ESPN Thematic Report on Inequalities in access to healthcare

Germany

2018

Thomas Gerlinger
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European Social Policy Network (ESPN)

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Summary/Highlights

Almost the whole of the population living in Germany is covered by health insurance. Altogether, in 2017, 72.6 million people (around 88 per cent of the population) were insured under the statutory health insurance (SHI) scheme, while in 2016 8.8 million (around 12 per cent) held private health insurance (PHI). Nevertheless, there is a small number of non-insured people, a total of 79,000 in 2015 according to official statistics, the proportion being higher than average among the self-employed and foreign persons.

The SHI scheme is funded mainly on the solidarity principle. Insurance contributions are levied as a percentage of gross wages and are transferred by employers to the federal healthcare fund. Hence there are no barriers to healthcare arising from the financing system itself. Compared with other health systems in the European Union, co-payments play only a minor role in the funding of healthcare. In 2017, they amounted to €3.97 billion (less than 2 per cent of total SHI expenditure on healthcare) and no more than €55 per insured person. The annual sum of co-payments for SHI patients is limited to 2 per cent of their annual income and to 1 per cent if they are chronically ill. However, it may well be assumed that co-payments might prevent people, particularly those on low incomes, from seeking healthcare, though valid data on this issue are not available. Dental care and dental prostheses are subject to deductibles, together with high out-of-pocket payments for patients.

The SHI scheme provides comprehensive coverage. PHI also offers comprehensive coverage, but PHI members are permitted to exclude certain services from their insurance policies and to agree higher co-payments. Again, there are no valid data on the extent to which they do so. Access for asylum-seekers is restricted to treatment of acute diseases and pain in the first 15 months of their stay in Germany.

Although the number of doctors and hospital beds per 1,000 people is very high compared with other EU Member States, the availability of healthcare is to some degree restricted:

- there is a shortage of doctors and other health professionals in disadvantaged regions, i.e. rural regions with poor infrastructure and poor economic performance and deprived areas in metropolitan regions;
- SHI patients face significantly longer waiting times for outpatient care, particularly specialist care, than PHI patients, due to the higher payments for treating PHI patients;
- prospective forms of remuneration in outpatient care (practice budgets) and inpatient care (hospital budgets, diagnosis-related groups) encourage informal rationing, the extent of which cannot be precisely estimated but should not be ignored.

It is recommended that:

- the current SHI/PHI divide should be abolished, or at least the remuneration for treating SHI and PHI patients should be equalised in order to promote a balanced regional distribution of doctors and to avoid longer waiting times for SHI patients;
- co-payments for healthcare should be abolished, at least for persons with low income;
- prospective forms of remuneration should be organised according to patients' needs for treatment in order to tackle informal rationing;
- asylum-seekers should be granted the same access to healthcare as SHI-insured persons; and
- information about preventive services should be focused on those vulnerable groups whose access rate is below average (e.g. the unemployed, low-paid workers, the poorly educated and ethnic minorities).

1 How people access healthcare in Germany

1.1 Coverage of health insurance

Anyone living permanently in Germany is obliged to take out health insurance, in either the statutory health insurance (SHI) or the private health insurance (PHI) system. The following population groups are compulsorily insured in the SHI scheme and are not permitted to switch to the PHI system (see in detail BMAS 2018): employees whose regular gross wages exceed €450 per month (mini-job threshold) and remain below a certain income limit (2018: €4,950 per month, adjusted annually according to the change in average gross wages); pensioners in the statutory pension insurance scheme (who have been in the SHI scheme for most of the latter half of their working lives); people receiving unemployment benefits; students; farmers; artists; and disabled people. The SHI scheme also covers family members at no extra charge. Spouses or civil partners and, up to a certain age (depending on their education/training status), children are co-insured provided that their income does not exceed €450 per month.

Access to PHI is permitted only for tenured public officials *(Beamte*), the self-employed and employees whose gross wages exceed the threshold mentioned above. Members of these groups may opt for PHI or for voluntary membership of the SHI system. Thus, the SHI scheme is composed of persons who are compulsorily insured and those who are voluntarily insured. The law places severe restrictions on reversion to SHI once PHI has been opted for.

