care scheme (PKV). In both countries primary health care is delivered by self-employed doctors, general practitioners (GPs) in Great Britain and *Allgemeinärzte* in Germany. Compared to Germany, where the free choice of doctors is a well-defended principle, in the British system choice of primary health providers is rather more restricted. Another crucial difference between the two systems lies in the fact that in the British system, ambulatory specialist care is delivered by salaried doctors in the out-patient units of hospitals, while in Germany these kind of services are delivered by self-employed specialists (*Fachärzte*). With respect to the governance of the health care system, state regulation plays a stronger role in Britain than in Germany, where self-administration takes on functions which in the British system are performed by the state and its arm's length bodies. Interestingly, however, during the last decade, market mechanisms have increasingly gained ground in both systems.

Germany continues to spend a higher amount per capita on healthcare than does the United Kingdom: 2996 US dollars per annum, compared to 2231 US dollar s per annum in the UK, with the OECD average being some 2307 US dollars per annum (according to the latest OECD figures).

Total health expenditure per capita, US$ PPP

	1985	1990	1995	2000	2001	2002	2003
Australia	1004	1307	1745	2404	2521	2699	2699[-1]
Austria	919	1338	1870	2184	2195	2280	2280[-1]
Belgium	960	1345	1820	2279	2424	2607	2827
Canada	1264	1737	2051	2503	2710	2845	3003 e
Czech Republic		555	873	962	1063	1187	1298
Denmark	1290	1567	1848	2382	2556	2655	2763
Finland	968	1422	1433	1718	1857	2013	2118
France	1118	1568	2033	2456	2617	2762 e	2903 e
Germany	1390	1748	2276	2671	2784	2916	2996
Greece	707[2]	840	1253	1617	1756	1854	2011
Hungary		586 [1]	676	857	975	1115	1115[-1]
Iceland	1135	1614	1858	2625	2742	2948	3115 e
Ireland	662	793	1216	1804	2089	2386	2386[-1]
Italy	1195 [3]	1391	1535	2049	2154	2248	2258
Japan	867	1115	1538 b	1971	2092	2139 e	2139[-1]e
Korea	193	377	538	771	932	975	1074
Luxembourg	925	1547	2059 b	2722	2940	3190	3190[-1]
Mexico		293	382	499	545	559	583
Netherlands	987	1438	1826	2259	2520	2775	2976
New Zealand	643	995	1247	1605	1701	1850	1886
Norway	953	1396	1897	2784	3287	3616	3807 e
Poland		296	417	587	646	677	677[-1]
Portugal	422	670	1079 b	1594	1693	1758	1797
Slovak Republic			543 [2]	597	641	716	777
Spain	498	875	1198	1525	1618	1728	1835
Sweden	1260	1579	1738	2273	2403	2594	2594[-1]
Switzerland	1478	2033	2579	3182	3362	3649	3781 e
Turkey	73	166	185	452	452[-1]	452[-2]	452[-3]
United Kingdom	710	986	1374	1833	2032	2231	2231[-1]
United States	1759	2738	3654	4539	4888	5287	5635

a) -1, -2, -3, 1, 2, 3 shows that data refers to 1, 2 or 3 previous or following year(s).
b) For Germany, data prior to 1990 refer to West Germany.

Source: OECD Health Data 2005.

As a percentage of GDP, Germany's health expenditure, at 11.1%, is some 2.5% above the OECD average of 8.6%, while Britain lags some way behind, at 7.7%. However, the rate of in-

crease in health expenditure in the UK has been significantly higher than in Germany, reflecting the Labour government's commitment to increase spending to the European average.

