



Quality in and Equality of Access to Healthcare Services

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Country Report for Germany *March 2008*

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1 Introduction

1.1 Country profile

The German health care system is characterized by a predominance of statutory health insurance (SHI) funding and a private/public mix of providers (Bismarck model). Germany is the only country in the European Union (EU) with substitute private health insurance (PHI), which coexists in separation from SHI funding and pooling arrangements. However, insured with PHI and SHI virtually see the same providers. Providers are regulated by type of care, virtually independent of their profit-status. Compared to other SHI countries the health system is also shaped by federalism, by multiple competing payers, a separate branch of long-term care insurance (STLCI) and a comparably strong role of payers and providers in SHI and their joint committees. Despite this traditional regulatory decentralism and the country's size (82.5 million inhabitants), rules for the delivery of care in SHI or STLCI are largely defined at central level and generally apply to the entire country. There is space for local adjustment, though ongoing reforms of payment mechanisms (in ambulatory physician care and acute hospital care) shall help to shift historically developed inequities increasingly towards inequalities based on need-oriented or performance-oriented criteria.

Coverage: About 95% of the population are estimated to be covered by some form of public health coverage, with statutory insurance covering the majority of the population (77% mandatorily and 10% voluntarily) and governmental schemes covering a smaller part. Most recipients of governmental schemes (5% of the population) take out complementary private health insurance, since governmental coverage accounts for only 50-80% of their health care costs. Another nearly 5% are covered by substitutive private health insurance, mainly self-employed and employees with high earnings above the threshold for mandatory insurance. The number of persons without health insurance coverage in Germany are estimated to range between 0.2% and 0.3% of the legal residents (82.5 million) (see general table 1b). Similar figures relate to the

coverage for long-term care. The 2007 reform has introduced a universal obligation to be health insured.

Benefits: All 70.6 million SHI-insured (December 2006) are entitled to the same in-kind benefits based upon the principle of need and independent of their health risk, their insurance status (member or dependent, mandatory or voluntary), the amount of contribution paid or the duration of insurance. The benefit basket is comprehensive in international comparison. Governmental subsidy and compensation schemes provide the same range of benefits as SHI. In addition, PHI is to offer a standard tariff that provides the same range of benefits at the maximum SHI contribution. Other PHI arrangement may be broader or smaller than the SHI catalogue depending on the individual contract.

Main source of finance: Even though SHI covers 87 % of the population (2003) and dominates the public debate on health reforms, its actual contribution to total health expenditure was only 56 % in 2004. The majority of the population (77 % in 2003), that is employees earning below the income threshold (€3900 in 2005) and their families as well as a variety of other social and occupational groups, have a mandatory SHI status by law. Members may choose freely among virtually all sickness funds. In 2003, about 10 % of the population were voluntarily SHI insured with sickness funds as employees with earnings above the SHI insurance threshold and their families.

The 242 sickness funds (May 2007) are responsible for collecting contributions, purchasing benefits on an in-kind basis and paying providers. Their members elect representatives who control the activities of the sickness fund administration (and the professionalized full-time executive) and decide about changes to the fund's statutes, e.g. on additional benefits ("self-government"). Sickness funds have a non-profit, quasi-public status. Traditionally, sickness funds had autonomy in defining the contribution rate for their members, thus, rates differed by fund. From 2009, the contribution rate shall be uniform and set by the Federal Ministry of Health, though sickness funds may have to raise additional premiums from their members.

Complementary sources of finance include further public sources: the statutory long-term care insurance (7.0 % of total health expenditure in 2004), statutory retirement insurance (1.5 %, mainly for medical rehabilitation), statutory (work-related) accident insurance (1.7 %) and funds from the budgets of federal government, *Länder* governments or municipalities (6.2 %). Complementary private sources include out-of-pocket payments (13.7%), private health insurance (9.0 %), employers (4 %) and non-governmental institutions (about 0.3 %). Out-of-pocket payments include direct payments and co-payments for SHI-benefits, while informal payments are uncommon. Altogether, public sources accounted for about 73 % of total health expenditure and private sources for 27 % in 2004. During the last decade, the share of private spending increased, mainly due to an increase in co-payments.

Expenditure: Germany's health expenditure is ranking high in international comparison. Total health expenditure accounted for 10.9 % of the gross domestic product in 2004 or \$3052 per capita, adjusted for purchasing powers.

Pooling: The introduction of free choice of sickness fund for most SHI insured in 1995 was preceded by the introduction of a risk structure compensation mechanism in 1994 in order to compensate for differences between funds concerning the income and risk structure of their insured. Currently, risk compensation relates to about 92% of the sickness funds' revenues and is performed according to age, gender, working incapacity, and the number of chronically ill insured participating in disease management programmes. In addition, a high cost pool is established.

Payment: Acute hospitals and psychiatric hospitals are financed on a dual basis: While investments are financed by *Länder* governments with the support from federal government, recurrent costs and maintenance costs are financed by sickness funds and private health insurers. Investment is granted upon application to hospitals which have been enlisted in hospital plans independent of public, non-profit and for profit ownership. The payment of acute hospital services has been changed from retrospective reimbursement via per diem fees to a mix of per diem fees and case-fees (from 1993) under prospective target budget conditions as negotiated for individual hospitals. Since 2005, the share

of revenues from individual hospital budgets has been gradually decreased, while the share from diagnosis-related groups has been increased. From 2009, DRGs shall be the sole system of paying for recurrent costs and maintenance costs of acute hospital services for SHI as well as PHI insured (except for psychiatric care, psychosomatic and psychotherapeutic inpatient care).

SHI-affiliated physicians receive their revenues from SHI (via the regional physicians' associations), from private health insurers, from out-of-pocket payments, and from other sources. Reimbursement of ambulatory physicians via SHI and PHI (the latter paying higher prices) considers recurrent and maintenance costs as well as the depreciation of investments ("monistic financing"). Payment is performed mainly on a fee-for-service basis although elements of per-capita and case-fee payments have been increased in recent years and shall be increased further by 2009. SHI affiliated physicians are controlled for over-supply and quality deficits. Sanctions are defined by joint committees of regional physicians' associations and sickness funds and may apply, when the individual physician exceeded the prescription or delivery target of the corresponding speciality group by more than 15% respectively 25% and cannot justify this by documented medical reasons.

Health professionals: In 2005, the 4.3 million working in the health sector accounted for 10.6 % of total employment (plus 3.5 % since 1997). About half of them worked in ambulatory care. The number of active physicians has increased continuously to 3.4 per 1000 inhabitants in 2005, and is ranking at EU average. Yet, the share of family physicians has decreased to 0.97 (minus 10 % since 1991) despite several policy interventions. The number of nurses has increased as well to 9.7 in 2004 and ranks above EU average (7.7). All health professionals are obliged by law to continuous professional development.

Delivery of primary and secondary ambulatory care: Ambulatory health care is mainly delivered by private for-profit providers working in single practice. Patients have free choice of and direct access to SHI-affiliated family physicians, specialist physicians, psychotherapists (since 1998) and dentists as well as pharmacists and emergency care. SHI-reimbursed allied health personnel are available only upon prescription. SHI-insured have basically free

access to 96 % of all ambulatory physicians, while 4 % are not SHI-affiliated and treat only patients who are privately insured or pay directly. SHI-affiliated physicians offer almost all medical specialities and non-surgical sub-specialities in ambulatory care. Family physicians (general practitioners, internists and paediatricians in family practice, that is, about half of all SHI-affiliated ambulatory physicians) are not generally gate-keepers. Yet, their coordinating competence has been strengthened in recent years. SHI affiliated physicians are mandatory members of regional physicians' associations which have a monopoly to secure ambulatory care and negotiate one collective contract for their members in the region per year. However, in recent years, options for selective contracting with sickness funds and for ambulatory treatment at hospitals have been increased.

Inter-sectoral care: However, the ambulatory monopoly and the traditional strict separation between ambulatory and hospital care have been eased in recent years by promoting ambulatory surgery and hospital outpatient clinics for psychiatric and highly-specialized somatic care as well as selective contracts for trans-sectoral disease-management programs and trans-sectoral integrated delivery networks.

Acute inpatient care is delivered by a mix of public, private non-profit and for-profit providers. Yet, 99 % of acute hospital beds are accessible to SHI-insured since they are contracted by sickness funds. For about 98 % of beds, hospital owners are entitled to investments from *Länder* governments independent of ownership since they are enlisted in hospital plans. From 1991 to 2005, the number of beds in private for-profit hospitals increased from 4 % to 29 % in general (acute) hospitals. The number of acute hospitals has been decreased to 2.6 per 100,000 inhabitants (minus 15 % since 1991), and the number of acute beds to 633 (minus 21 %). Yet, bed capacities still rank nearly 50 % above EU average. The number of admissions to acute inpatient care has increased up until 2000 and has decreased since then to 20.4 per 100 inhabitants in 2004, but ranks still high in EU comparison. Also, average length of stay is still comparatively high, though it has been decreased substantially.

Pharmaceuticals: All licensed drugs are reimbursable by SHI immediately after licensing unless they do not require a prescription (since 2004), are listed on a negative list (because of minor ailments or unproven efficacy), or because their use has been limited or excluded by directives of the Federal Joint Committee. For prescription-only drugs, uniform prices across the country continue to exist, while price-setting for over-the-counter medications has been liberalized (leading partly to lower and partly to higher prices). Since 2006, SHI insured are exempted from regular pharmaceutical co-payments (€5-10 per package) if the drug they have been prescribed is a reference-priced substance and is one of the cheapest versions available.

Recent reform: In March 2007, the SHI Competition Enhancement Act was passed and shall come into force stepwise from April 2007 to 2009 with planning even extending until 2011. The law provides for universal coverage and strengthens competition between statutory and private health insurance as well as within SHI and within private health insurance. While the revenue base was not changed fundamentally, as initially planned by the governing parties, a “health funds” shall be set up from 2009 where SHI revenues and tax contributions are pooled.

Joint decision-making on the payers’ side shall be centralized by fusing the seven federal associations of sickness funds into one (to fully function by 07/2007), while giving sickness funds more competencies to compete or to fuse, to purchase medical products via tenders, to contract on their own or voluntarily delegate some of these tasks to an association (now) of their own choice. Joint decision-making of payers and providers shall be accelerated by making their delegates full-time employees in the Federal Joint Committee (from 07/2009). Measures of external quality assurance and benchmarking shall be extended to rehabilitation and homogenized across sectors of care. The current quality assurance agency (BQS) is to be reformed towards more independence and cross-sectoral reach. Reviews of ambulatory physician services and prescriptions shall be reformed and accelerated as well.

In addition, SHI benefits have been extended by full mandatory coverage for ambulatory specialized palliative care, geriatric rehabilitation, preventive and

rehabilitative services, and vaccination for children. Malus regulations with limitations on co-payment exemptions shall apply to those who do not participate regularly in screening programmes (from autumn 2007).

The (few) cost-containment measures of the 2007 act include the exclusion of interventions to recover from cosmetic interventions, piercing and tattooing. Also, overall spending on acute hospital care shall be reduced. Limitations to SHI coverage of drugs shall not only be based on health technology assessment of criteria of efficacy, safety and effectiveness but also of cost-effectiveness. For patented high-cost drugs, a second opinion review by practicing specialists shall be introduced (which may partly decrease and partly increase costs).

1.2 Promoting social inclusion through policy action at the system level

Germany's National Action Plan 2003-2005 (BMA 2003) mentioned health care in relation to improving access, quality and long-term sustainability. However, strategies to minimize social exclusion within health care or to use health care to compensate social disadvantages were not specified.

The 2006 National Strategy Report (BMAS 2006) was written by the federal government in consultation with a broad set of stakeholders. Concerning health care, it reports on accessibility in relation to coverage (and related plan to introduce universal health insurance from April 2007). Accessibility is also being discussed concerning inequities in the nationwide distribution of physicians which were responded by a reform in 2006 increasing incentives for physicians to practice in rural areas, particularly in the eastern part.

Concerning quality, the report highlights the universal requirement for health care professionals to take part in continuous professional development and for providers to perform internal (and partly external) quality assurance measures or publish performance reports (acute hospitals). An improvement of care is

also being expected from integrated care models¹ and bonus models for participating in them or in preventive measures. Furthermore, the stepwise introduction of the electronic health card is (again) announced, and health technology assessment is being funded to support evidence-based regulation of benefit coverage (though the agency mentioned is but one of the active agencies).

Concerning sustainability, the report highlights the need for efficiency and reports on draft reform 2007's intention to make sickness funds more efficient through structural reforms and enhance competition within SHI. In addition, it announces the co-funding of SHI from the federal governmental budget by 2.5 billion which shall be increased in the ensuing years. (This overshadows the fact that the 2007 grant actually represents a cut compared to previous and planned funding, which was agreed during the coalition agreement ahead of the 2007 reform.)

In their report upon the implementation of the second National Action Report 2003-2005 from April 2004, experts from national NGOs (Huster et al. 2004) highlighted the need for covering the uninsured and to observe the efficacy of exemption schemes for co-payments. They referred to an expert report that highlighted inequities in health and health care for socioeconomic groups. They also warn of tendencies towards two-tier standards in the provision of care. They assume that the privatization of hospitals could contribute to this in future. Relating to the 2004 reform, the authors emphasize several structural policies to improve quality while criticizing the impact of increased co-payments and the slow minimization (institutionalized SHI insureds) or abolishment (homeless people) of the co-payment regulations thereafter.

The Socioeconomic Committee (2006) summarized the health care related targets and reviews of the NAP 2003-2005. It found amongst others that the report provided little insight of health-care related targets and policies

¹ Since 2004 there is a financial incentive for providers to conclude so called integrated care contracts with individual sickness funds. These contracts are intended to promote innovative ways to deliver health care. According to the Advisory Council on the Assessment of Developments in the Health Care System the interim result of these contracts is rather unsatisfactory, since there are hardly any published evaluations of such contracts and when they are available they do not point towards more efficient and effective care arrangements (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2007: 276ff.).

interrelated with other policy fields which are relevant to improve social inclusion. Also, targets for inclusion were seldom refined and quantified.

The National Action Plan 2006 to 2008 (BMAS 2006) identifies seven political priorities for 2006 to 2008, namely improving the integration of immigrants and fighting discrimination against disabled people, strengthening social services, civil society and governance, modernising child and family policies to eradicate child poverty, reducing disadvantages in education and vocational training as well as enhancing labour market participation. This shall improve access to resources, rights and services for all. The strengthening of social services includes plans for the 2007 health care reform, particularly the enactment of universal access to health insurance coverage, a special prevention act, and a special act on long-term care (likely to be passed in 2008) that shall improve care the quality and affordability of care for demented people, better coordinate care and align incentives.

1.3 Quality in and Equality of Access to Healthcare: summary of main findings

Coverage-related barriers mainly affect illegal immigrants and self-employed with precarious income at risk of poverty in work (while those receiving social assistance are usually covered). The 2007 reform introduced a universal obligation to health insurance coverage. Despite hardship regulations and sanctions, not all uninsured are expected to be able or ready to meet this obligation.

Benefit-related barriers mainly affect asylum seekers and refugees due to legal restrictions to the benefit basket. Illegal immigrants, due to the risk of expulsion after requesting funds from social assistance, often have to rely on the voluntariness of providers, which is likely to limit access to high cost interventions and continuous treatment. Demented persons are disadvantaged in statutory and private long-term care insurance due to their focus on somatic eligibility criteria. Interface problems with social care and long-term care particularly affect people with mental health problems and the mentally

disabled. SHI insured are more exposed to under-provision of care than PHI insured, while PHI insured are more exposed to overprovision of care, except for those whose contracts cover only certain benefits in order to limit costs.

Cost-related barriers mainly affect the adult at risk of poverty despite exemption schemes. Co-payments particularly affect the SHI insured non-institutionalized population, especially those mentally or physically disabled who lack the bureaucratic competencies (or the social support) to provide the bills required for applying for hardship exemption. In PHI, deductibles and increasing risk-related premiums mainly affect the elderly (who fear discrimination when changing to the standard tariff with lower premiums and provider payment), chronically ill and families with disabled children. Additional PHI coverage is more taken up by rich than by poor people.

Geographic barriers mainly affect (physically as well as mentally) disabled persons, people with mental health problems and children, particularly in rural areas. In the eastern part of Germany, access to ambulatory specialists and mental health care is more limited than in the western part. Limitations to transport coverage (in all schemes) particularly affect the poor and non-institutionalized people with mental health problems (due to disadvantages in being granted the status of severely disabled and related eligibility to free transport).

Organizational barriers are largely related to cost-containment measures (budgets, prescription controls) and the providers' as well as payers' way of responding to them. Rationing at micro-level affect the SHI insured more than the PHI insured, particularly in ambulatory care.

Lack of supply-side responsiveness particularly affects illegal immigrants (fear of sanctions) and other migrants (resulting in less satisfaction with – culturally sensitive – care), people with mental health problems and the mentally disabled (including elderly). In cases of complex morbidity with mental illness or disability, under-diagnosis, under-treatment and service delusion are more likely to occur than in less stigmatizing single somatic disease. In the care of people with mental health problems and migrants, conflicts arise more commonly and –

due to insufficient training – and may provoke latent discriminatory attitudes and inappropriate provider behavior.

Demand-side barriers are particularly relevant for illegal immigrants and people with mental health problems and for certain groups of elderly with disabilities, legal migrants and children. Most members of these groups have limited health care literacy and health literacy. Since the new options for patient information and choice of insurer and choice of care models do not specifically address these groups, the gap in health literacy has increased compared to privileged groups in society.

Elderly with disabilities are mainly affected by geographic barriers, organizational hurdles (limited home visits by specialists) and supply-side responsiveness (actual provision of sufficient services and safe products, ageism).

Migrants are mainly affected by barriers related to coverage (illegal immigrants) and benefits (asylum seekers, refugees), organizational hurdles involving administrative competencies, but also by cost-related barriers, supply-side responsiveness and demand-side barriers.

People with mental health problems are mainly affected by cost-related barriers, organizational hurdles and supply-side responsiveness which interrelate with demand-side barriers.

Main policy trends to improve access and remove barriers include the universal obligation to health insurance coverage (2007 reform), the introduction of new SHI benefits targeted at the needs of people with mental health problems, geriatric patients and socio-economically disadvantaged groups (setting approach to prevention), pilot projects and research tender and political plans to improve eligibility criteria for long-term care insurance and improve care for demented people, subsidies for contributions/premiums and exemption schemes for co-payments, tighter planning criteria and incentives to reduce under-provision of ambulatory physician care and the flexibilization of ambulatory physician practice (branch offices, employment of additional physicians), shifting the morbidity risk from ambulatory physicians to sickness

funds and improving the risk structure compensation scheme (from 2009), increase of qualifications for mental care and geriatric care, increase of provider information and quality regulations, introduction of socio-therapy to encourage utilization of care of people with mental health problems as well as anti-stigma campaigns (mainly targeted at the general public), an increase of patient information (partly in several languages and barrier-free) and collective patients' rights.