Altogether, in 2017, 72.6 million people (around 89 per cent of the population) were insured under the SHI scheme (GKV-Spitzenverband 2018: 23), while in 2016 8.8 million (around 11 per cent) held PHI (Verband der Privaten Krankenversicherung 2017: 25). Nevertheless, a small segment of the population remains uninsured (see section 2). In 2015, according to official statistics, around 79,000 persons had not taken out a health insurance policy (Statistisches Bundesamt 2016: 15). The proportion of non-insured persons is significantly above average among the self-employed and among foreigners (excluding asylum-seekers). Whilst the proportion of non-insured persons amounts to 0.1 per cent in the total population, it is 0.5 per cent among foreigners (Statistisches Bundesamt 2016: 10).

1.2 Healthcare coverage

The Social Code Book V on social health insurance stipulates that benefits under the SHI scheme have to be "sufficient, appropriate, necessary and effective" (para. 12). Every SHI-insured person is entitled by law to receive those benefits necessary to treat their individual disease according to the current state of medical knowledge. The doctors decide on the kind of treatment needed but their decisions have to be made within the scope of the fundamental decisions and regulations laid down by the federal joint committee (*Gemeinsamer Bundesausschuss – GBA*), whose decisions are taken by representatives of the SHI funds and the doctors' associations. They decide whether new diagnostic or therapeutic methods, including pharmaceuticals, dressings, therapies and aids, may be prescribed at the expense of SHI funds. The principles determining what constitutes a permissible benefit differ between outpatient and inpatient care. In outpatient care, services may be provided at the expense of the SHI scheme only if they have been approved by the GBA. In inpatient care, services may be provided as long as they have not been excluded by a decision of the GBA. In outpatient care, The Institute for Quality and Efficiency in Healthcare and the Institute for Quality Control and Transparency in Healthcare serve as independent advisory bodies supporting the GBA.

Most notably, SHI benefits include: inpatient and outpatient medical care, dental care and dental prostheses, mental healthcare, medicines, dressings, therapies and aids, hospital treatment, measures for the prevention and early detection of certain

diseases, domestic nursing care, rehabilitation and sickness benefit. Patients have the right to a free choice of authorised medical practitioners. The benefits offered by the approximately 100 SHI funds differ only marginally. The overwhelming majority of services are stipulated by law or by decisions taken by the GBA (compulsory benefits). Optional benefits granted by single SHI funds amount to – at a rough estimate – no more than 5 per cent of total SHI health expenditure.

Under PHI the benefit package is subject to an individual insurance policy. Additional benefits may be included in the individual scheme and to some extent certain benefits may also be excluded from it. There is no overview of the coverage of PHI policies. Moreover, PHI offers supplementary insurance not only for those with private insurance but also for SHI-insured persons. In 2016, more than 25 million supplementary insurance policies were taken out, most of them by SHI-insured persons, guaranteeing a one- or two-bed room in the event of admission to hospital, treatment by senior doctors, and extended coverage for dental care and prostheses (Verband der Privaten Krankenversicherung 2017: 32-34).

Access to healthcare for asylum-seekers is severely restricted. According to the act on benefits for asylum-seekers (*Asylbewerberleistungsgesetz*), this group may receive treatment only in cases of acute illness and pain. The adoption of these provisions differs among the *Bundesländer* and the municipalities responsible for the organisation of healthcare for asylum-seekers in the first 15 months of their stay in Germany. Nevertheless, entitlement to prenatal and obstetric services is in line with that for regularly insured persons.

1.3 Financing of healthcare

Insurance contributions

The SHI scheme is for the most part financed by income-based contributions collected from employees and employers. Since 2004, these revenues have been supplemented by federal subsidies (to the tune of €14.5 billion in 2017, equating to 5.4 per cent of total revenues). The level of the general contribution rate is stipulated by law and is levied as a percentage of employees' and pensioners' gross incomes irrespective of individual health conditions or age.

The compulsory health insurance contribution rate is fixed at 7.3 per cent for both employers and employees and applies to all SHI insurance funds. However, the revenue from general contributions may not be sufficient for every SHI fund to cover total expenditure. Thus, in order to cover any deficit, the SHI funds concerned have to charge additional fund-specific contributions to be borne by employees only. In 2017, the additional fund-specific contribution rates varied – depending on the SHI fund – between 0.0 and 1.8 per cent of gross income. On average, across all schemes, the additional contribution rate amounted to 1.1 per cent, meaning employers paid 7.3 per cent and employees 8.4 per cent of their gross wages (Gerlinger, Greß 2017).

PHI premium levels depend only on the individuals' health risk (at the time when the PHI policy is taken out) and age, their income being irrelevant. Thus the premiums charged for PHI rise considerably with the age of the insured persons. Moreover, in PHI, unlike in the SHI scheme, children and spouses with no income have to be insured individually.