Total expenditure on health - % of gross domestic product

	1985	1990	1995	2000	2001	2002	2003
Australia	7.4	7.8	8.3	9	9.1	9.3	9.3 -1
Austria	6.4	7	8	7.6	7.5	7.6	7.6 -1
Belgium	7.2	7.4	8.4	8.7	8.8	9.1	9.6
Canada	8.2	9	9.2	8.9	9.4	9.6	9.9 e
Czech Republic		4.7	6.9	6.6	6.9	7.2	7.5
Denmark	8.7	8.5	8.2	8.4	8.6	8.8	9
Finland	7.2	7.8	7.5	6.7	6.9	7.2	7.4
France	8.2	8.6	9.5	9.3	9.4	9.7 e	10.1 e
Germany	9	8.5	10.6	10.6	10.8	10.9	11.1
Greece	7.4 2	7.4	9.6	9.9	10.2	9.8	9.9
Hungary		7.1 1	7.5	7.1	7.4	7.8	7.8 -1
Iceland	7.3	8	8.4	9.3	9.3	10	10.5 e
Ireland	7.6	6.1	6.8	6.3	6.9	7.3	7.3 -1
Italy	7.7 3	7.9	7.3	8.1	8.2	8.4	8.4
Japan	6.7	5.9	6.8 b	7.6	7.8	7.9 e	7.9 -1e
Korea	4.1	4.5	4.2	4.7	5.4	5.3	5.6
Luxembourg	5.9	6.1	6.4 b	5.5	5.9	6.1	6.1 -1
Mexico		4.8	5.6	5.6	6	6	6.2
Netherlands	7.4	8	8.4	8.3	8.7	9.3	9.8
New Zealand	5.2	6.9	7.2	7.8	7.9	8.2	8.1
Norway	6.6	7.7	7.9	7.7	8.9 b	9.9	10.3 e
Poland		4.9	5.6	5.7	6	6	6.0 -1
Portugal	6	6.2	8.2 b	9.2	9.4	9.3	9.6
Slovak Republic			5.8 2	5.5	5.6	5.7	5.9
Spain	5.5	6.7	7.6	7.4	7.5	7.6	7.7
Sweden	8.7	8.4	8.1	8.4	8.8	9.2	9.2 -1
Switzerland	7.8	8.3	9.7	10.4	10.9	11.1	11.5 e
Turkey	2.2	3.6	3.4	6.6	6.6 -1	6.6 -2	6.6 -3
United Kingdom	5.9	6	7	7.3	7.5	7.7	7.7 -1
United States	10	11.9	13.3	13.1	13.8	14.6	15

NOTES:

a) -1, -2, -3, 1, 2, 3 shows that data refers to 1, 2 or 3 previous or following year(s).

b) For Germany, data prior to 1990 refers to West Germany.

Source: OECD Health Data 2005.

Similar challenges

Despite the differences between the British NHS system on the one hand and the German social insurance system on the other hand, both health care systems face very similar pressures. These arise primarily from the persistent progress within the field of medical technologies and from the

presence of an ageing population. The rapid progress in medical technologies challenges the British and the Germany health care system by putting increased demands on the health care decision-makers to make new drugs and therapies available as soon as possible. As a consequence health policy making in both countries is squeezed in between two contradictory pressures: those calling for cost containment and those calling for expansion of the health care budget. A third and significant source of pressure concerns the ageing population of both countries: whereas currently some 16% of the UK population and 19% of the German population are aged over 65, by 2025 these figures are expected to rise to 20% and 25% respectively. In both countries, this increases the number of patients requiring treatment, while reducing the number of taxpayers, or contributors to social insurance, who are able to contribute. This is exacerbated by the relatively low levels of labour market participation of older people: some 55% of those aged 55-64 in Britain, and just 39% in Germany. Responding to this situation as well as to the increased austerity faced by all European welfare states, during the last two decades both, Germany and the United Kingdom have fundamentally restructured and recalibrated their health care systems through a range of policy reforms.

Recent health care reforms in Britain

Despite the pressures for cost containment outlined, the British government recently has substantially increased its financial commitment to the NHS. Interestingly, the increase in financial resources comes along with the devolution of health care financing, which makes the newly established Primary Care Trusts (PCTs) responsible for the allocation of up to 80% of the overall health care budget. Further interesting policy developments have taken place in the provision of health care, where the government has advocated the strengthening of the choice element for the patients within the NHS, one result of this effort being the new GP contract that has eventually paved the way for acute specialist care in a GP setting, delivered by GPs with a specialist interest. In order to improve the responsiveness of the British system to local health and care needs, the government has also strengthened the role of community pharmacist. In the hospital sector, finally, the latest reforms have changed the remuneration mechanism by introducing the payment by results principle. This implies that in the medium term all hospitals will have to charge identical fixed prices, the national tariff, for in-patient treatment of cases which fall within the same Health Care Resource Group (HRG). Apart from this the hospital sector will also be transformed by the newly launched NHS Foundation Trust scheme, which gave hospital trusts the opportunity to become independent public interest companies legally independent of government, free to set their own pay scale, to enter contracts with private providers and to retain

operating surpluses. Thus, generally speaking, British health policy in recent years has been characterised by a devolution but also by a new diversity in service provision, which draws on the co-operation between the public and the private sector and which emphasise the value of patient choice and responsiveness of health care provision in general. Interestingly, theses changes were flanked by a quality assurance initiative, in the context of which the government introduced standard-setting institutions such as the National Service Frameworks (NSFs), specifying standards for key conditions and the National Institute for Clinical Excellence (NICE), which evaluates and recommends the utilisation of new health technologies within the NHS. Additionally the government also has created the Commission of Healthcare Audit and Inspection (CHAI). Now known as Healthcare Commission, the new super regulator not only sets standards and engages in the inspection and assessment of performance, clinical governance and finance in both the private and the public sector, it is also involved in the promotion of improvements in health care provision. Notwithstanding the binding nature of NICE recommendations, some local local variations in service provision remain, as local purchasers still decide which further, discretionary services to fund.