Good practice initiatives: Encouragement of mutual learning among prevention projects which are targeted at socio-economically disadvantaged groups (database and network), training of professionals for conflict resolution, local alliances against depression and other awareness projects on mental illness, increase of interpreter services in health care and "scout services" from migrants for migrant patients.

Political priorities have been concerned with universal access to health insurance (2007 reform) and the reduction of current under-provision with SHI affiliated ambulatory physicians in rural areas of the eastern part and the risk of future under-provision due to a retirement wave, expected for the next years. Also, the enhancement of quality assurance measures, equal treatment regimes and exemption rules sought to buffer negative effects of increasing competition and cost-containment.

In the public opinion, cost-related barriers and denial of services or products are subject to most concern. For individual patients, supply side responsiveness matters most. Media particularly hint at deficits in access to innovations and in financial sustainability.

In my view and in alignment with the ACCESS report on Germany, the main concern relates to the organizational hurdle of providers limiting the actual provision of eligible benefits in SHI at the micro-level, although, formally, the delivery or prescription medically necessary benefits (of a relatively cheap price) may not be subject to sanctions. In addition, limitations to the granting of benefits at micro-level on the payer side should be considered. The most striking disadvantages in coverage and benefits relate to illegal immigrants,

asylum seekers and refugees with “tolerance status” though their number is low and social status is weak. These issues deserve more political and scientific attention. Concerning policies other than health care, educational policies for socio-economically disadvantaged children, particularly migrant children, seem to be of utmost importance for current and future health and socio-economic well being.

Ongoing research (phase 2): relates to the development of new eligibility criteria for long-term care insurance (funded by SHI), improving shared decision-making and patient information, particularly for vulnerable groups (funded by the Federal Ministry of Education and Research, SHI and statutory retirement insurance), improve quality and safety of care (report 2007 of the Advisory Board on Developments in Health Care), developing criteria for the morbidity-oriented risk structure compensation scheme (specific advisory board to SHI), development of quality indicators and outcome-related payment schemes (several actors in SHI), large-scale evaluation of the disease management program diabetes compared to regular care (federal association of regional sickness funds, AOK Bundesverband), alignment of health reporting to the federal health target project (Robert Koch-Institute).

2 Major barriers of access

2.1 Introduction

2.1.1 Political context and regulatory characteristics

Health care is regulated by a diverse set of legislation and regulated by actors which differ by sector, though, in SHI, regulation will be further homogenized across sectors from mid 2008. The federal constitution (“basic law”) delegates access to health care to statutory insurance and provides for space for private health insurers. The only federal state to enshrine a “right to health” in its state constitution is the Land Brandenburg in the eastern part. Rights of patients and long-term care users are enacted in a variety of laws. They are summarized by the Guidance on Patient Rights (2004) and the Charter for Users of Long-term and Nursing Care (2006).

Despite the size of the country’s population (82.5 million) and its federalist structures, statutory insurance for health and long-term care as well as other social security branches are regulated by uniform country-wide legislation through the social code book. In SHI, the Federal Joint Committee (consisting of federal associations of providers and payers), have been delegated the task to further refine regulations on benefit coverage, quality assurance, general price regulations. Since 2004, representatives of legitimated patient organizations have a right to participate in the consultations on an ongoing basis and set the agenda, while not being eligible to vote in the final decision-making.

2.1.2 Groups at risk of social exclusion

In 2004, the overall at-risk-of-poverty rate was 13% but was substantially higher in unemployed (42%, above EU average), migrants (24%) and children, yet relatively similar in old age +65 (16%), though women (especially in the western part) are more effected then men (18% vs. 12%). Also, at-risk-of-poverty rate was higher in the eastern versus the western part, partly due to higher unemployment, a higher dependency ratio and lower wages. Overall in-work poverty stood at 5% (National Strategy Report 2006). People with mental health

problems have a high risk of poverty, are less likely to access and remain in the labour market, often due to the early onset and the chronic or recurring course of many types of mental disease (Stoppe et al. 2006).

2.1.3 Methods of this report

Pubmed was searched by a variety of MESH terms and other search terms:

- Germany or Europe or European

Plus different combinations of:

- Access or barrier or hurdle or equity or inequality or variation
- utilization or health services utilization or delivery of health care services or provision or supply or outcome assessment or variations or quality of care or satisfaction
- Coverage or benefit or geographical or organizational or budget or waiting list or rationing or responsive* or health literacy or stigma or discrimination
- Vulnerable or disadvantaged or low income or socioeconomic
- Elderly or geriatric or above 65 or migrant or immigrant or asylum or refugee (for mental disorders see below).

Key-informants were contacted by telephone or mail and asked to provide relevant publications and/or personal experience. A list of key informants, their role or organizational affiliation and their website for further information is provided in the annex.

2.2 Population coverage for health care under public programmes

Inhabitants of Germany are covered by a patchwork of multiple health insurance payers and insurance conditions, which may change over life time. Table 1b

shows that, altogether, about 95% of the population are covered by some kind of public scheme for health insurance, about 5% are covered by substitutive private health insurance and about 0.2% are uninsured.² The figures for long-term care are similar. Table 1a summarizes the main regulations for eligibility, mandatory and voluntary coverage as well as co-insurance.

2.2.1 Main system of coverage: statutory health insurance³

The by far most important system of coverage is the SHI since it covers 72.5 million (88% of the population) (data for 2003).

Eligible to SHI are those with mandatory coverage (78% of the population in 2003) as well as a set of specified occupational or social groups, who are neither obliged to take out SHI nor excluded from SHI, who choose SHI coverage on a voluntary basis (10%). A real choice between SHI and PHI is available to these 10% of the population plus about 3% of the population, who are eligible to SHI (not excluded) but choose PHI. Formerly, this group with choice between SHI and PHI also had the option not to be insured at all. This option has been closed formally by the 2007 reform and shall be fully in effect in 2009.

Mandatory SHI coverage: SHI coverage is mandatory for employees (and their non-dependents) whose gross income is below the so-called income threshold for mandatory insurance (*Versicherungspflichtgrenze*), that is €47 250 per annum or €3900 per month in 2007. This also relates to part-time employees except for those earning less than €400 per month who are exempt from mandatory coverage.⁴ SHI coverage is also mandatory for a set of other occupational and (low income) social groups that have been included in SHI throughout the past decades. This includes retired employees with former SHI coverage and their non-earning spouses, students, participants of other educational or occupational trainings or rehabilitation, disabled with sheltered

² The following coverage data refer to the micro-census of 2003 which surveyed 1% of the population and relates to permanent residents only (that is 81 million out of 82.5 million inhabitants). This survey is somewhat inconsistent with SHI data. An update, refinement and clarification of figures will be available in a few weeks in cooperation with a representative of the Federal Ministry of Health. We aim at compiling a table that would allow to reduce the amount of text in this sub-chapter.

³ SHI includes EU-wide cover under Regulation 1408/71/EEC.

⁴ They usually continue to be co-insured or receive some kind of welfare benefit.

work, as well as recipients of social benefits in case of incapacity to work, unemployment or social assistance. In addition, a few self-employed occupations are eligible to SHI, including farmers, retired farmers and their helping family members as well as artists, journalists and their dependents (for governmental subsidies and reduced contribution rates to SHI for selected groups see 2.4).⁵

Since April 2007, any uninsured person who did not have SHI or PHI before or who was previously SHI insured is mandatorily covered by SHI, except for those who are mainly active as self-employed. This also relates to immigrants who have an allowance to settle down (*Niederlassungserlaubnis*) or an allowance to stay (*Aufenthaltserlaubnis*) for more than 12 months, and who have not been required to earn their own living (and contribute to SHI accordingly). This does neither relate to asylum seekers during the first three years of stay (who continue to have limited benefit coverage) nor to residents of Switzerland, EU member states or EWR countries (who are covered according to EU regulations).

Eligibility to social assistance⁶ (and thereby to SHI benefit coverage except for sick-pay) requires a means test and requires that first grade family members use part of their income first before social assistance is actually granted. Eligible to social assistance are (a) those incapable of work with insufficient incomes (elderly with low pensions, people with mental health problems, mentally disabled and physically disabled) (*Grundversorgung*), and (b) those capable of work but currently unemployed (who received statutory unemployment benefits for one year, who are currently not available to the labour market like single parents for three years after the birth of their last child, or other transient reasons) (*Hartz IV* or *Arbeitslosengeld II*, *ALG II*). Eligibility includes amongst others homeless people. In addition, asylum seekers and refugees who have been in the country for more than three years are entitled to social assistance if

⁵ Exempt from mandatory coverage but eligible to SHI: is (still) available at request within three months for those who newly become subject to mandatory insurance because they now receive earnings below the insurance threshold or unemployment benefits, are in parental leave, in educational training or work in institutions for disabled and have been PHI insured or SHI insured before.

⁶ The term "social assistance" is used in the following text to summarize the following two major types of welfare that resulted from the Hartz IV reforms and that provide the same level of social benefits.

required and to the regular range of SHI benefits. This regulation does not apply to illegal immigrants.

Voluntary SHI coverage: Employees earning above the mandatory insurance threshold can choose to remain voluntarily SHI insured or to change to private health insurance. Since 2007, this applies only when the threshold was exceeded for more than three years during the past five years. Another group for voluntary SHI are self-employed who formerly were SHI insured. In 2003, of those with a choice between SHI and PHI (about 13% of the population) about 10% of the population had chosen voluntary SHI coverage, while about 3% of the population having a choice between SHI and PHI (well earning employees and self-employed with former SHI insurance) had changed to PHI. Those who are opting for voluntary SHI are mainly families or persons planning a family (due to co-insurance regulations for dependents) and chronically ill or disabled (physical or mental) (due to higher risk-related premiums in PHI).

Eligible to co-insurance are spouses⁷ and children⁸ of SHI members if they live in Germany, are not voluntarily insured, earn less than €400 and are not self-employed.

Excluded from SHI (Versicherungsfreiheit) are employees earning less than €400, civil servants and their dependents, other recipients of governmental subsidy or compensation schemes, illegal immigrants, asylum seekers and refugees with a “tolerance” status during their first three years of stay, and immigrants with an allowance of less than one year (unless they are eligible to SHI co-insurance or take part in state acknowledged educational programs). In addition, the self-employed are excluded unless they belong to specific occupations (see above), or unless they prefer to maintain their previous SHI insurance status when changing from employment to self-employment.

⁷ Spouses are marriage partners and common law spouses.

⁸ Children are children of the SHI member and the co-insured spouse including step-children, adopted and foster children or grand-children if grand-parents are the main care-takers. Children are co-insured until 18, or until 23 if unemployed, or until 25 if in education or serving a voluntary social year. Disabled “children” who are unable to earn their living are co-insured without age-limit.

2.2.2 Complementary systems: governmental subsidy or compensation schemes⁹

In 2003, about 7% of the population were eligible to some sort of governmental health coverage. 5% of the population were eligible to subsidies from governmental health care schemes as civil servants, retired civil servants or their dependents. Depending on tariff regulations, these subsidies cover 50-80 % of their health care costs.

Another about 2.2% were covered by other governmental subsidy or compensation schemes, including police and military personnel, victims of national-socialism and veterans. Most recipients of these governmental schemes take out complementary private health insurance to cover the remainder of the cost). This figure also included prisoners, recipients of asylum benefits and recipients of social assistance (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004).

2.2.3 Complementary systems: governmental schemes for asylum seekers, refugees and illegal immigrants¹⁰

In 2005, 211 000 inhabitants (0.26% of the population) were registered as asylum seekers¹¹ and were eligible to a specific governmental scheme which grants lower social benefits at stricter conditions than social assistance. For health care, this means that coverage is limited to acute disease, pain, pregnancy, birth and, in exceptional conditions, for other benefits like dentures. Only when they have stayed in the country for more than three years without a decision being taken, they are eligible to social assistance if required which also involves full SHI coverage. The same regulations apply to refugees for humanitarian reasons (see 3.1).

In addition, illegal immigrants are officially entitled to the same health care benefits as asylum seekers. De facto, however, they mostly do not utilize health

⁹ These programs are administered by the state and do not include EU-wide cover under Regulation 1408/71/EEC.

¹⁰ These programs are administered by the state and do not include EU-wide cover under Regulation 1408/71/EEC.

¹¹ Asylum seekers and about 1.3 other immigrants with non-permanent resident status are not included in the micro-census data since this survey only covers people with permanent residence in Germany.

services because of the fear that their illegal status would be disclosed, and they would have to leave the country (see 3.1) (Bühring 2001). The number of illegal immigrants is estimated at 450 000 by the Central Foreigners' Register (which is included in the overall accounts of 82.5 million inhabitants), while non-governmental organizations estimate their number up to 1 million (Braun et al. 2003) or even 1.5 million.

2.2.4 Complementary systems: private health insurance¹²

Germany is the only country in the European Union, where a substantial part of the population (4.2 million, about 5%) is covered by substitutive private health insurance without contributing to the revenue or pooling mechanisms of the main system of health care coverage.

Altogether, 8 million (about 10% in 2003) were covered by comprehensive private health insurance (Krankheitsvollversicherung) in 2003 (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004). This concerns occupational groups which are excluded by law, like persons with governmental schemes (other than asylum-seekers, refugees, illegal immigrants or prisoners) (about 5% of the population) and self-employed without previous SHI coverage (about 2%). In addition, about 3% were eligible to SHI but opted for PHI coverage (mainly employees with high salaries). While persons with governmental subsidies obtain complementary insurance (covering 20-50% of their health care costs), the others obtain substitutive insurance, which is mostly comprehensive but its actual coverage may differ depending on the contract. The 2007 reform provides that uninsured who were previously PHI insured and self-employed uninsured are obliged to obtain PHI coverage, while PHI insurers are to contract them and offer a basic tariff at an affordable price.

In addition, about 8% of the population have taken out supplementary PHI in addition to their SHI coverage, some hold several insurance policies like daily

¹² These PHI programs do not include EU-wide cover under Regulation 1408/71/EEC.

allowances during hospital stays, supplementary insurance for hospital or ambulatory care (PKV 2004; Wörz et al. 2005).¹³

A recent survey amongst SHI insured showed that people with high incomes held more supplementary and complementary insurance policies than people with low incomes (and that demand may increase in future) (Zok 2005). Thus, policies promoting additional private health insurance through PHI or SHI (as in the 2004 and 2007 reforms) enhance coverage for certain benefits not fully covered by SHI but are likely to enhance socioeconomic inequities in access to privileged services or products in health care.

Over the last ten years, coverage with substitutive and complementary PHI has remained stable due to several interventions to retain high income employees in SHI, including raising the threshold for mandatory insurance or the 2007 reform's requirement of prolonging the time of earning above the income threshold before granting the option to leave SHI.

2.2.5 Long-term care insurance

In 2003, 87.7% of the population were covered by statutory long-term care insurance (SLTCI) insurance, administered by sickness funds. In addition, 10.9% were covered by private health insurance, administered by private health insurers. Statutory and private long-term care insurance are regulated in Social Code Book XI under the term "social long-term care insurance" providing for mandatory membership, the same benefits and the same assessment of need and quality control (though contributions are set by government versus private insurers). In addition, 0.96% of the population were covered by other long-term care insurance arrangements, mainly by governmental schemes for police and military personnel. About 0.3% of the population had no coverage at all. In addition, a comparably small part of the population (0.9%) was taking out complementary private long-term care insurance for costs of care not covered by the main scheme or for daily allowances.

¹³ Furthermore, private foreign travel insurance was taken out by 32% of the population.

2.2.6 People not covered directly by any health care insurance or assistance system

Over the last ten years, the number of uninsureds is estimated to have increased, mainly due to an increase in self-employed with low incomes. In 2003, 188 000 permanent residents (that is 0.2% of the 81 million inhabitants with permanent residency) were not covered by any pre-paid health insurance (Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2004). This share rose to an estimated 300 000 people (0.37%) in the first half of 2005 following the tightening of social benefits and of eligibility criteria to SHI for recipients of unemployment benefits type II (Hartz IV recipients). Spouses and divorced spouses who were formerly co-insured with the recipient found themselves without SHI coverage and were now to insure themselves with SHI or take out PHI or remain uninsured. During the course of the year, this side-effect was partly counter-balanced by new re-insurance regulations for SHI (see below). A similar number of people lacks long-term care insurance arrangements (Rabbata 2005). Data on health insurance coverage among non-permanent residents are not available. The total number of uninsured is therefore unclear and is currently not being monitored by any agency.

Persons not covered by health insurance or long-term care insurance are mainly the self-employed, the formerly privately insured, or the formerly SHI insured who ceased to pay their premiums/contributions (for more than 2 months) and were therefore excluded from coverage. Also affected are spouses and divorced persons, who were formerly SHI-coinsured with Hartz IV recipients and who did not obtain own SHI coverage within 3 months after their divorce. In addition, people who do not access social assistance though eligible and are not covered otherwise by health insurance, remain uninsured. Most uninsured persons are expected to be at risk of poverty and are not eligible to social assistance or do not access it (Rabbata 2005).

Until July 2007, only about 15 000 non-insured had applied to sickness funds (though coverage is mandatory for eligible since April 2007), and 2 200 had applied to PHI (Bernardi, 2007). The larger part of uninsureds is expected to apply to PHI in 2008, when coverage becomes mandatory for those eligible to

PHI. However, it is expected that many will not be able or ready to take the additional financial burden to obtain coverage, rather wait until they require substantial amounts of care and then pay back contributions for a maximum of five years. Financial sanctions will in practice be limited if people's income is too low to comply with them. Lack of meeting financial requirements gives providers the limit benefit delivery as for asylum seekers. Despite affordability policies, the universal obligation to health insurance coverage is expected not to fully translate into a universal entitlement to health insurance.

2.2.7 Policies

Private insurers protest against the legal obligation to contract with their previous insurees and uninsured self-employed. According to the Federal Association of Consumer Agencies, they are currently planning to make tariffs unattractive for potential insurees and providers as well as to file a claim at court once insurance is mandatory for these target groups by 2009. For example, current treatments shall be only included into the benefit coverage when insurees apply for the modified standard tariff by December 2007, but excluded when people apply later. The Minister of Health objects these plans as undue risk selection of chronically ill that contravene legislation which requires to secure a benefit package as in SHI and allows only to differentiate tariffs by age and gender. Private health insurers also want to introduce waiting times for ante-natal care, dental care and psychotherapy of three months after inscription, but from 2008 these shall be extended to eight months (Finanztest 10/2007, p. 65).