Co-payments

As far as the SHI scheme is concerned, services are delivered as benefits in kind. Nevertheless, certain services, products or other benefits (e.g. drugs, aids and remedies) are subject to co-payments. Co-payments usually amount to 10 per cent of the cost per prescription, with a minimum of €5 and a maximum of €10. Inpatients have to pay a maximum of €10 per day for 28 days per year. Additionally, between 2005 and 2012, SHI patients had to pay a so-called 'practice fee' for their first consultation with a doctor in a quarter and for each further consultation with a specialist without referral in order to reduce the number of consultations ('doctor shopping'). The practice fee was abolished at the end of 2012 as it had failed to fulfil

its intended purpose. In 2017, co-payments totalled €3.97 billion (Bundesministerium für Gesundheit 2018: 17), i.e. on average almost €55 per insured person and less than 2 per cent of total SHI expenditure. There is an annual limit on co-payments of 2 per cent of annual income (gross earnings plus additional revenues) for every insured person and of 1 per cent for the chronically ill. Furthermore, for dental care and dental prostheses, a considerable share of costs has to be borne by out-of-pocket payments. Services are free of charge for children up to age 18.

Under PHI, co-payments and deductibles are specified in the individual contract between the insured person and the health insurer. PHI is based on the cost-reimbursement principle.

1.4 Availability of healthcare

The number of doctors per 1,000 people ('physician density') is high compared with other healthcare systems in Europe and has steadily increased in the past. By the end of 2017, there was on average 1 doctor per 214 inhabitants (1990: 335; 2000: 279). The city-state of Hamburg had the highest density, of 1 doctor per 139 inhabitants, and Brandenburg the lowest, at 1 doctor per 251 inhabitants (Bundesärztekammer 2018). In 2017, physician density in Germany was considerably higher than the OECD average (OECD 2017). In both the outpatient and inpatient sector, a system of capacity planning is being adopted in order to ensure a balanced distribution of doctors and hospital beds to meet the needs of the local population. Patients enjoy free choice of doctors. Specialists are available in both the hospital and outpatient sectors.

Availability of outpatient medical care

Outpatient medical care is provided either by doctors in private practice or by doctors in medical treatment centres (*Medizinische Versorgungszentren – MVZ*). Medical treatment centres are organisations in which various healthcare professionals work together in order to ensure more integrated care. In contrast, privately insured persons have the option of outpatient treatment in). In 2016, 154,400 physicians were practising in outpatient care, 118,400 of whom were independent practitioners and 36,000 employees.

Legislation provides a broad framework for capacity planning, whilst the joint self-regulatory bodies are responsible for negotiating details and for implementing the decisions taken. The GBA is, by law, obliged to stipulate guidelines for capacity planning encompassing the number of doctors per 1,000 inhabitants, differentiating between medical disciplines (e.g. there is more need for general practitioners than for dermatologists) and certain types of regions (e.g. needs may differ, due among other things to population density, between metropolitan and rural areas). These guidelines are, in principle, binding but may be adapted according to regional or local characteristics by the regional self-regulatory bodies.

Availability of inpatient healthcare

In general, hospital admission has to be ordered by a practitioner, who has to suggest two appropriate local hospitals. Like outpatient care, inpatient care in Germany is characterised by a high density of healthcare facilities. In 2016, there were 1,951 hospitals and 498,718 hospital beds, both figures representing a sharp decrease since 1991 (Statistisches Bundesamt 2017: 8-13). Compared with other healthcare systems in Europe, however, the number of hospitals and hospital beds per 1,000 inhabitants and the average length of stay in German hospitals are high. As with the outpatient sector, there is a significant oversupply of hospitals and hospital beds in metropolitan areas.

Responsibilities for capacity planning in hospital care are strictly separated from those in outpatient care. In the inpatient sector, the *Bundesländer* are responsible for hospital planning. They decide on the number of hospitals necessary for adequate provision of care after having consulted other stakeholders (e.g. SHI funds, municipalities, hospital owners).

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

All in all, Eurostat data on unmet healthcare needs in 2016 indicate that Germany is performing well compared with most other EU member states, as 0.9 per cent of the population aged over 16 reported unmet needs whereas 4.5 per cent in the EU 28 did so. Moreover, the share of the population reporting unmet needs has decreased significantly since 2008. It should be noted that one third of unmet healthcare needs (0.3 per cent) was due to reasons related to the healthcare system: 0.2 per cent indicated that treatment was too expensive and 0.1 per cent were referred to waiting lists.