Recent health care reforms in Germany

Overall, last two decades of German health policy have been characterised by a strong emphasis on cost containment measures. As outlined above, this has proven necessary due to the increasing costs of the German system (exacerbated, from 1990, by the impact of reunification, which added additional patients without a history of contributions). Policy-makers have been reluctant to countenance increasing social-insurance contributions of employers, in particular, still further, as these would have a potentially detrimental effect on an already-fragile labour market. This need to contain costs is reflected in the implementation of budgets for different health care sectors and in the noticeable cuts in the benefit package provided by the GKV, as well as in the rising level of co-payments. The latter not only includes higher co-payments for drugs but also the introduction of the so-called entrance fee (*Praxisgebühr*), which also can be seen as an attempt to strengthen the gate-keeping role of the GPs in the German health care system (*Hausarztprinzip*). In order to contain the costs for hospital care, the Health Reform Act in 2000 has set up a diagnosis related groups (DRG) system - leading to a change in hospital financing that is to be completed by 2007. Apart from cost-containment measures the recent reforms however have also introduced structural change, with one of the most fundamental shifts already taking place during in the early 1990s, when the government introduced free choice of sickness funds for almost the entire insured population. The launch of competition between sickness funds and the introduction of a

corresponding risk-adjustment mechanism introduced competition as a co-ordinating mechanism of German health care for the first time. Taking the market principle even further, the most recent reform of the German health care system gave patients a (limited) right to choose between different packages of health services. Besides the introduction of market mechanisms, however, health policy has also witnessed an increased effort to overcome the strong 'sectorisation' of health care delivery not only through Disease Management Programmes (DMPs), but also by promoting integrated care elements or by attempts to put up outpatient departments in hospitals. The recent establishment of the Institute For Quality And Efficiency in Health Care (*Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen* - IQWIG) and the strengthening of the role of the (joint) federal commission (*gemeinsamer Bundesausschuß*) are further examples of a government intervention aimed at improving the effectiveness and efficiency of the self-regulated system.

Tendencies towards convergence

When we consider the developments in British and German health care in a comparative perspective, it becomes clear that the two systems, even though they are frequently used as archetypical cases of the national health service system and the social insurance system respectively, have become more similar over the last two decades. This convergence processes can be seen in the fact that both Britain and Germany have strengthened the role of private providers in service provision as well as in the field of capital investment, where public-private-partnerships are an increasingly important method of procurement in both countries. Apart from this, the two health care systems have also emphasised patient choice as important mechanism for mobilising the efficiency resources of the system. However the strengthening of the choice principle is taking place at different levels: while in Germany the government increased levels of patient choice among the sickness funds, the British government increased the freedom of the patient to choose his or her primary and secondary care service provider(s). A third and fairly clear convergence pattern can be observed in the area of remuneration, where both countries have modernised hospital financing by introducing a DRG-based system. Albeit the two DRG systems differ in detail, both are based on the idea that that a Payments by Results system is more efficient and more responsive than the established remuneration mechanism. Finally, the description of the recent reforms has also shown that Britain as well as its neighbour Germany have recently emphasised the issue of quality assurance in health care - with both countries introducing a body responsible for Health Technology Assessment, and also with both countries introducing treatment guidelines, which specify standards for key conditions. Interestingly, the outlined convergence tendencies in Britain and Germany draw on a rather different set of motivations among the policy mak-

ers: while the German policy reforms where predominantly framed in the context of cost-containment, in the British reforms this aim was less prominent. Here, it was the search for quality, efficiency, responsiveness, and market mechanisms, that have driven policy-makers to introduced far-reaching structural reforms ranging form the internal market to Foundation Trusts.

Perspectives

The recent developments and reforms in the health care system of the UK and Germany make an Anglo-German perspective on health policy particularly interesting. The prevailing differences, as well as the growing similarities, contain a huge potential for policy learning and policy transfer efforts as they allow policy makers in both countries to exchange best practice and also to share experience of particular instruments and mechanisms that have been recently introduced in both systems.

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