In addition, the modified standard tariff (right to voluntary insurance for non-insured July 2007-December 2008) and the basic tariff (obligatory insurance from 2009) are being associated with increased administrative requirements for physicians. These shall be deterred from encouraging their patients to change from their current insurance contract (with 2.3 fold payment and potential benefit limitations) to the new tariff forms (with 1.8 fold payment and SHI benefit package)

2.3 The scope of the health basket

All in-kind benefits covered by SHI are available within the country. Benefits in SHI and governmental schemes may be claimed through administrative procedures and – characteristic for the German system - in separate social courts. Also, decisions taken for SHI or within SHI impact upon other coverage schemes, e.g. governmental schemes and PHI tariffs that provide benefits as in SHI or the alignment of PHI's payment mechanisms to SHI mechanisms for health services in acute hospitals.

2.3.1 Benefits of statutory health insurance

All SHI insureds are eligible to all in-kind benefits legally covered by SHI in case of need from the first day of their insurance until their death or their exit from SHI. Benefit packages of sickness funds. Eligibility is independent of personal characteristics like age and gender (for certain limits see below) or previous and current disease or disability. Eligibility to legal benefits is also independent of sickness fund, the amount of the SHI insured's contributions or income, the number of dependents, their co-insurance status, or their place of living (difference between working and living place, living on the street). Disadvantages in access to nursing care benefits for people living in homes or outside their previous household (with their children) have been abolished by the 2007 reform. Sick pay is available only to contributing insureds (members).

SHI insured are eligible to a comprehensive set of benefits. Indeed, a recent study found the most extensive spectrum of benefits in the German SHI catalogue compared to other OECD countries (Beske et al. 2005).

The following generic types of benefits are currently included by law (Social Code Book V) in the benefit package (see also table A.2):

- prevention of disease, health promotion at the workplace (linked to bonus programs), screening for disease (linked to malus programs since April 2007);

- treatment of disease (ambulatory medical care, dental care, prescription drugs (and certain non-prescription drugs in severe conditions), care provided by allied health professionals, medical devices, inpatient/hospital care, nursing care at home, geriatric rehabilitation at home (since 2007), socio-therapy, palliative care in hospices (from 2007 also in ambulatory care), rehabilitative care, and preventive spa treatment for parents;
- emergency and rescue care, patient transport in certain health conditions;
- certain other benefits like patient information, support of self-help groups or logistic support in case of health care-related harm.

SHI members are entitled to cash benefits in case of maternity and in case of sickness-related absence from work. From day 1 to week 6 of an episode with certified illness, the employer is to continue to pay 100% of the salary. From week 7 to 78, the sickness fund pays about 70 % of the last gross salary. The actual net sick pay depends upon the size of income and tax group. In single-person households, sick-pay amounts on average to 67% of the net salary. This may lead lower income groups fall below or come close to the poverty line. It is not known, how many SHI insureds are affected and how many actually apply for compensatory social assistance if they fall below the line (Mielck, Huber 2005).

Sick pay is also available for parents during the sickness of their children aged below 12.

In addition, sickness funds may extend the range of benefits available to their insureds (as long as these have neither been excluded nor by the Federal Joint Committee) as part of their statutes or as part of contractual agreements for innovative forms of care, including integrated care, family physician care models, or other regional contracts (until 2008) or selective contracts. Yet, access to these coordinated models of care was not provided by all sickness funds, the To homogenize access to special contractual arrangements for the chronically ill, the reform 2007 obliged all sickness funds to provide disease

management programs and family physician care models (with gate-keeping function) to their insureds (Finanztest 2007).

Furthermore, sickness funds may offer private complementary or supplementary co-insurance arrangements in cooperation with private health insurers or by themselves (since 2007). Additional benefits include, for example, complementary therapies not covered by SHI. Thus, access to additional benefits differs between sickness funds.

General gaps in SHI coverage relate to non-prescription drugs, daily amenities for self care (condoms), cosmetic interventions and tattoos (since April 2007, also the treatment of complications from cosmetic and tattoo interventions are excluded). In addition, glasses are excluded unless serious visual impairment exists. Explicitly excluded by law are pharmaceuticals which are intended to increase quality of life like e.g. erectile dysfunctions, hair loss or smoking cessation (Hilfer et al. 2007).

Pharmaceuticals: SHI insureds are eligible to all prescription-only pharmaceuticals as soon as they have been licensed for the particular indication (i.e. there is no positive list), unless they have been excluded or their use has been limited by the Federal Joint Committee. Problems of coverage may occur in case of off-label use unless physicians provide sufficient evidence of efficacy and need. This legal uncertainty may lead to access problems for certain patient groups, especially children, cancer patients, rheumatological and neurological patients, though in practice sickness funds do not question payment for the former two groups. Excluded by law are life-style medications including smoking-cessation and erectile dysfunction treatment. In principal, prescription-free medicines are excluded from the SHI benefit catalogue, except for children below the age of 12 years, for children with developmental disabilities below the age of 18 years, and for prescription-free medicines prescribed because of a severe illness as outlined by the Federal Joint Committee (Busse, Riesberg 2004).

Screening: SHI insureds aged 35 or older are entitled to annual check-ups for cardiovascular and kidney disease as well as diabetes. In addition, adults are

eligible to a defined set of benefits for the early detection or screening programs for cancer.¹⁴ The former is performed on an annual basis (thus more often than international guidelines recommend), the latter on a 2-annual basis (mammography, upon individual invitation) or a 10-annual basis (colonoscopy). Limits for a minimum age apply and differ by type of cancer and gender (Busse, Riesberg 2004). There is no regulatory limit for a maximum age except for the screening programmes with mammography and colonoscopy. Yet, in practice, uptake decreases from the age of 60 for most of the screening services. Uptake is highest among middle class women and lowest among lower class men (Robert Koch-Institut 2006; Statistisches Bundesamt 2006).

Dental services: SHI insureds are eligible to early detection, prophylaxis treatment, basic dental care and dentures (the latter with subsidies only). Visits to the dentists for individual prophylactic treatments are twice a year free of the 10 Euro co-payment for adults. In order to be eligible to bonus regulations for co-payment to dentures, adults are supposed to visit a dentist at least once a year.

Children aged three to six years are entitled to a yearly individual preventive medical check-up of the mouth, the teeth and the jaw. Children between the age of six and eighteen are entitled to a prophylaxis examination twice a year. In addition, group prophylaxis is financed and provided for children younger than 12 years by the SHI funds and public health authorities (§21 SGB V). Children under 6 years are eligible for several dental check up treatments, children above 6 and below 18 years are eligible for a “tooth sealant” and individual prophylaxis is also provided for adults (§22 SGB V). The uptake of the eight preventive examinations decreases by age, starting from 97% at the post-natal examination to 31% for the youth examination. Non-utilizers tend to come from lower social classes, otherwise little is known about their structure, barriers and attitudes (Robert Koch-Institut, Statistisches Bundesamt 2006).

¹⁴ Women above the age of 20, are entitled to examinations for the early detection of cervical cancer; above the age of 30, they are entitled to early detection examinations of the breast and skin and from the age of 50, they have an additional entitlement to early detection examinations of the rectum and of the colon. After the age of 45, men are entitled to examinations for the detection of cancer of the prostate, the external genitals and the skin. After the age of 50, they are entitled to early detection examinations of the rectum and the colon. Since 2003, the existing SHI cancer-screening benefits have been extended to cover colonoscopy (two tests, at age 65 and 75), as an alternative to stool-testing, and a systematic mammography screening programme for women aged 45–64.

For children below the age of twelve years the legislator has obligated the sickness funds to encourage and finance dental prophylaxis for groups in school and nursery school settings. In social groups with an above average danger of caries, group prophylaxis measures are continued on up to the age of sixteen years. This relates e.g. to disabled children or children in socio-economically disadvantaged areas. In practice, children receive educational interventions in their setting, partly they visit the local dentists in attendance of their teacher for regular dental check-ups. The interventions emphasize information on dental hygiene, dental enamel protection and advice on eating habits.

Despite several initiatives, disabled adults are not eligible to group prophylaxis. Dental treatment in this group is limited by the need for home visits with insufficient dental technologies or with transport to a dental practice. Also, payment of dentists is insufficient to meet the complex needs of this group (e.g. due to spasms dental care needs to be performed under specific medication or anesthesia) (Jalali 2007).

Maternity services: Ante-natal care and care during delivery is available to all pregnant women free of co-payments. After delivery, midwife services are covered at home as well as in hospitals, usually for 2 weeks. Beyond this period women are eligible to general gynecologist care. There is no specific demarcation of a postnatal period until the age of six months after delivery. Also, still-births are covered.

Family planning: SHI insureds, that is in fact, young women up to the age of 20 are eligible to prescription-only contraceptives free of cost like oral hormonal contraceptives, the morning-after-pill and the diaphragm. Formally, also injectable contraceptives and the spiral are covered, though these are not recommended for this age group. Women above this age are to pay contraceptives fully out-of-pocket. Condoms are not covered by SHI, neither for primary prevention nor for secondary prevention for people affected by sexually transmittable diseases. That means that young men have little incentives to access SHI-financed family planning, and young women are advised at early age to focus on hormonal or barrier methods. Sexual health advice for young

men is usually performed by general practitioners and paid by SHI via fee-for-service payments for general health advice. The morning-after pill is still only available upon prescription. Care during still-birth and abortion services are covered by SHI. By civil law, abortion requires a certificate of the mother's need from an independent agency (usually NGOs).

Contraceptives including condoms are available free of charge at specific sexual health centres of the local public health office (which often has a stigma of prostitution, marginalized psychiatric people and compulsory interventions) or at non-governmental organizations focusing on family planning (e.g. Pro Familia) and/or HIV prevention (German AIDS Support). Recipients of social assistance are to cover contraception from their regular budget since 2003, while formerly they were eligible to apply for additional financial support. There are no data whether this led to an increase of unmet need for contraception.

Treatment of sexually transmittable diseases (infections and cervical cancer) is mainly performed by SHI-affiliated physicians. Benefits are available according to need. Any licensed medication, including highly active anti-retroviral treatment and related testing of resistance, is available to all SHI insured. Testing for HIV and other STDs is covered upon clinical suspect. Screening for HIV, syphilis and gonorrhea is only available to pregnant women.

Mental health counseling is covered by SHI and is performed either by SHI affiliated psychiatrists, other physicians or psychologists with a special training in conversation therapy, psychoanalysis or behavioral therapy. Other types of treatment are not covered. Treatment is provided in ambulatory care as well as rehabilitation, psychiatric day clinics of hospitals, acute psychiatric or psychosomatic inpatient care and partly in other segments of hospitals. Mental health counseling by SHI affiliated psychologists does not require a prescription but may be accessed directly, though clients need to see a physician for a somatic check-up after the probatory sessions. This regulation was introduced in 1999 to avoid under-provision due to under-recognition by somatically oriented physicians. Treatment may be performed in groups or on a face-to-face basis. It is usually limited for 12 or 30 sessions. Though data are not available, the requirement of certified "treatability" and "treatment prognosis" based on the

therapist's judgment tends to prioritize younger adults with light disorders, little co-morbidity and high educational status, while mentally retarded people, people with severe mental health problems, severe somatic co-morbidity, elderly and people with low educational status tend to be disadvantaged (Bundesverband Psychiatrie-Erfahrene, 2007; Melchinger 2003). Mental health counseling is also covered for children by specially trained ambulatory therapists or in special departments for youth psychiatry or psychosomatic medicine (for capacity problems and inequities see 2.5).

Physiotherapy is available upon prescription only. Eligibility to certain treatments is linked to certain indications by the Federal Joint Committee and usually limited by the number of sessions (usually six at first hand). Ongoing physiotherapy (i.e. in disabled children, stroke patients) requires repeated applications and special examinations. Physiotherapy is usually performed on the therapist's premises though home visits are covered as well. Hospitals and rehabilitation centers also commonly include physiotherapy in their range of services.

Rehabilitation: SHI insureds are entitled to rehabilitation which requires a certificate by the treating physician and an acknowledgement by the sickness fund's medical review board. These entitlements include post-hospital rehabilitative care immediately after major treatment in severe disease, but also interim rehabilitation measures. Since some sickness funds were reluctant to offer these interim services, the 2007 reform has clarified this and obliged all sickness funds to finance rehabilitation, unless another payer is responsible (statutory retirement insurance for employees, statutory accident insurance after work-related accidents or in case of certified occupational disease). Similarly, preventive spa treatment for parents has been made mandatory. In addition, entitlements for specific geriatric rehabilitation at home were introduced. Benefits are usually delivered on an inpatient basis, though ambulatory rehabilitation may be financed as well if locally available (Hilfer et al. 2007).

Home visits: SHI covers home visits by family physicians (general practitioners, internist practicing as family physicians, and pediatricians practicing as family physicians) (Busse, Riesberg 2004). Also, home visits of specialist physicians

and physiotherapists are covered. However, specialists rarely perform home visits since financial incentives are lower than practice-based services (which often involve immobile technologies). Also, pediatricians and internist family physicians perform few home visits due to incentive structures. Since home visits have been integrated into the general practitioners' budgets, the number of home visits is said to have decreased. In addition, SHI covers home nursing for basic care and medical nursing care for 28 days, in exceptional circumstances also for longer. Some sickness funds grant generally longer periods of home nursing care according to their statutes.

Patient transport (see above and 2.5)

Hearing aids and incontinence pads are covered upon prescription by SHI in case of need. However, payment covers standard hearing aids, while improved quality standards require co-payments by patients. The quality of hearing aids covered by SHI has improved during the last years but may continue to be a barrier for poor people to fully participate in social life.

Glasses: Glasses are excluded from SHI coverage except for people with severe vision impairments as defined by the Federal Joint Committee. The costs of glasses' frames are generally not covered by the SHI.

Wheelchairs and Zimmer frames are covered upon prescription by SHI in case of need. This includes specialized wheel-chairs and out-door wheel-chairs. The entitlement includes necessary individual adaptations, the repair of the therapeutic appliance as well as any training to use the appliance. Costs are covered up to a reference price or the rebate negotiated by sickness funds. Additional costs, due to higher prices or higher quality standards are to be paid out-of-pocket. Disadvantages for institutionalized people in need of long-term care concerning the provision of individualized wheel-chairs by SHI have been abolished by the 2007 reform. The former regulations excluded persons (esp. with apallic syndrome) with no certified prospect of improvement by rehabilitation for actively participating in social life. The new regulations allow for the target of passive participation in social life and abolish disadvantages of institutionalized versus persons living at home (Hilfer et al. 2007).

Age-limits: There are no formal limits for a maximum age, except for youth-only preventive services (6,12,18 or 20 years), in-vitro-fertilization (women 40, men 50), and the screening programs for mammography and colonoscopy. Minimum limits exist for early detection and screening programs and geriatric rehabilitation. Also, the malus regulations introduced by the 2007 reform only concern the younger age groups who first become eligible to early detection and screening benefits in 2009 (see 2.7).

Inter-face problems of SHI with social care often arise with social long-term care insurance, especially concerning medical aids and (transient) medical nursing care. In face of unclear responsibilities, providers of institutional long-term care are often not ready to provide the tools and services. Claims against the decision of SHI or providers delayed access to benefits, since family members willing to pay waited for the final decisions before paying out-of-pocket. This does not only relate to the elderly but also to disabled in need of long-term care (Hilfer et al. 2007). The reform 2007 has clarified and extended the range of benefits to be covered by SHI. Also, the clarification of responsibility to finance medical rehabilitation may pose complications in practice.

2.3.2 Benefits of governmental subsidy and compensation schemes

The benefit catalogues of governmental subsidy schemes for civil servants as well as governmental compensation schemes for victims of national-socialism, veterans or other groups are aligned to the SHI benefit catalogue (Grabka 2004: 24). The benefit catalogue for recipients of free governmental health care for the police and the Federal Armed Forces is less formalized than that of the SHI, yet there are no substantial differences to SHI (Busse, Riesberg 2004).

In practice, access to benefits is influenced by the fact that governmental schemes impose little control of treatment practices. Also, most recipients are co-insured by private complementary and/or supplementary health insurance which pays higher prices to providers and similarly imposes less individual controls and no collective cost-containment measures.

2.3.3 Benefits of governmental schemes for asylum seekers, refugees, illegal immigrants and prisoners

By law, health benefits for asylum seekers, refugees and illegal immigrants are limited to the treatment of acute diseases and pain, during pregnancy and birth. Provision with dentures is only paid by municipal social assistance if a delay is not possible. The law also states that medically necessary preventive medical checkups and vaccinations shall be provided. If asylum seekers and refugees have been in the country for more than 36 months, they qualify for social assistance and thereby to comprehensive SHI coverage. The benefits reimbursable for a certain (acute) indication are limited according to the SHI benefit basket and are paid according to the SHI payment scale. However, the process of delivery is not controlled by SHI mechanisms. The provision of additional benefits is up to the discretion of the respective provider (Rabbata 2005; Thomas, 2007).

Although illegal immigrants are officially covered by the same range of benefits, they are more likely to be left with no or little health care due to the legal barriers for disclosure of the non-residence status (Rabbata 2005; Thomas, 2007).

Though public health offices are financed by municipalities or Länder, they may provide low-threshold services to social groups who are either not covered by any prepaid health coverage, do not carry a SHI card or do not (want to) access mainstream health care, including illegal immigrants. Services are legally limited to the diagnosis, prevention and acute treatment of tuberculosis, sexually transmitted infections and other infectious diseases. Yet, in practice many public health offices do not provide treatment of infections themselves. The degree of low-threshold service and acceptance among marginalized groups and the general population depends very much upon the Land's legislation and the office's management (Klee 2007).

Prisoners, by law, shall get all medical necessary benefits, however they are excluded from free choice of physicians and from getting psychotherapy except for forensic psychiatric patients (Merten 2005). A review of health care in

prisons showed that needle exchange programmes continue to be available in one prison project, while other harm reduction projects of the early/mid 1990s in prisons (with international best practice status) have been abolished despite high prevalence of blood-transmittable infections. Outside prisons, harm reduction services are available via municipal or non-governmental arrangements in large metropolitan areas, often in a comprehensive manner. Methadone substitution is available via SHI to drug addicts with severe comorbidity, yet accessible to only a limited number of drug addicted prisoners (Weilandt 2007).¹⁵

2.3.4 Benefits of private health insurance

PHI is characterized by a wide range of types of cover on offer (insurance covering the cost of out-patient treatment, hospital treatment, dental care, daily hospitalization allowances, cover for loss of earnings resulting from sickness, the risk of the need for long-term care, supplementary cover for expenses not borne by statutory insurance, health insurance for travel abroad etc.). Benefits of PHI are largely granted in-kind except for sick-pay and daily allowances during hospital stay or long-term care.

Private health insurers have some freedom to define their own package for substitutive, complementary and supplementary insurance (though jurisdiction has limited this freedom to some extent), except for the legally prescribed substitutive standard tariff (since 2000 for people above 55) and the new standard tariff (from July 2007 for uninsured and currently PHI insureds wishing to change tariff), where privately health insured are entitled to the range of benefits in SHI at the price of average SHI contributions (Busse, Riesberg 2004).