However, it could also be argued that the fact that 0.9 per cent of the population aged over 16 reported unmet needs amounts in absolute terms to around 600,000 people living in Germany whose needs for medical examination or treatment were not being met. Moreover, in some areas of healthcare Germany's performance fell below the EU average. Particularly worrying is the fact that in Germany younger people (aged 15–44) were more likely to report unmet needs for the healthcare service due to financial barriers (6.1 per cent) than in the EU 28 (3.2 per cent). Moreover, in Germany the proportion of persons aged 15 and over with a lower-secondary level of education or below reporting unmet needs for mental healthcare due to financial reasons was significantly above the EU average (4.4 vs 3.1 per cent).

2.1 Health insurance coverage

As far as health insurance coverage is concerned, a small group of uninsured persons remains as a core problem. Until the end of 2008, persons entitled to opt for PHI had also been permitted to opt not to be insured, and a minority of them actually did so. This is why, in 2008, a right of return for uninsured people came into force, allowing them to return to their appropriate type of health insurance (SHI or PHI). Moreover, since the beginning of 2009 they have been obliged by law to take out a health insurance policy, either SHI or PHI. This piece of legislation was adopted as the number of non-insured people had been rising. As a result, the number of non-insured people decreased from 196,000 in 2007 to 79,000 in 2015 (Statistisches Bundesamt 2008; Statistisches Bundesamt 2016: 15). Evidence from a comprehensive study of persons without health insurance in Frankfurt/Main shows that there are various paths to non-insurance (Schweiger 2018). Hence there is no 'one-size-fits-all' approach to dealing with non-insurance; rather, the problem requires a differentiated set of measures if it is to be tackled successfully.

PHI premiums rise with age and, for certain groups of PHI members, premiums account for a growing share of their household income or may even become unaffordable as they get older. Rising premiums mainly affect living standards but may also affect access to healthcare as individuals might be inclined to exclude certain services from their insurance policies or agree to higher co-payments or deductibles in order to save money. There are no valid data on individual behaviour in this regard. In order to contain health insurance costs, the legislature obliged private insurers to introduce a new tariff for PHI members by 2009, the so-called 'basic tariff' (*Basistarif*), which works in a similar way to the SHI scheme: no medical examination is required; there is no extra premium for individual risks; there is no exclusion of certain benefits; benefits are the same as those provided under the SHI scheme; premiums may not exceed the maximum contribution in the SHI scheme; and the health insurer cannot reject a person wishing to switch to the basic tariff. However, in 2016 only 30,000 persons had in fact opted for this tariff (PKV-Verband 2017: 30).

2.2 Healthcare coverage

Though the list of benefits provided by the SHI scheme is considered to be comprehensive, access to medical innovations is sometimes not granted as quickly as

possible for SHI patients, even though these innovations are, in principle, available. A major reason is that the GBA's approval process is too slow. Consequently, the 'grand coalition' government agreed to speed up the process in order to facilitate rapid access to medical innovations.

For asylum-seekers, the gap between need for and entitlement to healthcare is extraordinary high, as these groups often suffer not only from physical but also from psychological disorders (e.g. post-traumatic stress disorder). They should therefore be granted the same entitlement to healthcare as SHI-insured persons. Moreover, access to treatment can be speeded up if asylum-seekers are given a so-called sickness fund 'health card' (a kind of certificate conferring entitlement to medical treatment), as this gives them direct access to a doctor and at the same time avoids the time-consuming paperwork associated with applications to local authorities for authorisation to receive treatment (Bozorgmehr, Razum 2015).

2.3 Financing of healthcare

Insurance contributions

The SHI scheme is funded mainly on the solidarity principle. Insurance contributions are levied as a percentage of gross wages and are transferred by employers to the federal healthcare fund. Hence there are no barriers to healthcare arising from the system of contribution financing itself.