Private health insurers may also adapt the client-specific package by excluding certain services due to previous disease or according to the client's wish. For privately health insured, coverage of benefits depends upon their contractual agreements with the insurer. This may leave them with underinsurance of major

¹⁵ Currently, the legalization of a certain type of heroine as medical substance is being discussed in parliament, which would make it available to severely addicted people via SHI.

fields of care or with certain benefits. Though underinsurance for major types of benefits seems uncommon, respective data are not available.

Benefits generally covered by SHI but not by substitutive PHI packages (or only with additional payment) include cash benefits in maternity or sick pay during the sickness of own children, reproductive services like in-vitro-fertilization, more social services like housekeeping during sickness, more recent innovations in chronic care like socio-therapy, specialist palliative care or geriatric rehabilitation. Also, payment of mental health counseling and rehabilitation may in practice be limited. The range of medical benefits provided by SHI and substitutive PHI differ especially in ambulatory physician services and allied services outside acute hospital care. Inside, they primarily differ little since both type of payers finance acute inpatient care by the same payment system and amount. Differences arise in the number of consultations with head physicians and the level of “hotel services” which are often covered by private substitutive and supplementary insurance (Wörz et al. 2005).

Due to comprehensive SHI, there is little space for those complementary VHI packages that cover benefits that are otherwise uncovered. This includes certain dental treatments fully excluded from SHI coverage (or partly covered) and – less commonly – coverage for non-physician complementary therapists and complementary treatments not covered by SHI (e.g. non-prescription drugs, ambulatory mind-body-therapies) (Dixon et al. 2003).

In practice, access to benefits is influenced by the fact that private health insurers pay higher prices to providers. Due to the reimbursement principles they hardly contract with providers and therefore impose less individual controls and no collective cost-containment measures. This may reduce under-provision and increase over-provision of care (see 2.5.5).

2.3.5 Social long-term care insurance

People insured on a mandatory basis by statutory long-term care insurance and private long-term care insurance are eligible to the same benefits according to the same criteria of need as assessed by the same agency (medical review boards of sickness funds). Recipients may choose between institutional and

ambulatory care when they need long-term care for more than six months. In the latter case they can choose between in-kind benefits or cash benefits (which they may use to pay their informal care-takers) or a combination of both. In-kind benefits relate to basic nursing which is focused on somatic needs. The professional care may be delivered with increased frequency and duration according to the level of need (3 grades plus hardship which may include night-care). In addition, interim care, day care, training for informal care-takers and contributions to their statutory pension are part of the entitlement (Busse, Riesberg 2004).

Demented people have more problems in accessing these benefits due to the mainly somatic criteria for need. Also, the type of benefit and their arrangement in the course of the day often does not meet the needs of demented people. This is associated with a higher level of exhaustion in informal caretakers and a higher level of institutionalization in advanced stages than for people with primarily somatic ailments. Both deficits shall be improved by the planned reform of social long-term care insurance from 2008 .

Groups of that have similar access problems but have been overseen by this reform and the broader public debate concern people with mental health problems and mentally retarded people in need of long-term care – in middle age as well as old age (Aktion Psychisch Kranke 2007).

From 2008 benefits of long-term care shall be available to recipients of long-term care and disability benefits. They shall allow for more flexible arrangements, autonomy and better case management. Pilot projects have been promising, though the uptake was partly low from the side of payers, providers and users (Aktion Psychisch Kranke 2007).

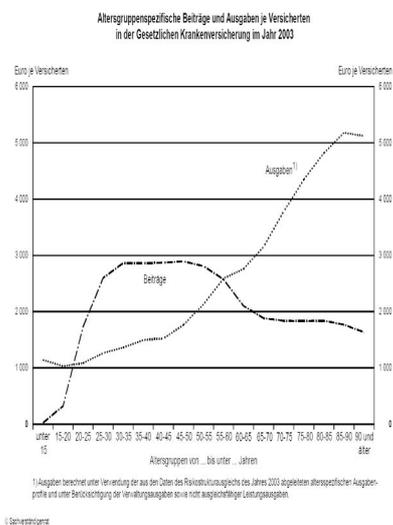
2.4 Cost-related barriers to access

2.4.1 Fundamental policies of financial solidarity and pooling

Contributions and redistribution: The solidarity principle of SHI secures an SHI-internal transfer of money for the same eligibility to (in-kind) health benefits from earning to non-earning SHI insureds (co-insurance), from insureds with low income to those with higher incomes (proportional rates), and from the currently healthy insureds to the currently ill (pay-as-you-go principle). This also implies a redistribution from the young to the old (see

Figure 1). In addition, students receive SHI coverage at a reduced rate, and farmers, artists and journalists received governmental subsidies (while other self-employed are excluded from SHI eligibility).

Figure 1. Contributions and expenditures (in Euro) per SHI insured by age group, 2003



Source: Sachverständigenrat zur Begutachtung der gesamtwirtschaftlichen Entwicklung 2005.

Note: dotted line: contributions, dashed line: expenditures.

The **redistribution among the SHI insureds** of one sickness fund is complemented by a risk structure compensation scheme between all the (competing) funds. Current pooling criteria relate to income (partially), age, gender, the number of recipients receiving incapacity to work benefits and of participants in disease management programs (DMPs) for diabetes (type II and I), breast cancer, ischemic disease/hypertension and chronic obstructive lung disease/asthma. In addition, a high-risk pool for high cost diseases is in place. Since the current scheme does not fully compensate for differences in revenues and morbidity-related need, sickness funds with a high share of poor members (esp. regional sickness funds) are currently still disadvantaged since they still have less revenue to cover benefits for high disease burden than funds, who have attracted a higher rate of wealthy and healthy insureds. This led to increased inter-fund differences in the morbidity structure, which is reflected by a rising share of SHI revenues that were redistributed via the risk structure compensation scheme (from 7.6% in 1996 to 11.1% in 2005) (Busse, Riesberg 2004). Since 2004, this rise was, in part, influenced by the improved adjustment criteria for disease management programs and high-cost diseases (see policies).

2.4.2 Cost-related barriers in SHI

Despite the redistribution mechanisms of solidaric funding and pooling, **proportional contributions to SHI** affect poor households more than richer households, since basic living costs of households are not deduced (which was suggested by the World Health Report 2000 as the most acceptable form of fair health care financing).

Also, in practice, poor people, especially the elderly and little educated, currently pay **higher contribution rates** from their incomes than many others who have changed to a cheaper fund, though the traditional differences between the contribution rates of the different types of sickness funds (blue collars paid more than white collars due to lower earnings and higher morbidity) have been narrowed since the introduction of the risk structure compensation scheme in 1994 and the free choice of funds in 1996 (Busse, Riesberg 2004).

In addition, the German SHI contribution system has a **regressive component** due to the limit for mandatory insurance (€3975 in 2007) above which employees are no longer subject to mandatory SHI health insurance but may choose SHI insurance voluntarily or opt out of SHI and obtain PHI insurance (until the end of 2008 they are also allowed by law not to be health insured at all). In addition, among those mandatorily insured, the maximum contribution limit provides for an additional regressive component. That is people earning between €3562 and €3975 pay the same absolute amount of contributions which represents a deviation from a sheer proportional contribution rate system (as e.g. in France). Furthermore, a regressive component is also supported by the restriction of income sources to salaries and welfare benefits rather than property and other sources of income, due to the use of mainly indirect tax for governmental SHI subsidies, and due to the maximum contribution limit.

The regressive component of SHI financing has been enhanced by an increase of **co-payments** during the last two decades which was one of the strategies of federal health legislation to contain costs in SHI. Virtually all types of in-kind benefits¹⁶ covered by SHI are now liable to co-payments by adults (Table A.3).

2.4.3 Exemption policies

Exemption mechanisms have been in place since co-payments were introduced by federal law. Yet, the current annual ceiling regulations¹⁷ are less “pro-poor” than before 2004, when the general hardship exemption for poor

¹⁶ Since 2004, a co-payment of €10 applies for the first visit to a physician or a psychotherapist plus to the first dentist visit per quarter. Any further, unreferred physician contact during these three months requires again €10, while referred visits do not require further co-payments. Also, €10 are to be paid for any inpatient day (in acute or rehabilitative care, limited until the 28th day). For ambulatory allied health care like physiotherapy, home nursing and socio-therapy, € 10 plus 10% of the cost apply to each prescription which defines the number of sessions required at first hand.

For crowns and dentures, SHI insureds pay 50% of the costs of the “standard treatment” (currently defined for 52 diagnostic findings). When they provide evidence of regular annual preventive visits (and the dentist confirms compliance with personal dental hygiene), co-payment is reduced (to 30% after five years and to 20% after ten years). For any above-standard treatment of the covered diagnostic findings, insureds receive the subsidy for standard treatment from the sickness fund but are to pay the remaining costs out of their pocket. For pharmaceuticals, 10% of the package price are to be paid by the patient, at least €5 and maximum €10. Since 2006, co-payments for pharmaceuticals may be zero for patients if the package obtained is 30% or more below the reference price (physicians are required to inform patients about potential financial impacts of their prescription) (Busse, Riesberg 2004).

¹⁷ Since 2004, an SHI-insured person is eligible for exemption from user charges for SHI benefits if more than 2% of the gross household income per annum has been spent on co-payments, or 1% of the gross household income for a sufferer from a serious chronic illness. Co-payments may be prepaid for the entire year, yet discounts for prepaid charges are not available (and not utilized co-payments may not be reimbursed except when the insured leaves the sickness fund or dies.) Eligible SHI insureds receive a certificate/voucher that they are exempt from further co-payments until the end of the year.

households was abolished. Since then, all exemptions require an application with the sickness fund by the insured or care-taker, which tends to disadvantage people from lower educational background, vision impaireds and people with mental health problems (see Table A4). Also, eligibility criteria for exemptions due to chronic illness were tightened.¹⁸ Children below 12 years and pregnant women continue to be fully exempted. In addition, low income people with “not to be delayed” need for dentures may be fully exempt from co-payments if approved by their sickness fund and delivered by selected contracted providers (Jalali, 2007).

Legal options to lower or avoid co-payments include bonus regulations for utilizing preventive dental care (see above) and participating in disease management programs or family physician models or integrated care models (since 2007 all sickness funds are obliged to offer these care models based on selective contracts). Since 2006, co-payments for pharmaceuticals may be zero for patients if the package obtained is 30% or more below the reference price (physicians are required to inform patients about potential financial impacts of their prescription). Measures impacting upon pharmaceutical prices may impact to a certain degree upon co-payments due to the proportional cost-sharing within the legal range of €5 to €10.¹⁹

Besides the SHI exemption mechanism, **relief from income tax** is granted for out-of-pocket health care spending over €600 per year and over a certain percentage of the annual household income (the “extra burden” also includes spending on disability-related tools and long-term care).

¹⁸ Chronic illness is defined as an ill-health condition that has been treated at least once per quarter for at least a year and is associated with at least one of the following additional characteristics:

- a certified need for long-term care grade II or III
- a certified severe disability of at least 60%
- a certified incapacity to work of at least 60%, or
- a certificate from the treating physician that the omission of continuous health care (at least one physician contact per quarter for the same disease) would cause a life-threatening aggravation, a reduction of life expectancy or a long-term reduction in the quality of life.

¹⁹ This currently includes direct price negotiations (optional for patented drugs since 2007), reference prices (since 2007 optional also for patented drugs), legal rebates for SHI, rebates negotiated by sickness funds, profit margins for whole-salers and pharmacists, aut-idem substitution of pharmaceutical substances by cheaper drugs (unless the prescribing physician explicitly excludes this) and cost-conscious prescribing including of generics.

2.4.4 Evaluation of the 2004 regulations on co-payments and exemptions

The 2007 reform obliged the federal associations of sickness funds to evaluate the impact of co-payments upon SHI-insureds in 2006. The impact of the 2004 and 2006 laws that modified co-payments and exemptions rules are currently being evaluated. A preliminary descriptive analysis of the federal associations of sickness funds shows that, in 2006, co-payments to SHI amounted to about €5 billion, that is about 3% of total SHI expenditure. This decrease is linked to the (and somewhat less than in previous years, especially due to co-payment relaxations for reference priced drugs).

As a consequence of the new exemption regulations from 2004, the number of eligible people was reduced. This affected especially social assistance recipients and others who had been eligible for poverty-related full exemption before. In 2006, about 6.9 million SHI insureds were exempt from co-payments, that is about 10% of the SHI insured population according to the preliminary analysis of the federal associations of sickness funds. Of these, more than 90% had been acknowledged for exemption due to chronic disease; that is who were eligible to exemption after having paid 1% of their household income. The other less than 10% obtained exemption after they had paid 2% of their household income.

Pharmaceutical co-payments account for the largest part of co-payments. They affect the chronically ill and people with expensive medication needs disproportionately. The uneven distribution of need for drugs is illustrated for example by an analysis of the 1.2 million persons insured with the Gmündener substitute fund (GEK) of whom 3% required 50% of the fund's expenditure on pharmaceuticals in 2006, and 25% required 90% of the drug expenditure (GEK 2006). The increase (and modification) of co-payments on drugs by the 2004 reform also led to a decrease in the number of drug prescriptions which were exempt from co-payment. The share of exempted prescriptions decreased from 48% in 2003 to 29% in 2004 (Busse, Riesberg 2004).

Physician co-payments: Evidence on the impact of co-payments on household budgets and health care utilization is mixed. According to the longitudinal socioeconomic panel, the number of ambulatory physician contacts of SHI insureds decreased in 2004 compared to 2003, though the share of those who saw a physicians at least once remained stable. The analysis did not show disadvantages in this respect for people with disability, poor health or low income (Grabka et al. 2006).

Several months after the introduction of the physician co-payment in 2004, several representative population surveys found that the number of unreferral physician contacts had decreased, but indicated that the new co-payment might impact disproportionately upon the care seeking behavior in low income groups (Zok 2005; Braun et al. 2006). In addition, early data from Berlin show that the utilization of emergency units decreased in areas where there a high proportion of recipients of social assistance lived (Meißler 2005).

During the first quarter of 2004, a representative survey among 3 000 adult SHI insureds showed that 11.7 % reported to have avoided or delayed ambulatory physician visits (Zok 2005). This share was substantially higher among insureds with income below €1 000 (19 %) and unemployed (21 %). However, a survey among the same respondents in the first quarter of 2005 showed that a slightly smaller share had avoided or delayed physician visits (9.4%). Yet this effect had decreased to insignificant differences with 8.2 % and 10 % versus 9.4 % avoiding or delaying treatment (Zok 2005). This was probably due to the full operation of the exemption clauses by 2005 and to the increased familiarity with the co-payment regulations. However, in 2005, avoiding visits to save co-payments was still reported by 9.5 % of the respondents. This share was 7 % among the severely ill and 10 % among those who reported mild illness during that period. The subgroup of those who avoided or delayed visits was not further investigated.

Similar to 2004, 42 % of patients had only contacted their family physician. Yet, the number of those seeing only one specialist decreased to 11 %. Of those who saw more than one physician, 84 % (2004: 87 %) went by referral only and 6.9 % (7.1 % in 2004) paid additional co-payment because they went directly

without referral. Paying an additional co-payment was mainly due to unplanned acute reasons and little due to insufficient knowledge about co-payment regulations (Zok 2005).²⁰

A negative impact upon satisfaction with physician care was not observed, when comparing the data for 2005 with a cross-sectional survey from 2002 (when no physician co-payment was required). On the contrary, less patients were dissatisfied with the duration of the physician contact (14.5 % vs. 24.2%), the diagnostic efforts (19.4 % vs. 28.4%), the shared decision-making on treatment (10.7 % vs. 27.0%), and the information about treatment (16.6 % vs. 21.0%) (Zok 2005).

Following the increase of co-payments and the exclusion of SHI benefits, **out-of-pocket expenditures** have increased as a share of total health expenditures from 9.1% in 1992 to 10.8% in 2005. The exclusion of SHI benefits by federal law (especially massage since 1998, funeral cash benefits, glasses and non-prescription medicines since 2004) shifted costs to private households. Other welfare programs were not affected (unless social assistance had to take over). On the contrary, municipal budgets were relaxed by the introduction of the statutory long-term care insurance and an expansion of SHI benefits for nursing care.

Catastrophic household expenditure due to out-of-pocket payments (more than 40% of total household income) affected 0.03% of all households in 2001 (that is about every 330th household). When not only out-of-pocket payments but total spending on health required more than 40% of the household's income this share rose to 0.54% of all households (Murray, Evans 2003). There are no detailed studies which households are affected. It is likely that particularly affected were non-insureds with illness, social assistance households in the first year of (chronifying) illness, those who do not claim exemption, and PHI insured households who impoverish or PHI insured households whose premiums raise due to illness but who had not reached the age of 55 when they could change to

²⁰ In an earlier study in 2000, a survey among SHI insureds who had not applied for exemption but were likely to be eligible, found that one third did not know about the poverty-related full exemption, and two thirds were not aware of the exemption threshold. Among those who were generally informed, most did not think that their income was low enough to be eligible. Others expressed (Eller et al. 2002).

the cheaper standard tariff at the maximum SHI contribution rate. From 2009, PHI insureds below the age of 55 will also be allowed to change to the basic tariff. However, there is some narrative evidence that patients are afraid to change and fear discrimination by their physicians. Also, PHI insurers seem to design the basic tariff in such a bureaucratic way that physicians don't find them attractive and would not recommend them to their patients.

Informal payments are not wide-spread (yet not registered by statistical offices). They are mainly paid to care teams at the end of a hospital stay. Donations in-kind are mainly given to providers during home visits and to physicians in rural areas. Recently, demands of a few head physicians for informal payments as a precondition for receiving a timely consultation date have received wide attention in the press. Except for these exceptional cases there is no evidence that informal co-payments impact negatively upon access to health services.

2.4.5 Cost-related barriers in PHI type of arrangements

In substitutive PHI, premiums are set according to risk, that is current or previous disease and risk factors, age at entry, and gender. Premiums increase to a certain degree with age (and actual morbidity). That is, women, elderly and the ill or disabled are to pay higher premiums than men, the young and healthy. Particularly expensive are premiums for children born disabled.

Since April 2007, sickness funds may offer themselves voluntary tariffs for certain additional benefits and to complement for co-payments (esp. dentures). Most of these schemes require a health risk assessment and thus disadvantage the ill.

Sickness funds may also offer deductible schemes to all insured (not only to voluntarily insureds as before). These new tariffs are also attractive to many sickness funds because subscribing insured are obliged to stay with the respective fund for at least three years even if the contribution rate is raised. Preliminary evaluation of a pilot scheme of the Techniker sickness fund on optional deductibles led to a decrease in the utilization of health care services, especially ambulatory physician visits. The sickness fund also found his

deductibles to be effective to prevent voluntary SHI insureds to change to private health insurance (Putz, Hagist 2006). Yet, the independent consumer magazine Finanztest (2007) found in a survey of current schemes, that some are restricted to the rich, and that ill people would lose money by these arrangements. They also found little transparency.

In addition, the Federal Insurance Office who is to accredit the new insurance schemes, warns that the schemes could affect the financial basis of the major scheme. On this ground, the office declined several applications altogether.

2.4.6 Policies regarding cost-related barriers

However, malus regulations impacting upon access to exemptions from co-payment have also been introduced by the 2007 reform. From August 2007, patients with diseases, for which preventive check-ups, early detection and screening are being covered by SHI, shall not be entitled to the 1% exemption for chronically ill but only to the 2% for all other SHI insured if they are unable to show evidence of regular participation in these services. For chronic diseases assessed by the check-up, this relates only to the (younger) part of the population born after 1972, and for cancer assessed by the legal cancer screening, this relates to women born after April 1987 and for men born after April 1962 (due to reaching the minimum age of eligibility in 2007). For this group of young people, the legislator provides for a life-long lifting to the higher exemption ceiling in case they fall ill from a certain set of diseases. This would then include co-payments for all sorts of benefits and for other diseases as well.

The Federal Joint Committee is currently developing a directive which (generously) interprets the legal requirements of this malus regulation, e.g. by defining exemptions, utilization rhythms and the benefits for which an evidence basis is secured.

From 2009, the inter-fund pooling of SHI contributions and (increasing) governmental subsidies (in a "health fund") shall be strengthened by a complete adjustment for income differences between sickness funds. In addition, a specific adjustment for 50 to 80 ill-health conditions shall better counter-balance inter-fund differences in the morbidity structure. Contribution rates shall no

longer differ by fund but be determined uniformly for all funds by the federal assembly.

However, these “pro poor” regulations are somewhat buffered by the requirement, that sickness funds are to raise additional premiums from their members, if the revenues from the “health fund” are not sufficient to cover their expenditures. Whether in form of absolute amounts or proportional to income, these highly visible premiums shall provide incentives for efficient management and are expected to encourage SHI insureds to change to funds with lower or no additional premiums. Although additional premiums are capped (at individual and overall SHI level) and linked with income-related hardship limitations, the additional premiums are expected to particularly affect sickness funds with a high rate of poor members. To reduce hardship, the additional premium shall not exceed 1% of the member’s contribution relevant income. Except for recipients of social assistance and basic social security, the means test shall not generally be performed, but only when the additional per capita premium exceeds €8 per month.

The expected negative impact of additional premiums upon equity is enhanced by the provision that these premiums shall not be subject to risk structure compensation. Until the features of the morbidity-oriented risk structure compensation have been clarified, sickness funds see little incentives to excel in using selective contracting for purchasing better care for their insureds with high-cost diseases, thereby also attracting similar risk groups from other sickness funds. Instead, they rather prefer nationwide contracting or wait-and-see strategies.

An integration of PHI into the new pooling regulations of SHI, as envisaged by the social-democratic party, did not find the approval of the Christian-democratic coalition partner.

2.5 Geographical barriers of access to health services

There are regional variations in the density of personnel, institutional and technical capacities. In areas with lower density this is associated with less choice (which may impact upon perceived responsiveness) and more requirements for time, transport and cost to the patient and potentially to the accompanying persons. There are substantial differences between rural and metropolitan areas as well as between the Länder. These are largely “legitimated” by criteria for capacity planning that recognize a certain unequal distribution between rural and urban areas. In particular, geographic inequities have been interpreted as as geographic barriers in access to care for psychotherapist care and sub-speciality care (Busse, Riesberg 2004), as well as to dental care, long-term care and allied health services (Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 2001) and emergency care (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2005).

2.5.1 Hospital care

There is no tendency to move hospitals to suburbs. There is a decline in the absolute number of hospitals and there is also a tendency of hospitals to unite and concentrate services.

Concerning acute hospital beds the actual geographic differences among the 16 Länder range between 860 beds per 100 000 inhabitants (Bremen) and 518 beds per 100 000 persons (Schleswig-Holstein). If the 3 Länder with metropolitan areas only (Berlin, Hamburg, Bremen) are excluded, the range between the 13 remaining Länder (with differing size of rural territories) still was 697 (Saarland) to 518 (Schleswig-Holstein) per 100 000 inhabitants in 2004. The density of acute hospital beds was slightly higher in the eastern part than in the western part. In addition, the current level of investments per acute bed is substantially higher in the eastern part than in the western part (except for Brandenburg, the scarcely populated state surrounding the city state of Berlin) (Busse, Riesberg 2004; Wörz et al. 2005).

These pro-east inequities in acute hospital care reflect the agreements of the state treatise 1990 following the German reunification which sought to reduce geographic inequities in acute hospital infrastructure by federal government grants to be used as investments for the modernization of hospitals (As part of the “solidarity contribution” paid by all tax payers in the country until 2015, these grants have been reduced and are no longer earmarked for hospital care. Similar arrangements existed for institutional long-term care while for people with mental health problems a de-hospitalization strategy was supported) (Busse, Riesberg 2004).

Within the Länder, there are substantial rural and urban variations in the density of acute hospitals, hospital beds overall and hospital beds for certain specialities which provides for geographic barriers to those living in rural areas. In particular, tertiary inpatient care and tertiary outpatient care at highly specialized hospitals are largely located in urban areas. The topic of geographical undersupply in certain areas has received, however, both coverage in the media and the attention of relevant political actors (The Federal Ministry for Health and Social Security, the associations of the sickness funds and the associations of the SHI physicians). Several reports were produced which analyzed if there is currently an adequate supply (in particular with ambulatory physicians) and if there will be an adequate supply in the future. A review of these reports concluded that there is an “undersupply” in certain regions which will become more undersupplied without any counteracting measures. Most of these undersupplied regions are located in rural areas of the eastern part of Germany (Rambøll Management 2005: 63).

Still, the overall density of acute hospital beds in Germany is one of the highest in the European Union (WHO 2007). In that sense, it is surprising that according to Eurobarometer data Germany ranks number 9 as far as the percentage of the population is concerned which has access to a hospital within less than 20 minutes (Alber & Kohler 2004: 24). This may in part be related to the medium geographic population density. If all these data are correct, this means that there must be other factors which are more important for proximity to hospitals

than bed capacity. For example: there is a positive correlation between these proximity-to-hospitals data and the population density in the EU.

Van Doorslaer and Masseria et al. (2004) analyzed if there are income inequities in the use of medical services. Concerning nights spent in hospital they found that regional variations (measured as differences between *Länder*) did not contribute to the explanation of inequities which were marginal and not significant (van Doorslaer & Masseria 2004: 22). Andersen and Schwarze found that there are only marginal differences in hospital expenditure for people with different driving times to urban centres (Andersen & Schwarze 2003: 180).

2.5.2 Ambulatory physician care

There are geographic differences in access to ambulatory physician care. Concerning SHI affiliated ambulatory physicians per 100 000 inhabitants the range is between 190 SHI ambulatory physicians per 100 000 persons (Bremen) and 121 SHI ambulatory physicians per 100 000 persons (Brandenburg). Concerning GPs per 100 000 inhabitants the range is between 60 family physicians per 100 000 persons (Bavaria) and 43 family physicians per 100 000 persons in North Rhine Westphalia. Thus, in *Länder* with more rural areas there are relatively more family physicians but substantially less specialist physicians than in *Länder* with mainly urban areas or in city states.

In the eastern part of Germany, the density of general practitioners is higher than in the western part (55 vs. 52). However, the density of ambulatory specialists is substantially lower than in the west (77 vs. 100). Also, the overall density of SHI-affiliated ambulatory physicians (132 vs. 152) and of active physicians in general (323 vs. 386) is lower than in the west. The latter figure supports current debates and a representative survey indicating that hospitals in the eastern part report more problems in filling physician posts than in the western part (80% vs. 43%). In general, recruiting problems are relatively novel but seem to be increasing (Offermanns 2003: 32f). Increasing recruiting problems are also anticipated for the ambulatory sector in rural areas e. g. in Brandenburg, Mecklenburg-Western-Pomerania and North-Rhine Westfalia.

As far as planning for the ambulatory sector is concerned, since 1993 the number and geographical allocation of SHI-affiliated office-based physicians is regulated by guidelines by German self-government. According to these guidelines all planning areas are classified into one of ten groups. These groups range from large metropolitan to rural areas. The “need” (i.e. inhabitants per GP or specialist) per group is defined as the average actual ratio of SHI affiliated office-based physicians working in that group per population as measured in the year 1990. No other factors (e.g. age, gender, morbidity, socioeconomic status or supply of hospital beds) are taken into account in order to measure the concept of “need”. This means that these ratios rather reflect historically evolved structures than the actual “need” for physicians (Wörz & Busse 2005). **Table 1** shows the ratios which show a full satisfaction of “need” as measured by the “needs baseds planning” directive of German self government for four specialities and GPs and three planning areas (large metropolitan areas, rural areas, and the Ruhr area). This would mean e.g. – to take an extreme example – that one needs circa nine times as much psychotherapists in urban areas than in rural areas. So, there is a real problem concerning the appropriate measurement of the concept of “need” as far as the appropriate planning for ambulatory physicians in Germany is concerned.

Table 1: Differences in capacity planning criteria for ambulatory SHI affiliated physician care by type of speciality and geographical type of planning unit, 2004

Type of geographical planning unit ^a	Capacity criteria are met by 100% if x inhabitants are covered by 1 SHI affiliated				
	family physicians	paediatricians	gynaecologists	neurologists/psychiatrists	psychotherapists
large metropolitan areas (e.g. Berlin, Hamburg, Munich)	1 585	14 188	6 916	12 864	2 577
multi-city areas (Ruhr area e.g. Essen, Dortmund)	2 134	19 986	10 686	31 373	8 743
rural areas (e.g. Uckermark, Altmark, Rügen)	1 474	26 505	13 697	46 384	23 106

Source: Kassenärztliche Bundesvereinigung 2005.

Note: ^aThe table shows differences in capacity planning criteria for the 3 most diverse types of geographical planning units out of a total of ten types.

2.5.3 Is access guaranteed for people dependent on public transport?

There is no access guarantee for people who are dependent on public transport. Access to public transport rather deteriorated for people who are dependent upon welfare benefits, since with the introduction of unemployment benefit type II these benefits are paid out as lump sums and the calculated lump sum for transport is rather too small (this is particular the case for children). Therefore regular access to public transport is not guaranteed. In addition, there is no free transport to health care services there is a co-payment for such transport services.

2.5.4 Are ambulance services provided within defined time limits?

Regulations for access to emergency services vary by Land. In 2002, all *Länder* except for the city states Berlin and Hamburg, had provided quantified targets for emergency medical services concerning the maximum time until arrival at the place of accident. Three *Länder* (Bavaria, North Rhine Westfalia and Thuringia) explicitly allow for lower standards in rural areas compared to urban areas with maximum times ranging from 12-17 minutes compared to 8-14 minutes. In all other *Länder*, no difference was made between urban and rural areas. The maximum time until arrival at the place of accident ranges from 10 to 15 minutes. Yet, nine *Länder* allow for exceptions (e.g. in 5% of all cases) (Schmiedel & Behrendt 2002: 60). In order to achieve similar arrival times, higher investments per inhabitant are required in rural than in urban areas. Research for (the largely rural) Brandenburg showed that costs per life saved were 2.6 higher in rural areas than in urban areas (Felder & Brinkmann 2002: 43f.).

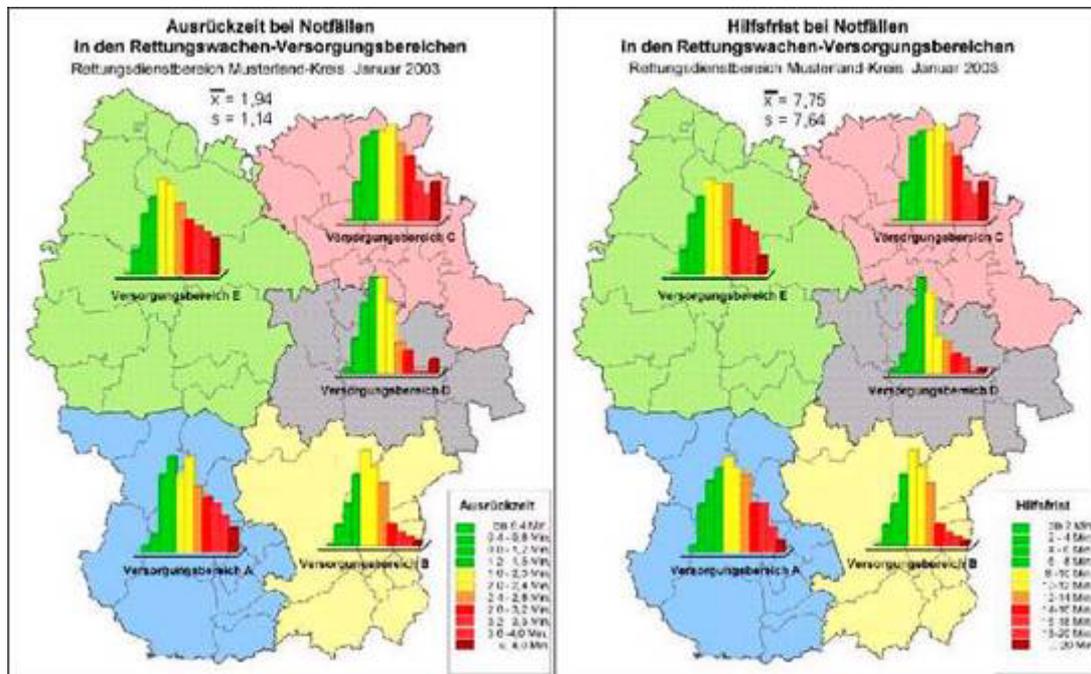
In 2000/2001, emergency medical services arrived at the place of emergency in 30% of the emergencies within 5 minutes, in 72% within 10 minutes, and in 89% arrived within 15 minutes. For 11% of the emergencies, medical help arrived later. The speed of arrival had worsened compared to 1990/1991 (with 36%, 77% and 91% respectively) (Schmiedel & Behrendt 2002: 73).

In 2003, (non-medical) rescue services arrived at the place of emergency on average 7.8 minutes after the call was received, though arrival times differed widely. **Figure 3** shows that about one third of all emergencies were not reached within 14 minutes in the north-eastern part, and somewhat less in the north-western part, but only one fifth was affected in the mid- and south-eastern part. While these cumulative figures partly reflect the extent of rural areas in the different parts of the country, they also result from a slower reaction upon the call for help and thus from organizational delays (**Figure 2, Figure 3**). Information on smaller planning units and rural/urban differences are not available. Access barriers to timely emergency care may also occur when calls for personal emergencies and material damage are received via the same telephone line, e.g. in Berlin where calls for emergency care (provided by firework services) have been blocked by calls to help with flooded cellars after strong rains.

The outcome of differences in rescue times has not been studied systematically. Yet, several studies have shown that disparities in geographic access to appropriate emergency care lead to worse outcomes in stroke and myocardial infarction (Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 2001, 2003).

Figure 2. Percentage of rescue services being ready to leave within x minutes by aggregated planning district, January 2003

Figure 3. Percentage of rescue services having arrived at the place of emergency within x minutes by aggregated planning district, January 2003



Source: Schmiedel & Behrendt 2007.

2.5.5 Policies

Several policy measures have been implemented in order to counteract geographic inequities.

- Coverage of transport has been reduced by the 2004 reform and co-payments increased. Now, also children are to pay co-payment to transport. Still, SHI benefits include transport with emergency and rescue services, transport to specific ambulatory treatments e.g. dialysis and chemotherapy. In other conditions, transport may also be covered but requires a certificate of medical need from the treating physician who also determines which type of transport is required.

- Some model projects started which work with “community medicine nurses”. These are intended to substitute some of the work which is so far done by physicians. Until now there are no evaluations of these model projects.
- Regulations have been liberalized by law, which makes it easier for ambulatory physicians to employ other physicians and/or start branches in neighboring areas.
- The regional associations of SHI physicians (which are responsible for service planning) have been forced to act more rapidly in case of undersupply of planning areas (for planning of ambulatory services see also below).

2.6 Organizational barriers

2.6.1 Waiting lists and waiting times

Except for transplantations there is no obligation for institutions to document waiting lists. Many hospitals, rehabilitation centers and elderly homes use a waiting list for their own organizational purposes but these are usually not reported externally (Busse, Riesberg 2004). Politically, waiting lists have long been considered to be no problem in German health care, the fear of waiting lists motivated policies of high capacities (Organisation for Economic Co-operation and Development 2003; Stapf-Finé & Schölkopf 2003). In OECD comparison the rate of inpatient elective surgeries and interventions is comparably high in Germany. This relates to PTCA and CABG (OECD 2003, 2007) as well as to cataract surgery, knee replacement and hip replacement.

The high frequency of interventions translates in a relatively high satisfaction with waiting times in chronically ill and primary care physicians compared with other OECD countries (Schoen et al. 2005, 2006).

2.6.2 Private and statutory health insurance

The unequal geographic distribution of the population's salaries impacts upon the number of privately health insured in a given region as well as the amount of SHI revenues that is used for provider payment. In addition, in poor areas the willingness to pay out-of-pocket for services not covered by SHI is limited. Yet, the burden of disease is higher in these areas than in better-off areas. Physicians working in rural areas and poor urban areas thus have lower income prospects than their counterparts in rich areas. Thus, organizational arrangements interact and reinforce geographic disparities.

Policies determining PHI coverage rates thus matter to the overall governance of the health system, since PHI pays higher prices to providers (usually 2.3 times more than SHI) and for medical products (no SHI rebates) with less administrative requirements and control of efficiency or quality, which provides some incentives for providers to prioritize PHI patients over SHI patients.

In inpatient care, privately health insured usually obtain smaller rooms (1-2 beds) and are mainly treated by the head physician. Otherwise there are virtually no differences in the inpatient sector between the two kinds of insurance, since the expenditure for normal inpatient treatment of the PHI is contained within a hospital budget and also there is identical reimbursement of the two kinds of insurance for regular inpatient treatment. This means a hospital does not have an incentive to try to attract people with PHI (this is different for the head physicians as they charge their personal services, on contrast to SHI, separately to PHI patients). However, hospitals do have an incentive to attract patients from abroad, since their payments are extra and not contained in the budgets. Therefore many German hospitals try to attract patients from other countries.

Things are different in the ambulatory sector. There, SHI budgets and PHI expenditure are separated. In addition, the reimbursement for people with PHI is higher than for people with SHI. If ambulatory physicians transgress their SHI-budgets, they have a financial disincentive to treat insured in the SHI. So their incentive to treat people with PHI (in addition to higher reimbursement)

gets even stronger. There is anecdotal evidence (and also coverage in the media) that ambulatory physicians (and dentists) organize their practices in such a way that insurees in PHI are preferred over SHI insureds.