Having to pay an additional contribution of 1.1 per cent (2017 average) on top of the contribution rate of 7.3 per cent paid by both employers and employees places an extra burden on employees but does not affect access to healthcare. As this contribution rate is expected to increase in the future, employees will have to bear a growing share of the financial burden for the SHI scheme. This is why the restoration of equal financing by employers and employees is a major challenge for health policy. The 'grand coalition' government has announced its intention to restore equal financing, and legislation to that effect is expected to be enacted in 2018

Co-payments

The total sum of co-payments in 2017 (€3.97 billion) represented less than 2 per cent of the SHI funds' total expenditure. Though the annual sum of co-payments for SHI patients is limited to 2 per cent of their annual income and to 1 per cent for the chronically ill, it may well be assumed that these co-payments constitute a barrier to access to healthcare, particularly for those on low incomes. However, no valid data are available to prove or disprove this supposition. Moreover, enforcing their co-payment limit turns out to be difficult for many patients. They have to collect the receipts, submit them to their health insurer and apply for a certificate of exemption from further co-payments (until the end of the year) or for reimbursement of the overpaid sum. In 2017, 5.22 million patients were exempted from co-payments by the 1 per cent rule and 262,000 by the 2 per cent rule. Co-payments for healthcare should be abolished at least for people on low incomes. In the case of dental services, deductibles are obviously a high barrier to access as they go hand-in-hand with high out-of-pocket payments for patients.

2.4 Availability of healthcare

As far as the availability of healthcare is concerned, the German health systems faces a number of major challenges:

- the shortage of doctors in disadvantaged areas has to be tackled;
- the long waiting times for some SHI patients in outpatient care have to be reduced; and
- informal rationing in outpatient and inpatient care has to be contained and rolled back.

Tackling the shortage of doctors in disadvantaged areas

Despite the high level of physician density compared with other EU member states, deficiencies and inequalities in access to the outpatient healthcare sector certainly exist. The number of areas with insufficient availability of medical care (including primary care) has grown in recent years. These problems primarily affect rural and remote regions with poor economic performance and infrastructure but they also occur in deprived metropolitan areas with high shares of poor people, unemployed persons or welfare recipients (Bertelsmann Stiftung 2014). At the same time, many urban agglomerations have a significant oversupply of doctors.

According to the guidelines of the GBA, undersupply in general practice is assumed if physician density falls below 75 per cent of the physician/inhabitant ratio regarded as representing standard provision. A ratio of more than 110 per cent of this standard is assumed to be oversupply. As measured by these criteria, only 8 out of 957 planning districts were below the official threshold of 75 per cent in 2016. However, a further 86 districts had reached a critical level of supply of only 75 to 90 per cent of the standard (Klose, Rehbein 2017: 30). However, unless action is taken, the situation will probably deteriorate as in many regions the number of general practitioners expected to retire soon far exceeds the number of doctors going through qualifying. Both the medical associations and the health insurers agree that it will soon be difficult to find successors for retiring general practitioners, particularly in rural districts but also in deprived or poor urban areas (Kopetsch 2010; Klose, Rehbein 2017).

In 2011, the Care Structures Act was passed, supplemented in 2015 by the Healthcare Strengthening Act. Both comprise detailed packages of instruments aimed at tackling the shortage of doctors in disadvantaged areas. Among other things, these reforms:

- reformed capacity planning for outpatient care (see above);
- allowed self-regulating regional bodies to deviate to some degree from federal capacity-planning guidelines in order to meet specific regional needs;
- increased the leeway for regional bodies to offer financial incentives to encourage doctors to practise in under-served areas;
- obliged the associations of SHI physicians (*Kassenärztliche Vereinigungen – KVs*) to allow more doctors working in hospitals, rehabilitation or long-term care to work in outpatient care;
- allowed municipalities to run medical service facilities in order to create and strengthen alternatives to solo private practice as the most common form of provision; and
- obliged the KVs to establish service centres to offer SHI patients a doctor's appointment within a reasonable time (see below).

Moreover, in 2017, the federal government launched a so-called 'Masterplan 2020' for the reform of medical degrees. The weight given to general medicine in medical degrees is to be strengthened and the Bundesländer are to be permitted to reserve up to 10 per cent of medical school places for students willing to move to under-supplied regions or to regions where under-supply is foreseeable.

Regional under-supply of doctors affects all people living in those disadvantaged areas, regardless of health insurance status and income. Nevertheless, on the whole, among the people living in those regions the share of people on low incomes and the share of older people are above average, while the share of privately insured individuals is below average. Patient health might be directly affected as a result of regional under-supply. Moreover, time and distance constitute further barriers to access. In rural areas, it is not uncommon for a visit to the doctor to take a whole day, as public transport in these regions is often poor and patients are typically old and unable to drive themselves.