However, there is no evidence that PHI insured use services more often than SHI insured. On the contrary: Three studies show that PHI insured use ambulatory physician services less often than SHI insured (Bergmann & Kamtsiuris 1999; Lungen et al. 2005; Ulrich & Schneider 2004) whereas one study results in no difference of utilization patterns between the two kinds of insurance (Thode et al. 2005: 304). It is not clear why people with PHI tend to use services less than people with SHI. One apparent explanation is that they are generally simply healthier than people with SHI and contact physicians therefore less often. In addition they might face higher occupational opportunity costs and have sometimes financial incentives (in the form of no-claim bonuses or cost sharing arrangements) to avoid physician contact (Lungen et al. 2005: 28f.; Ulrich & Schneider 2004: 83).

There is some evidence that SHI budgeting of drugs leads to better access of people with substitutive PHI to pharmaceutical treatment. A study analyzed the provision of patients with sumatriptan, a drug for the acute treatment of migraine (data refer to the year 1994). It found that insurees in PHI were 2.3 times more likely to receive sumatriptan than insurees in SHI (Krobot et al. 2004). The study assumes that the reasons for SHI-PHI disparities are probably multifactorial: Besides budgeting in SHI, insurees in the PHI in general are better educated, enjoy socio-economic privileges and might therefore learn about medical innovations earlier and can demand them more successfully. In addition PHI patients bring more revenue to physicians (Krobot et al. 2004: 489).

Another study with more recent data (referring to the year 2001) which compared expenditure data on sumatriptan and prevalence of severe migraine estimated that there is considerable underuse of sumatriptan and that there should be additional expenditure of ca. 170 mio. € in the SHI. However, it did not come up with data for PHI (Dietrich et al. 2003: 70f.). This study also reported considerable under-use of several other pharmaceuticals. For example, there is in principle coverage of beta interferon for people with multiple

sclerosis. This study estimated that there is under-use of beta interferon and an additional need of 200 mio. € for beta interferon (Dietrich et al. 2003: 43f.). It does not contain explanations if this lack of expenditure is due to budget or e.g. inefficient allocation of resources. In addition, as already mentioned, it doesn't analyze data for the PHI.

Studies of the PHI federation found that PHI insureds are prescribed less generics than SHI insured (PKV 2007). Also, differences in expenditures between PHI and SHI were found to be mainly associated with PHI paying higher prices to providers and for drugs (PKV 2007a). While a few innovative drugs were more often prescribed to PHI insured, these related to fields where good alternatives are available. The fundamental innovations were evenly distributed between SHI and PHI.

In SHI, budgets for drugs in combination with ex-post prescription controls and ex-ante agreements on prescription targets pose a potential for rationing drug prescriptions in ambulatory care. For example in Lower Saxony, 825 out of 9200 SHI affiliated ambulatory physician practices (9%) face claims for refunding (Richtgrößenprüfung) related to exceeding apriori defined quantitative prescription targets, inefficient prescribing or prescribing of drugs excluded for coverage. Overall the potential refunding claimed by sickness funds for 2003 to 2005 in that region amount to €106.5 million with a maximum of €600 000 for a single practice. If physicians can prove during the review process that the prescription was necessary, that they choose a relatively cheap version of the substance, and that the substance was not excluded from SHI coverage, they do not have to pay back. The 2007 law provides that claims for the time before 2006 which have not been reviewed and set correctly by the end of 2007 become outdated, and that in future any claim needs to be settled latest within 2 years after the prescribing year. This shall shorten the period of uncertainty for physicians whether they are to face refund claims (Gesundheitspolitischer Informationsdienst 2007).

The budget-related constraints may be increased by the so-called bonus-malus-regulation for pharmaceutical prescriptions, which was introduced by the Pharmaceutical Prescription Efficiency Act in 2006. Individual ambulatory SHI

affiliated physicians may be sanctioned (malus) if his prescriptions exceed the ex ante defined amount of expenditures by more than 10%. When total pharmaceutical expenditures remain below the ex ante defined limit in a certain region, sickness funds are to pay a bonus to the regional physicians' association which is to redistribute the bonus to physicians who have prescribed in an efficient manner.

As an alternative to the bonus-malus regulation, regional physicians' associations may implement other measures if these obtain similar savings as the bonus-malus regulation. This exemption was inserted in the law to meet the substantial criticism from physicians' organizations.

2.7 Interlinkages and overarching policy initiatives (Phase 2)

2.7.1 Overarching policies

The 'principle of the social state' which is laid down in the German constitution implies that the state guarantees its citizens an existential minimum of standard of living. This implies also that the state guarantees access to health care provision which is reflected by the public assistance programme which provides its recipients with SHI coverage. More important and more detailed are the legal regulations concerning the SHI, since this affects ca. 90% of the population. The Social Code Book which is the regulatory framework for Germany's SHI system contains the following principles concerning access and equity:

- The SHI has the task to maintain, restore or improve the health of the insured.
- The provision of services and their financing has to be based on the principle of solidarity. The principle of solidarity has the following features:
- contributions proportional to income up to an income threshold and free insurance of family members who are not gainfully employed;

- no differentiation of contribution rates according to age, sex or health risk;
- provision of medically necessary services according to the principle of appropriateness in a sufficient and efficient way.

Sickness funds and service providers have to guarantee a needs-based and consistent provision of services which meets the standards of medical knowledge. Health care for the insured has to be sufficient and expedient, must not be in excess of what is medically necessary, and has to be provided efficiently, humanely, and up to the required quality. SHI insureds may claim their individual rights at specific social courts. Their collective rights are represented by elected (or nominated) SHI representatives within the self-governmental decision-making structures of the sickness funds and their associations.

There are no overarching policy initiatives which address all seven areas of equality of access to health care services as analysed above at the same time. Yet, there is the Federal Health Target Programme which contains six health targets (a seventh is being developed currently). These have been consented by a committee where the major stakeholders of the German healthcare system are represented including federal and Länder governments, provider organizations, sickness fund associations, patient associations and. While some of the strategies of the programme address health issues in settings outside health care (e.g. schools), policies of other sectors are not being. Policy fields outside health care are not tackled by this Target Programme, for example traffic, social or educational policies.

2.7.2 Impact of other sectoral policies upon health care access

Labour, social and economic policies impact upon access to health care in as far as they affect personal income, mandatory coverage and, in general, the affordability of health care. A major negative impact on health care coverage was observed following the exclusion from coverage for a set of recipients due to social policies reforming eligibility to unemployment insurance and social assistance in 2005 (see 2.2).

Good social policies help to improve access to and the appropriateness of health care and reduce unnecessary health care, for example, good social care for people with mental health problems is widely agreed to reduce hospitalizations, particularly forced hospitalizations (Priebe et al. 2005). Good nutrition in institutional settings and work-places help to improve nutritional status and improve dental health in severely disabled and employees.

In contrast, the current social assistance level was found to be insufficient to provide healthy nutrition to children (Deutsche Gesellschaft für Ernährung 2007). As a consequence, the political debates has taken up the long-standing demand of welfare organizations to calculate the need for children and youth specifically, while currently a level of 60% of a single adult is assumed for children below 14 and of 80% for youth aged 14-17. In addition, the recent rise in food prices has triggered demands to increase social assistance according to the consumer price index and not according to the – politically determined – increase of pensions.

Some immigration policies have impacted upon access to health care in the past. Immigrant policies have impacted upon health care especially in 1993 (Asylbewerberleistungsgesetz) when asylum seekers were excluded from general social assistance and provided with a separate, less generous welfare scheme. Another issue concerns the ongoing administrative hurdles for illegal immigrants to utilize health care services and other social services. While this has not been a political priority, illegal immigration has been addressed in specific branches. This concerns health care in as far as the German government made waiver agreements with eastern European governments to legalize informal care-takers supporting elderly in need of long-term care in their homes, thereby improving access to long-term care for persons in need of care (also for their caretakers?). The overarching Integration Programme for Immigrants 2007 of the federal government provides a list of ten priorities which focus on access to labour and education. Health care is mentioned as a potential field of improving integration in the broader background document, where actors are encourage to voluntarily promote integration of immigrants in their sphere of influence. Progress in this respect shall be evaluated in 2008 .

Other immigration policies may impact upon health care access in future. According to the 2007 immigration act from July 2007 (which translates 11 EU directives into national law to harmonize asylum policies) refugees with a long-term tolerance status have been given the prospect of a formal resident status if they are under employment by the end of 2009. This regulation will provide those who obtained employment and their families with the general right and duty to obtain comprehensive health insurance coverage.

At the second integration summit in July 2007, the federal government published a national program for the integration of immigrants which had been developed in cooperation with a broad set of stakeholders including state and local governments, immigrant organizations, media and associations of industry, culture and sports. The national action plan outlines 400 recommendations in ten priority fields, mainly in employment, education and language skills. The recommendations are regarded as self-obligations on a voluntary basis. Their realization shall be evaluated at the next integration summit in 2008. Organizations of health care providers and payers were not involved, and access to health care mentioned on a general level. Ahead of the National Action Plan, the Ombudsperson of the Federal Government for Migration, Refugees and Integration, had issued a Charter of Multiplicity in December 2006 in cooperation with four large German companies, in order to foster the employment of employees with immigrant background. By May 2007, another 30 companies, public media and non-governmental organizations had accessed the charter. Similarly to the integration summit, payers or providers in health care or long-term care have not yet accessed the charter.

Internal affairs policies impact upon access to health care for prisoners. Prisoner initiatives and researchers assume that the decentralization of competencies in prison management (Federalism Reform) in 2005 will affect the quality of care in prisons negatively in most Länder. Germany is the only country in the European Union which does not take part in the Healthy Prison Initiative of the WHO.

Traffic policies affect the potential to actually reach health services by the comprehensiveness and timing of the public transport system. This relates

particularly to disabled, the frail elderly, children and their families, and potentially to asylum seekers whose circle of mobility is restricted to their district of living. They also affect the affordability of accessing health care. In most cities, affordability was reduced for the poor during the last decade due to price increases and a reduction in exemption rules and subsidy provisions. The potential of policy-makers to influence transport affordability is somewhat reduced by privatization policies. The actual impact of traffic policies upon health care access has not been evaluated.

2.7.3 Major challenges from a political, public and personal perspective

Political priorities have been concerned with universal access to health insurance (2007 reform) and the reduction of current under-provision with SHI affiliated ambulatory physicians in rural areas of the eastern part and the risk of future under-provision due to a retirement wave, expected for the next years. Also, the enhancement of quality assurance measures, equal treatment regimes and exemption rules sought to buffer negative effects of increasing competition and cost-containment.

In the public opinion, cost-related barriers and the actual access to benefits of the SHI benefit catalogue. Rationing is an [ubiquitous](#) catchword in public and political debates, although there has been relatively little documentation or research on this issue.

For individual patients, denial of benefits and lack of provider responsiveness matter most.

In my view and in alignment with the ACCESS report on Germany (Wörz et al. 2005), the main concern relates to the organizational hurdle of providers limiting the actual provision of eligible benefits in SHI at the micro-level, although, formally, the delivery or prescription medically necessary benefits (of a relatively cheap price) may not be subject to sanctions. In addition, limitations to the granting of benefits at micro-level on the payer side should be considered. The most striking disadvantages in coverage and benefits relate to illegal immigrants, asylum seekers and refugees with “tolerance status” though their

number is low and social status is weak. These issues deserve more political and scientific attention. Concerning policies other than health care, educational policies for socio-economically disadvantaged children, particularly migrant children, seem to be of utmost importance for current and future health and socio-economic well being.

2.8 Conclusions (Phase 2)

Coverage-related barriers mainly affect illegal immigrants and self-employed with precarious income at risk of poverty in work (while those receiving social assistance are usually covered). The 2007 reform introduced a universal obligation to health insurance coverage. Despite hardship regulations and sanctions, not all uninsured are expected to be able or ready to meet this obligation.

Benefit-related barriers mainly affect asylum seekers and refugees due to legal restrictions to the benefit basket. Illegal immigrants, due to the risk of expulsion after requesting funds from social assistance, often have to rely on the voluntariness of providers, which is likely to limit access to high cost interventions and continuous treatment. Demented persons are disadvantaged in statutory and private long-term care insurance due to their focus on somatic eligibility criteria. Interface problems with social care and long-term care particularly affect people with mental health problems and the mentally disabled. SHI insured are more exposed to under-provision of care than PHI insured, while PHI insured are more exposed to overprovision of care, except for those whose contracts cover only certain benefits in order to limit costs.

Cost-related barriers mainly affect the adult at risk of poverty despite exemption schemes. Co-payments particularly affect the SHI insured non-institutionalized population, especially those mentally or physically disabled who lack the bureaucratic competencies (or the social support) to provide the bills required for applying for hardship exemption. In PHI, deductibles and increasing risk-related premiums mainly affect the elderly (who fear discrimination when changing to the standard tariff with lower premiums and provider payment),

chronically ill and families with disabled children. Additional PHI coverage is more taken up by rich than by poor people.

Geographic barriers mainly affect (physically as well as mentally) disabled persons, people with mental health problems and children, particularly in rural areas. In the eastern part of Germany, access to ambulatory specialists and mental health care is more limited than in the western part. Limitations to transport coverage (in all schemes) particularly affect the poor and non-institutionalized people with mental health problems (due to disadvantages in being granted the status of severely disabled and related eligibility to free transport).

Organizational barriers are largely related to cost-containment measures (budgets, prescription controls) and the providers' as well as payers' way of responding to them. Rationing at micro-level affect the SHI insured more than the PHI insured, particularly in ambulatory care.

Lack of supply-side responsiveness particularly affects illegal immigrants (fear of sanctions) and other migrants (resulting in less satisfaction with – culturally sensitive – care), people with mental health problems and the mentally disabled (including elderly). In cases of complex morbidity with mental illness or disability, under-diagnosis, under-treatment and service delusion are more likely to occur than in less stigmatizing single somatic disease. In the scase of people with mental health problems and migrants, conflicts arise more commonly and – due to insufficient training – and may provoke latent discriminatory attitudes and inappropriate provider behavior.

Demand-side barriers are particularly relevant for illegal immigrants and for people with mental health problems and for certain groups of elderly with disabilities, legal migrants and children. Most members of these groups have limited health care literacy and health literacy. Since the new options for patient information and choice of insurer and choice of care models do not specifically address these groups, the gap in health literacy has increased compared to privileged groups in society.

Main policy trends to improve access and remove barriers include the universal obligation to health insurance coverage (2007 reform), the introduction of new SHI benefits targeted at the needs of people with mental health problems, geriatric patients and socio-economically disadvantaged groups (setting approach to prevention), pilot projects and research tender and political plans to improve eligibility criteria for long-term care insurance and improve care for demented people, subsidies for contributions/premiums and exemption schemes for co-payments, tighter planning criteria and incentives to reduce under-provision of ambulatory physician care and the flexibilization of ambulatory physician practice (branch offices, employment of additional physicians), shifting the morbidity risk from ambulatory physicians to sickness funds and improving the risk structure compensation scheme (from 2009), increase of qualifications for mental care and geriatric care, increase of provider information and quality regulations, introduction of socio-therapy to encourage utilization of care of people with severe mental health problems as well as anti-stigma campaigns (mainly targeted at the general public), an increase of patient information (partly in several languages and barrier-free) and collective patients' rights.

Good practice initiatives: Encouragement of mutual learning among prevention projects which are targeted at socio-economically disadvantaged groups (database and network), training of professionals for conflict resolution, local alliances against depression and other awareness projects on mental illness, increase of interpreter services in health care and "scout services" from migrants for migrant patients.

3 Improving quality of and access to health care for people at risk of poverty or social exclusion

3.1 Migrant population, asylum seekers and illegal immigrants

3.1.1 Definition and living conditions of migrants

According to the microcensus 2005,²¹ 18.6% of the inhabitants (15.3 million) have an immigration background. People with immigration background include

- 10.4 million (12.6% of the population) with personal migration experience, who immigrated since 1950²²;
- 4.9 million (5.9 % of the population) who were born in Germany and have at least one parent who had personal immigration experience (2nd generation) or who was born as foreigner in Germany (3rd generation).

This includes about 1 million ethnic Germans who immigrated after 1999 from eastern European countries and the former Soviet Union, but does not include about 2 million ethnic Germans from countries of the former Soviet Union who immigrated before 1999 and obtained citizenship until then.

In the population below 40, the share of people with immigrant background was nearly 40% in 2005, and in the age below 5 years, every third has an immigration background. In 10% of the marriages a person with immigration background is involved.

With regard to citizenship, 9.7% of the population (8.0 million) were German citizens and 8.8% (7.3 million) had a foreign citizenship. Of those born in

²¹ The microcensus is a representative survey of 1% of the households and includes all inhabitants, also children and other people living in institutions, immigrants with non-permanent status which, includes in principle also illegal immigrants. Excluded from the survey are a few foreign-passport holders with a specific status, mainly diplomats. The 2005 survey focussed on immigration issues and reviewed the immigration background for the first time. The results were published ahead of the 2nd National Integration Summit in July 2007 (Statistisches Bundesamt 2007). Further details on the legal status and language skills were not surveyed. Differences in the overall number of foreign passport holders compared with the Central Foreigners' Register may result from selection bias of the 1% survey sample or may in fact hint at a higher number of illegal immigrants (e.g. 1 million) living in the country.

²² This includes the 1.8 million ethnic Germans who immigrated from countries of the former Soviet Union and eastern Europe, mainly Romania and Poland since 1999. This does not include those who immigrated before (e.g. 2.4 million between 1960 and 1998). According to the OECD's definition, the number of foreign-born persons living in Germany would be about 13-14 million (15.8%-16.9% of the population).

Germany, 40% still had a foreigner status and 60% held German citizenship (1.7 vs. 2.6 million). This ratio was 54% versus 56% among people with personal immigration experience (5.6 vs. 10.4 million). On average, people with personal immigration experience have been living in Germany for 18.5 years.

On average, people with immigration background differ from people without by a younger age, a higher number of men and singles, a lower educational and professional level a. o. a higher unemployment rate, a lower participation rate in the labor force, especially among women, and a lower educational as well as professional level (Statistisches Bundesamt 2007).

Among the foreign passport holders, 8.2 % of the inhabitants (6.8 million) were officially registered by the Central Foreigners' Register to hold a foreign passport in December 2006 (Statistisches Bundesamt March 2007). The majority of them, about 6.8 % of the population (5.7 million), had a permanent resident status, while 1.4% (1.1 million) had a non-permanent resident status. Among the non-permanent residents were 150 000 refugees seeking asylum for humanitarian or political reasons or under international law (0.2% of the population) and 165 000 people (another 0.2% of the population) who had been assigned with exceptional leave to remain for humanitarian reasons, mainly refugees from countries affected by war and civil war (tolerance status). The number of "illegal immigrants", officially defined as persons with neither a legal residence status nor a "tolerance" status or an "allowance", was documented at 445 070 (0.4 % of the population) according to the Foreigners' Central Register and is included in the overall number of immigrants (Statistisches Bundesamt , March 2007). However, welfare organizations estimate that the number of "illegal immigrants" could be up to 1.5 million (Rabbata 2006).

Among those with personal immigration experience, nearly 62% have immigrated from eastern Europe. Altogether, about 200 ethnic minorities are living in Germany.

In addition, about 3 million ethnic Germans from the former Soviet Union and eastern Europe have immigrated into Germany since 1988. Most of them obtained citizenship before 1999. Despite German ethnic origin and a

favourable legal status and socioeconomic support, this group experiences difficulties relating to language (elder generation), social and labour integration (younger generation).

Among the foreign passport holders, the largest group originates from Turkey (2.0 million), followed by the former Yugoslavia (627 000) and Italy (616 000).

3.1.2 Immigrants and health

According to the microcensus 2005, the number of people reporting to have had an illness or accident in the twelve months was lower among people with immigrant background than among people without immigrant background (10.7% vs. 13.2%). This was mainly related to the younger age structure of the immigrant population though underrecognition of disease and different reporting behaviour may also play a role (see below). The lower share of people with immigrant background reporting illness and accidents was found within all age groups except for the elderly above 65 where people with immigrant background were more often affected (**Table 2**).

In ethnic Germans from the former Soviet Union, health satisfaction was observed to deteriorate quickly after immigration (though starting from a better level than in the German background control group, and though socio-economic status improved (Razum et al. 2004). Overall, the age-standardized mortality rate from cardiovascular disease was lower in ethnic Germans than in the non-immigrant population (Becher et al. 2007).

Other studies from a population-based database in the region of Augsburg showed that ethnic Germans perceived their health worse than other migrants (Aparicio et al. 2005; Wittig et al. 2005). They were more likely to be obese, not to exercise and to have hyperlipidemia. Yet, differences decreased with the length of stay in Germany (Aparicio et al. 2005).

3.1.3 Immigrants and utilization of health care

Despite the higher share of reported illness and accidents among the 65+ surveyed in the microcensus 2005, more elderly with immigrant background

reported not to have accessed the health system for the reported ailment compared to people without immigrant background (7.9% vs. 5.9%). A lower utilization was also observed in the total immigrant population (11.6% vs. 10.1%). People with immigrant background had a lower hospital admission rate (mainly relating to the younger age structure of those born in Germany), while the ambulatory utilization rate was slightly higher than in the non-immigrant population. Characteristically for the German health system with many practice based specialists, the overall number of visits to hospital outpatient clinics was low. The share of hospital outpatient clinic users was highest among people with foreign citizenship (Statistisches Bundesamt 2007). This may be consistent with previous (smaller) studies that found that immigrants utilize emergency units more frequently, mainly for complaints that could be treated by ambulatory physicians during regular hours, and partly for protracted stages of disease (Lampert, Ziese 2005). Non-German ethnicity was also found to be a predictor for inappropriate utilization of emergency care units at three internist emergency outpatient departments of hospitals in a study of 4930 patients in 2001/2002. Appropriate utilization was defined relatively strictly by meeting two out of four criteria (urgency as assessed by the treating physician, hospital admission, performance of technical diagnostic tests in the hospital, utilization of a mobile rescue or emergency physician service). Altogether 43% of the emergency unit patients did not meet these appropriateness criteria (David et al 2006b). Yet, in an analysis of a sample of 815 patients of internist and gynaecological emergency units in Berlin, ethnicity did not predict the appropriateness of emergency outpatient services, nor did this influence the likelihood of subsequent hospital admissions (David et al. 2006a).

Table 2. Reported health, health risk and health care utilization by immigration status (in 1000 or percent), 2005

	Total ^a (in 1000)	No immigration background (in 1000)	Immigration background (in 1000)			
			Total ^b	Immigration experience		Born in Germany
				German citizenship ^c	Foreign citizenship	
Inhabitants reporting health ^{a, d}	71 121	58 188	12 464	2 631	4 604	3 687
Reporting ≥ 1 illness or accident ^d	9 058 (12.7%)	7 668 (13.2%)	1333 (10.7%)	314 (11.9%)	517 (11.2%)	304 (8.2%)
of these:						
no contact with health system	938 (10.4%)	775 (10.1%)	154 (11.6%)	28 (8.9%)	60 (11.6%)	44 (14.5%)
≥ 1 contact with ambulatory physician	6481 (71.6%)	5481 (71.5%)	960 (72.0%)	232 (73.9%)	364 (70.4%)	222 (73.4)
≥ 1 contact with hospital outpatient clinic	499 (5.5%)	421 (5.5%)	76 (5.7%)	17 (5.4%)	31 (6.0%)	17 (5.6%)
≥ 1 hospital admission	1057 (11.7%)	929 (12.1%)	129 (10.9%)	35 (11.1%)	55 (10.6%)	19 (6.3%)
Age > 65 with illness or accident ^d	3207 22.1%	2961 22.0%	246 23.0%	95 23.8%	73 21.1%	-
Of these: no contact with the health system	6.0%	5.9%	7.9%	7.2%	9.8%	-

Source: *Microcensus 2005 (Statistisches Bundesamt 2007)*.

Notes: ^a extrapolated from the 1% population sample; ^b excluding people without clearly defined migration status; ^c excluding Germans without formal Einbürgerung; ^d during the past twelve months.

Earlier representative surveys showed no difference by citizenship concerning acute hospital admissions and physician visits when adjusted for age and socioeconomic status (Lampert and Ziese 2005; Anderson 2003; RKI 1999). Similar to other people with low socio-economic status, utilization of specialists was below average (see cost-related barriers). Smaller studies showed a lower overall utilization of health care, e.g. in German ethnic immigrants except for dentists, gynaecologists and medical lays (Zeeb et al. 2004).

While figures on the utilization of curative care services show differing results, utilization of preventive services was lower than in people with German citizenship, though participation improved over time. Underutilized services (compared to non-immigrants) included influenza vaccination, dental check-up (women) and cancer screening (men). In addition, access to psychotherapy and rehabilitation have repeatedly been documented to be lower in the population

with foreign citizenship than with German citizenship (Lampert and Ziese 2005; Spallek and Razum 2006; Aparicio et al. 2005; Zeeb et al. 2004; Nickel et al. 2006).

3.1.4 Barriers to health care access for immigrants in general:

Most profoundly, access to health care differs by legal status which may pose coverage-related barriers and benefit-related barriers. These types of barriers tend to reinforce the other types of barriers (see below). **Coverage-related barriers** affect those immigrants, who have lost or never obtained an illegal status (see below), and may also affect self-employed immigrants and their families who may be hesitant to obtain private insurance coverage for a transient stay in the host country (shopkeepers etc.). **Benefit-related barriers** mainly affect asylum-seekers and tolerated refugees (see below). In addition, immigrants (particularly of the first generation) tend to be affected more by benefit-related barriers, when obtaining benefits requires written applications and health care literacy (knowledge of social rights, choice of provider, treatment options). **Cost-related barriers** tend to affect migrants more than others, partly because exemption mechanisms require writing skills and health care literacy. In particular, the low socio-economic status of most immigrants and the requirement to share earnings with more dependents in the host country and in the home country makes migrants particularly vulnerable to cost-related barriers (see cost-related barriers). **Geographic barriers:** 98% of inhabitants with immigrant background (14.7) are living in the western part of Germany or in Berlin and 2% in the new Länder in the eastern part. Most live in metropolitan and urban areas (Statistisches Bundesamt 2007) and are thus, in general, less affected by geographic barriers to health care access than inhabitants without immigrant background. However, immigrants who are living in rural areas (see asylum seekers) are similarly affected by geographic barriers. Racism in public places and public transport may pose a characteristic barrier for migrants, particularly in areas with a low density of migrants and little experience of living in multi-cultural settings as in the eastern part of Germany (Thomas 2007).

Responsiveness: *Limited language and communication skills* of professionals are a major barrier. In most health care institutions, the distribution of immigrant backgrounds or language skills among the staff does not reflect the distribution of immigrant backgrounds and languages spoken in the patient population. Written patient information at the point of care is still infrequent and even less frequent in the commonly spoken immigrant languages. Information that is available at the point of care is often supported by pharmaceutical industry, and is not the best evidence that is in fact available online or in written format from public or medical societies, often neither from neutral sources (but pharmaceutical industry) nor does at the highest level of evidence. Except for the Federal Ministry of Health's website, the patient information of the German Cancer Society and a few other country-wide initiatives, most telephone services and written patient information are not available in commonly spoken immigrant languages. The federal associations of sickness funds jointly finance the Independent Patient Information which provides information and advice via telephone, in face-to-face settings and online until 2010 as part of a model project. However, the website still is in German only. Similarly, the Institute for Quality and Efficiency in Health Care which has been charged with publishing health information for patients provides information in German and English but not in common immigrant languages. The documents for informed consent (mainly two companies) are still in German only (and do not provide a full extra copy for the patient's information). Finding a translator for patients with limited German language skills is mostly seen as the duty of the patient rather than the institution, although institutions usually seek a translator among their staff or else in urgent cases or no other translator is available. Physicians and other staff often have limited communication skills to deal with a group of communication partners and clarify roles. The lack of communication skills in the treatment situation is associated with underreporting, under-information, misunderstandings and under-recognition of problems (Toraman 2007). As a result, there is an increased risk of patient safety, non-compliance, dissatisfaction and conflict.

Staff attitudes and behavior: Even when patients do not have limited language skills, immigrant background complain that their information needs are

underestimated, that staff is less attentive and patient with them compared to non-immigrants. Especially mental problems and side effects of drugs tend to be not sufficiently taken serious when staff perceives patients as “strange” (Toraman 2007). Unfriendly treatment can be more easily perceived as xenophobia or racism, particularly when patients have experienced real xenophobia or racism before in health care or other fields. The capacity of staff to identify psychosocial vulnerabilities and de-escalate conflicts is still limited. Except for a few seminars on dealing with “the difficult patient” and a few intercultural communication seminars, there is still training on offer to deal with conflicts in health care settings.

Food: Though hospitals have increased choice of food, the selection and preparation of food as well as flexible eating times are still limited, which concerns many patients but immigrants more often.

Demand-side barriers: *Health literacy:* Knowledge about diseases, especially mental disorders and addiction has been documented to be lower in immigrants than in non-immigrants (Zeeb et al. 2004; Lampert and Ziese 2005). *Differing disease concepts:* Patients who immigrated from Turkish, Arabic and southern European countries more commonly report somatic than emotional problems to physicians, mental disorders tend to be under-diagnosed and under-treated as e.g. reflected in the lower rates of psychotherapy compared to peers of the same age. Their reports on somatic problems often highlight generalized than localized complaints, and localized symptoms are explained with symbolic terms that do not directly match with the terms of the medical language (Toraman 2007). Spanish background immigrants explained myocardial infarction with more external attributions, while German origin people had more psychosocial explanations (Bermejo 2006).

Health care literacy and differing treatment concepts: There also seems to be less knowledge and conviction about the current preventability of diseases and manageability of chronic diseases and mental diseases in particular. On the other hand, expectations in the curability may be high. Turkish background patients were found to be more convinced about the effectiveness of drugs and to expect a drug prescription more often than a German background control

group. Despite their insistence, physicians did not show differences in prescribing behavior by ethnic origin. Thus dissatisfaction may be a relative disappointment of expectations (von Ferber et al. 2003). Therapists for illegal drug addiction report that immigrants from Russia trust and participate less often in participatory approaches to addiction treatment and prefer more authoritarian forms of communication and therapeutic direction. Also, radical detoxification approaches with little symptomatic relief seem to be favored by clients of addiction advice centers. They report that there is a network of non-registered practitioners offering addiction treatment, partly in Germany and partly in Russia (Salman et al. 2007).

Especially recent immigrants often have limited knowledge how the health system works, what their rights are and what is expected from them in the role of the patient. Implicitly they transfer their experience from their home country to the health system here. This may lead to increased utilization of hospital outpatient clinics, a merely demand for somatic treatment and drugs as well as an underutilization of certain services. In addition, lack of trust in the confidentiality of data may inhibit them to utilize diagnostic services, in particular HIV tests. Also, lack of trust in respectful treatment in institutions, particularly mental health institutions may be a cause of underutilization and resistance towards treatment (Weilandt et al. 2003, 2004; Rommel, Weilandt 2005).

3.1.5 Impact upon satisfaction and appropriateness:

There is little information about whether any of the reported barriers lead to lower satisfaction or appropriateness of care in immigrant background people or certain sub-groups.

The perception of a lower responsiveness compared to non-immigrant patients or compared to (not addressed) expectations, satisfaction with health care has been documented to be lower in immigrants, although there is a wide variation (Zeeb et al. 2004). Turkish dentist patients more often expressed that they missed information, were incontent with the communication and expressed mistrust in what the dentist said. They also expressed more often that the

dentist made them feel guilty because of poor oral hygiene (Van Steenkiste 2004).

A review of the database of 132 555 deliveries at all hospitals in Berlin from 1993 to 1999 compared process and outcome of antenatal and maternal care in German 132 555 women and 19 638 women of other ethnic origin, adjusted by parity and social status (matched pair analysis in four sub-groups). Significant results included that pregnant migrants came later for their first antenatal check-up. They had significantly higher rates of pre-natal and also post-natal anemia and were less likely to receive an epidural anesthesia during delivery. Yet, the rate of planned cesarean sections was higher. Newborns had a higher rate of congenital malformations. Yet, infant and maternal mortality did no longer differ significantly compared to previous studies showing disadvantages for migrant women (David et al. 2006c).

3.1.6 Special subgroups of the immigrant population

Elderly migrants

Although elderly migrants still account for a small part of the elderly population, their share is increasing. In recent years, awareness of their specific needs has increased. The national elderly reports and several surveys have highlighted that long-term care of elderly migrants is largely provided by informal caretakers, but that the need for professional care is increasing. Within the professional structures of health care and long-term care, the special needs of elderly migrants are not yet sufficiently met by professional care structures. In particular, language barriers, nutrition and social support issues are seen as challenges. In particular, there is an insufficient number of caretakers with mother tongue or sufficient language skills, especially for Turkish and Arabic patients (Hofmann 2003; Adolph 2001; Mohammadzadeh and Tempel 2006; Schopf and Naegele 2005).

Children: The reported overall health-related quality of life in children is worse in children with immigrant background than others according to the representative BELLA study. Though socioeconomic status seems to play an important explanation, migrant status seems to be an independent risk factor

(Ravens-Sieberer et al. 2007). The rate of children suspected to have attention-deficit syndrome is higher in migrant background children but the rate of those with a known diagnosis is lower, which may hint at an under-recognition of the disorder by the health system and parents (Schlack et al. 2007). Migration background children also had a higher rate of eating disorders (50% higher than in non-migrants) (Hölling, Schlack 2007) and behavioural disorders. A higher rate of them had already been victim of violence and had also performed violence, also a more permissive attitude towards violence was observed (Hölling et al. 2007).

The dental status was substantially worse in school children with immigrant background from various national backgrounds (Kühnisch et al. 1998, 2003; Heinrich-Weltzien et al. 2007) especially in children from the former Soviet Union, Turkey, the former Jugoslavia (van Steenkiste et al. 2004). Oral hygiene improved less in school children with Turkish background than in German background children from 1993 until 2003. About three quarters of the caries (DMFT) were observed in 10% to 30% of the children, depending on age and type of schooling (Heinrich-Weltzien et al. 2004).

According to the representative federal survey on children's health, parents with immigration background report worse oral hygiene behavior of their children than parents without immigrant background, including the use of pharmaceutical preparations. Brushing teeth once a day or less often is found more often in migrant background children than others (45% vs. 22%) and has a socio-economic gradient (low: 39 %, middle: 28 %, high: 22 %) (Schenk, Knopf 2007).

Illegal immigrants:

The number of "illegal immigrants", officially defined as persons with neither a legal residence status in Germany nor a "tolerance" status or an "allowance", was estimated at 445 070 (0.4 % of the population) in December 2006 by the Foreigners' Central Register, and is included in the overall number of immigrants (Statistisches Bundesamt 2007). In contrast, refugee organizations estimate that the number of so called illegal immigrants extends to 1.5 million (1.8% of the population) (Rabbata 2006). Illegal immigrants are particularly

affected by coverage-related barriers which tend to enhance other types of barriers. Although they have the right to access the same set of benefits as asylum seekers and refugees via application at the local social assistance office, there are contravening laws that hinder the realization of this right in practice. Applicants receive the publicly financed acute health care or pain treatment but risk to be sent out of the country since the local social assistance offices are obliged to report to the immigration office. Similarly, public health care providers are obliged to report. Private and non-profit providers do not have this obligation but when they claim reimbursement, the patients' data are transferred. Furthermore, providers may potentially be charged with supporting illegal residency which deters some to provide care (Rabbata 2005, 2006).

Asylum seekers and refugees with tolerance status:

In December 2006, 150 000 people were registered as refugees seeking asylum. Of these, 42 908 people had applied for asylum (for the first time) throughout the year 2006. Applicants originated mainly from Serbia and Montenegro, Turkey (10%) and Irak (6.9%). Yet, only few applications are being accepted. In 2005, only 0.9% of all finalized procedures were decided positively. This was the lowest rate ever (Bundesamt für Migration und Flüchtlinge 2007). In December 2006, the number of people with a tolerance status was 165 000.

Asylum seekers and, for the first three years, refugees with a tolerance status are more exposed to the various access barriers compared to other immigrants and to people without immigrant background. While they are covered by a specific governmental scheme, the benefits covered are explicitly limited to acute care, maternity care and pain relief. Thus, chronic diseases are not covered officially, e. g. high blood pressure, coronary heart disease. Furthermore, mental problems are not clearly covered. In addition, access to health care requires an application with the local office either by the migrant or by the provider. Although co-payments do not apply when covered by the specific scheme, cost-related barriers (for transport, non-covered services) matter in particular, since their social income is below social assistance and often issued in form of tokens (for food) rather than in cash.

Geographic barriers matter more to asylum seekers and refugees with tolerance status than to other (mainly urban dwelling) immigrants since these are distributed equally across the districts of the country, and since their allowance to move around is restricted. In geographic areas where xenophobia and racism are prevalent this limits their readiness to access public spaces and transports, sometimes also in order to seek health care (Thomas 2007). Organizational barriers specific to asylum seekers and refugees include the lack of institutions that are financed and qualified to recognize and treat trauma. The few specialized trauma centers, that are qualified to treat people with torture experience and social conflict exposure, tend to be financially instable, and have hitherto been separated from general health care settings (Pross 2006). Barriers related to responsiveness and demand are in principle similar to other immigrants who have immigrated recently, though socioeconomic resources and conditions for social integration are less favourable, and mental distress is often worse. The interrelations of barriers in this group have been characterized as “third class medicine” (Pross 2006).