There is as yet no indication that these measures have helped to stop or even reverse the trends outlined. However, it has to be conceded that some of them need time to

take effect and that the problem of under-served areas cannot be solved by health policy alone but is a crucial issue for public policy as a whole.

However, it also has to be pointed out that the current SHI/PHI divide is one crucial reason for the disparities in the distribution of doctors (see above) and that the government has not yet been willing to replace it with a unitary, solidarity-based people's health insurance scheme (*Bürgerversicherung*).

Waiting times for SHI patients in outpatient care

Since general practitioners and outpatient specialists are allowed to charge PHI patients much higher fees, privately insured patients can be assumed to be priority consumers. Various studies show that SHI patients face significantly longer waiting times than those for PHI members, even if they requested an urgent appointment with a doctor (Lüngen et al. 2008).

In order to reduce waiting times for SHI patients the Healthcare Strengthening Act (*Versorgungsstärkungsgesetz*) obliged the KVs to establish at their expense so-called 'appointment service points' (*Terminservicestellen*), where patients could request a doctor's appointment within an appropriate timeframe. Within one week these appointment service points have to arrange an appointment to be fixed within the following four weeks, otherwise the patient is entitled to request outpatient care in a hospital to be paid for from the KV's overall budget. The federal government's commissioner for patients has been critical of the fact that appointment service centres are not always available.

As well as regional disparities in the distribution of doctors, the SHI/PHI divide is a crucial reason for the longer waiting times for SHI patients. If the problem of longer waiting times for SHI outpatients is to be resolved, either a unitary, solidarity-based people's health insurance scheme has to be established or, at the very least, equal remuneration for the treatment of SHI and PHI patients has to be introduced.

Informal rationing

Another source of inequalities in access to healthcare is the prospective remuneration of doctors and hospitals. In both the outpatient and the inpatient sectors, a certain form of budget or expenditure limit, the level of which depends on factors such as the number and age of patients or the level of morbidity, is being adopted in order to contain healthcare costs. To the same end, diagnosis-related groups have been introduced in the hospital sector. These forms of remuneration set incentives for providers to contain or reduce healthcare services. Thus it is reported that they may lead to informal rationing, i.e. not providing services regarded as medically necessary (e.g. diagnostic or therapeutic services, or drug prescriptions); or, in the outpatient sector, postponing them to the next quarter; or, in the hospital sector, simply discharging patients too early from hospital (e.g. Strech et al. 2009; Braun et al. 2010). In addition, recent research highlights the enormous influence of financial incentives on medical treatment in hospitals (Naegler, Wehkamp 2018). There is no valid information on the extent of informal rationing and no evidence as to whether certain population groups are particularly affected. It is rather difficult to collect data on this issue, since most patients will not be able to recognise informal rationing. However, it is apparent that these patterns occur so frequently that they should not be ignored. The financial incentives in place are clearly not working properly. Prospective forms of remuneration should be organised according to patients' needs in order to prevent informal rationing.

Further aspects

Inequalities in the use of secondary prevention (early detection of diseases, particularly cancer and detection of risk factors for cardiovascular diseases and diabetes) have also been reported. Access rates to secondary protection for the unemployed, the low-paid and the poorly educated and ethnic minorities are clearly below average. There are numerous reasons for this phenomenon, one of which may be a lack of knowledge about health (Schaeffer et al. 2016). However, it is clear that

health insurers, healthcare providers and other actors need to target information about secondary prevention services on these and other vulnerable groups.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The most suitable indicators to be proposed for measurement of access in Germany are:

- the number of persons and/or the share of the population entitled to receive healthcare benefits;
- the extent of coverage according to the benefits list (or similar documents, decisions or legal provisions);
- the distribution of doctors as measured by the number of doctors per 1,000 of the population (physician density) determined by the GBA;
- the benefits and co-payments and deductibles specified in PHI policies;
- financial barriers to access by type of barrier (co-payment and type of service);
- distance and time needed to reach the nearest doctor or hospital;
- distance and time needed to reach the nearest accident and emergency department;
- unmet need, by reason; and
- a survey of doctors on their treatment practices (even though they might not be inclined to tell the truth, this could help to identify a minimum level of rationing).

The term 'unmet need' refers to the perception of patients; but patients will, in most cases, probably not be able to recognise whether or not a need has been met. Hence, cases of informal rationing will presumably not be recognised by patients. Self-reported unmet need can only refer to those services that are accessible to the immediate lay experience. In most cases, doctors do not point out when they refuse or delay services.

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