HIV-positive people:

The study *HIV and migrants – health risks, social situation and specific in Germany, Greece and Spain as well as Italy and Austria* found substantial health risks and insufficiently targeted programs for the prevention and treatment of the 1200 migrants interviewed. Utilization of HIV-related health care was aggravated by problems in legal status, language barriers, marginalized living conditions and economic hardship. An additional survey showed that the German sample plus a subset of sex workers had little knowledge about disease transmission, prevention and treatment as well as about the availability of anonymous testing (Steffan and Sokolovsky 2005).

3.1.7 Policies and initiatives

Immigration policies relevant for health care access have been described above (see Cross-sectoral policies). Health care actors have not got formally involved in the overall strategies for the better integration of migrants into the labor force, education, language, media and culture. Within health care, there is no

comprehensive written policy to improve health and health care access for immigrants (other than in Switzerland, 2007). However, federal agencies have taken several initiatives to increase access to health (care) information, awareness of migration issues and the cooperation of actors. The federal ministries and some Länder ministries including those responsible for health and long-term care are providing the major information about policies and social rights in common immigrant languages as well as English and French. This relates to their websites as well as to paper-based information leaflets and advice by telephone. The Federal Reports on Poverty and Wealth 2001 and 2005 include each a chapter on inequalities in health and health care that also address migrant issues and were developed by the Robert Koch-Institute (Lampert et al. 2005). Since 1998, the Federal Ministry of Health is co-sponsoring the annual conference on health and poverty where migration issues are featuring as well. The Federal Ministry of Education and Research in cooperation with the federal associations of sickness funds and retirement funds are funding a program on health services research. The current tender relates to improving patient information and shared decision-making and shall especially target vulnerable groups including migrants. The successful applicants shall be announced at the end of 2007 (BMBF 2005).

Since 1998, the Federal Agency for Health Education has been issuing a newsletter on migration and health in order to support the exchange of information and networking among the actors involved in the delivery of care and research.

Migrants are target group of a broad variety of prevention projects that are directed at socio-economically vulnerable groups in everyday-life settings across the country to reduce inequities in health chances. The Federal Centre for Health Education provides a database to support the mutual learning among the various projects and the professionalization of their quality management. Since 2006, the federal associations of sickness funds support the establishment of “network-knots” at Länder level, where activities shall be registered and interlinked. Since 2005, the Federal Centre is coordinating an EU project to foster the exchange of best practice in reducing health inequalities

across the EU. The projects partly address access to health care institutions but largely focus on providing support for prevention activities in settings outside health care, relating to the living conditions and/or life-style.

The Federal Ministry of Health has just issued a basic plan for a Prevention Act. As a separate social code book this shall summarize existing regulations on (personal) prevention and shall help to better coordinate the activities of the various actors including social insurance actors, governmental bodies and potentially private health insurance. The pooled funds shall be spent on large-scale population-wide prevention campaign as well as setting projects for socio-economically vulnerable groups. The Advisory Board for the Assessment of Developments in Health Care reporting to the Federal Ministry of Health has recently recommended to spend 40% of the pooled funds on setting approaches for socio-economically vulnerable groups and to evaluate prevention programs adequately (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2007).

Best practice: The community translation service in Berlin has trained 90 people with immigrant background to translate and support communication in the context of health care institutions. Partly these are migrants already working in the respective institution as health care professional or administrative staff, who mainly support their own institution. Partly these are mobile free-lancers who may be booked by a health care institution with the translation services at a reduced rate. While potentially patients can book a translator as well, translation is regarded as part of the institution's obligation to secure informed consent and patient-centred care. The programme is attached to the multi-stakeholder agency Health Berlin and is funded by the Federal Ministry of Economy and Work with resources from the European Social Fund. Altogether, translation in 19 commonly spoken languages is at offer. The training recognizes the need for lay people to get accustomed to medical terminology and intra-institutional structures. Trainees also learn to organize communication and clarify roles. They are encouraged to reflect their tacit knowledge about culturally sensitive issues and learn how to mediate in conflicts (Möllmann 2007).

Translation services are also operating in a few other cities. Language skills of ambulatory SHI physicians are documented in the online directory the regional physicians' associations. Yet, most physicians and hospitals mainly rely on family members or on their own staff, either from health care personnel, kitchen or administrative personnel, only some of them having been trained specifically for the purpose. The university of Bochum and a few other training centres offer Turkish language courses specifically for health care personnel since more than a decade.

In the EU project migrant-friendly hospitals the Berlin hospital Immanuel Krankenhaus participated until 2004 (www.mfh-eu.net). In its obligatory biannual quality report the hospital publishes additional information on migrant-friendly (www.immanuel-krankenhaus.de). The initiative is being sustained as a task force of the WHO network on health promoting hospitals based on the project's Amsterdam Declaration 2004. In Germany, 74 of about 2000 hospitals are currently members of the network of health promoting hospitals.

There is an increase of projects, seminars and institutional initiatives on intercultural communication in health and culturally competent care. Also, the share of health professionals and assistant personnel with immigrant background is increasing, particularly in long-term care institutions and hospitals (see Responsiveness-related barriers). Yet, there are few countrywide initiatives. To enhance culturally sensitive care and communication in the training of elderly caretakers, the Federal Ministry of Family, Elderly, Women and Youth has recently edited a handbook for teachers of future elderly caretakers. The book was developed by a several universities, caretaker schools and a non-profit organization for migrant health (BMFSFJ 2005).

While improving access for illegal immigrants is currently not seen as a political priority by government, several strategies are being taken to improve their access to health care:

a) The Assembly of German Physicians, other physicians organizations and refugee organizations have repeatedly demanded to abolish the social assistance office's obligation to report (other countries do not allow reporting or

do not demand it), and to improve legal security for providers (Rabbata 2006, 2005). The International Physicians for Peace and Against Nuclear Weapons (IPPNW) and several national refugee organizations recently started the campaign “respect instead of disrespect” in order to convince policy-makers to allow for anonymous treatment (anonymous infant care has been introduced at several hospitals).

b) Public health offices may provide diagnostic services and treatment for notifiable infectious diseases if no other payer is responsible or the threshold for seeking care in a physician surgery seems too high. The actual resourcing of these services and their responsiveness determines whether the services are actually used, mainly by sex workers and homeless people with tuberculosis or by a broader set of people. Among the users there is an increasing number of immigrants, although officially public health offices have the same obligation to report as social assistance offices.

c) One way to get around these restrictions is borrowing the chip card from an SHI insured although misuse is liable to financial penalties and – if combined with a false signature as common at hospital admission – up to five years imprisonment. This form of problem-solving is expected to become more difficult when the electronic health card with will be issued containing a personal photography. Yet, the Federal Physicians’ Chamber and other physicians’ organization have been refusing to encourage their members to ask patients to provide their identity card when seeking care. However, some hospitals do so. In Berlin for example, where sickness funds are under immense financial pressure and have refused payment to hospitals before, hospitals require that elective patients obtain an approval of insurance before being admitted.

d) Several refugee organizations and welfare organizations are being active to lower access barriers to health care for illegal immigrants on a project level, mainly in metropolitan areas. For example, the Berlin Refugee Support Office has referred about 8000 illegal immigrants to regular providers since 1996. The office does not provide care itself but cooperates with about 100 providers, does fundraising for medication or medical aids, and provides translation services if required. The number of persons in need has increased to about 100 per month

since the 2005 Immigration Act came into force (Institut für Menschenrechte 2007). Other organizations do provide basic medical care at their premises (Rabbata 2005), in homes for asylum seekers or as part of street work, although the degree depends upon the local interpretation of the ambulatory monopoly of regional physicians' associations and of the professional medical law that requires health care to be provided in specific health care practices (see Organizational barriers).

3.2 Older people with functional limitations

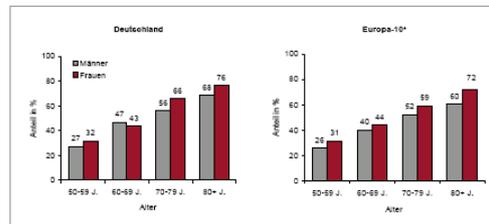
3.2.1 Socioeconomic status and disability conditions

Figure 4 shows that self-reported health in the elderly is slightly worse in Germany than other Europeans in the age group 50 to 59 up until the age group 80 to 89 where 76% of women and 68% of men report "less than good health" (Menning 2006).

Figure 4. Subjective health status from the age of 50 in men (grey) and women (red) in Germany and the average of 10 European countries¹, 2004

Die subjektive Reflexion der eigenen gesundheitlichen Situation kann im internationalen Maßstab außerdem durch unterschiedliche kulturelle Muster und Konnotationen beeinflusst werden.

Abbildung 14
Selbst eingeschätzte Gesundheit nach Alter und Geschlecht, SHARE 2004 (Less-than-good-Anteil)



Daten SHARE 2004, gewichtet, eigene Berechnungen
* Österreich, Deutschland, Schweden, Niederlande, Spanien, Italien, Frankreich, Dänemark, Griechenland, Schweiz

»Würden Sie sagen, Ihr Gesundheitszustand ist ...sehr gut, gut, mittelmäßig, schlecht, sehr schlecht?« (Anteil der Befragten mit Antwort »mittelmäßig«, »schlecht« oder »sehr schlecht«)

Source: Menning et al. 2006.

Note: ¹ as share of respondents of the SHARE study reporting less than good health currently. Other countries participating in the SHARE study included Austria, Denmark, France, Greece, Netherlands, Spain, Sweden and Switzerland.

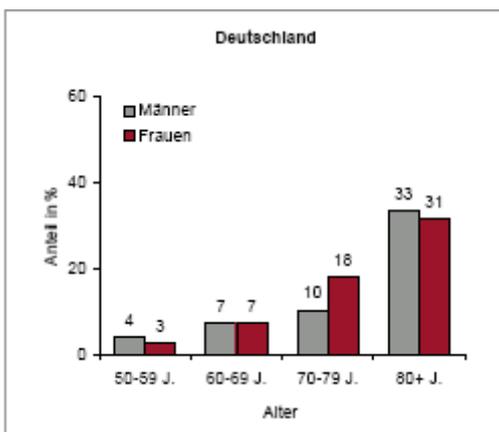
Self-reported ill-health depends upon reported chronic conditions and somatic or mental disability not on age per se (Robert Koch-Institut 2006). In 2005, 2 % (1.65 million) of the population had a recognized reduced capacity or incapacity to work and received disability benefits from statutory retirement insurance. This status applies only to the part of the population below 65 who worked in formal employment for at least three years during the preceding five years. In 2003, 2.5 % (2.1 million) of the population were in need of long-term care and received benefits either from statutory or private long-term care insurance schemes. The share of recipients increased by age: from 0.5 % among those below 60 years, to 1.6 % among the age group 60-65, 5.1 % in the age 70-75, 20.6 % in the age 80-85, and 39 % in the age 85-90. Three quarters of the overall recipients were cared for at home and one quarter was cared for in nursing homes, elderly homes or homes for disabled. The share of people

cared for in institutional settings increased by age. In 2003, 8 % of the population (6.6 million) was officially registered as severely disabled. In more than 6 % of the population had a severe disability due to (chronified) disease, the rest due to inborn ailments. This status allows to claim certain tax reductions and access public transport and facilities at a reduced rate (Busse, Riesberg 2004).

Disability increases with age as reflected by the International Indicator of Activities of Daily Living in the SHARE study 2004. Those affected by disability are often disabled in several activities at the same time (

Figure 5) (Menning 2006).

Figure 5. Limitations to activities of daily living in the age above 50 by gender, 2004

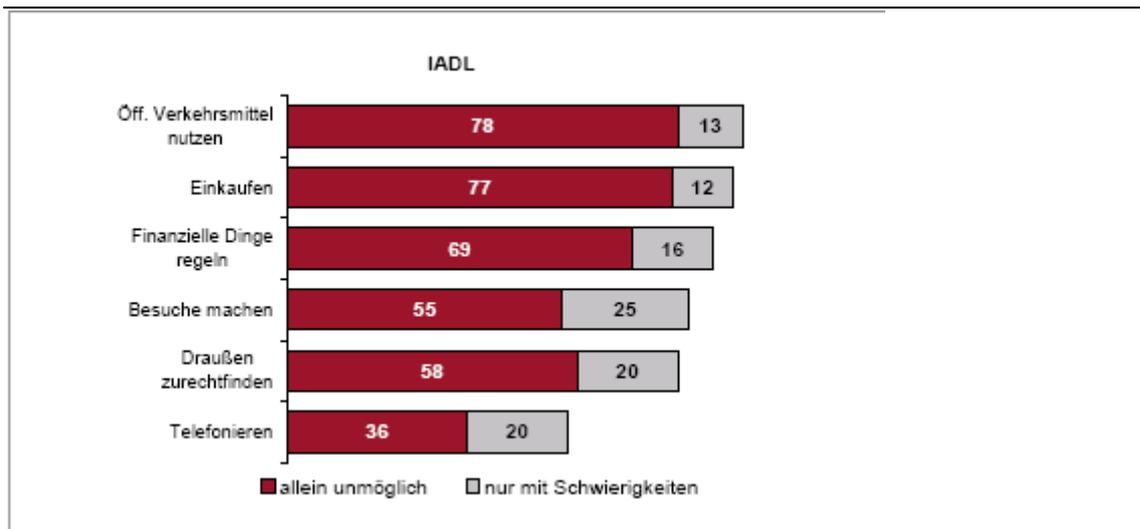


Source: Menning 2006.

The main functional limitations documented by the SHARE study applied to visual impairment, hearing impairment, mobility (Menning 2006). These put affected persons at risk of dysbalance, falls and accidents as well as dependency, social isolation and depression. Among those reporting substantial limitations to their daily activities, the vast majority reported that on their own it was impossible to use public transport, go shopping and arrange their financial affairs, make visits, find their way outside their home and making a phone call

(**Figure 6**). All these limitations impact upon their potential to access appropriate health care in time.

Figure 6. Limitations in social participation at age 50+ when daily activities are reported to be severely limited, 2004



Source: Menning 2006.

Though comparably infrequent, cognitive dysfunction/dementia is by far the most disabling chronic disease/health problem rendering people above 50+ dependent upon care. As a cause of disability, dementia is followed by cardiac failure, hip fracture, stroke, other mental disorders, angina pectoris, myocardial infarction, then by pain, incontinence and consequences from falls (Menning et al. 2006).

Based on international figures, the prevalence of dementia in the age group 65+ in Germany is estimated at 5%, that is 650 000 affected persons. However, other reports estimate the number of medium to severe dementia twice as high in Germany. Diabetes is more often reported to put people in need of care than is cancer (Robert Koch-Institut 2006).

3.2.2 Cost-related barriers

Overall, the financial burden induced by cost sharing arrangements has been shown to increase with age (Gericke, Wismar, & Busse 2004: 24; Pfaff et al. 2003: 58).

The economic status varies substantially among the elderly. There is still a proportion of elderly with income below or close to the poverty line and little or no capital (DATA federal poverty report). Yet, their share is decreasing (and substantially lower than in any other preceding generation); while the share of children in poverty is increasing (DATA).

Although men and women have some similar challenges with regard to health insurance, women face unique barriers to becoming/staying insured. More significantly, women have greater difficulty affording health care services even once they are insured.

- On average, women have lower incomes than men and therefore have greater difficulty paying premiums,
- women also are less likely than men to have coverage through their own employment status rather they are more likely to obtain coverage through their spouses;
- in addition, they are more likely than men to have higher out-of-pocket health care expenses; (since they have to use more health care services than men).

3.2.3 Benefit-related barriers and most important interface problems between health and social services

The needs assessment the (social long-term care insurance) SLCTI is mainly focused on somatic needs and does not acknowledge sufficiently mental illness including dementia, mental retardation and reduced levels of consciousness. This leaves severely affected persons with insufficient care and/or increases the work-load of informal care-givers and professional care-givers in institutional settings where the share of severely mentally and physically handicapped

dwellers is increasing. An expert committee is currently developing recommendations to better adjust assessment criteria. The reform shall also shape benefits to better meet their needs.

Since the coming into force of the SLTCI in 1995/1996 there have been interface problems with SHI. These concern in particular the following areas:

- ambulatory long term care services,
- the supply of medical aids, in particular in long term care homes,
- long term care services in long term care homes and,
- the implementation of the legal requirement “rehabilitation before long term care” (BMGS 2004).

Basic reasons for these interface problems are that legal responsibilities have been not exactly clarified between the two social insurance systems. Moreover the SHI has strong financial incentives to shift the provision of services (and therefore expenditure) to the SLTCI since there is a complete compensation of expenditure between SLTCI funds but not between SHI funds. Moreover, a shift to SLTCI means more expenditure for private households since services of SLTCI have fixed upper limits per recipients and expenditure above certain thresholds have to be borne by them. Whereas legal responsibilities between and of the two social insurance systems have been clarified in some ways by the courts, the incentive of SHI to shift expenditure to SLTCI still remains in entirety. As far as legal responsibilities are concerned, a major problematic refers to the difficulty to differentiate, in practice, between medical nursing (for which health insurance funds are responsible) and basic nursing (for which long-term care funds are responsible beyond a period of acute sickness). Health insurance funds are to pay medical aids, for example wheel-chairs which secure positioning, for long-term care recipients if these serve to prevent disease complications or to reach rehabilitation or self-determination. But according to interpretations of current law from the Federal Social Court in 2003 and 2004, this does not apply to home dwellers, for example with apallic syndrome, when self-determination and participation in social life is not possible

and rehabilitation is therefore not feasible. On the other hand, providers of long-term care are required to perform mobilizing basic nursing and secure medical aids, which does, however, not include special wheel-chairs. In practice, the lack of appropriate wheel-chairs limits the mobilization of long-term care recipients on liability and practicality grounds, which increases health risks and social isolation. Claims against decisions of the SHI Medical Review Board can be submitted to appeal committees or social courts, but decision-making may take more than six months, during which the provision of appropriate aids is often delayed. While long-term care providers are responsible for coordinating nursing care and family physicians are responsible for coordinating medical and overall care, there may be undue delay or omission of care when these actors formally occupy this role but do not fulfill it sufficiently.

3.2.4 What evidence is there about high thresholds to services

It is a widely acknowledged fact that SLTCI in its current state is not ready to meet the needs of people with dementia. As was mentioned above this is so since needs assessment is based upon somatic needs and does not sufficiently take into account mental illnesses. Currently there are reform proposals under way which are intended to reform the somatic oriented needs assessment towards a system of assessment which is more comprehensive and takes into account also aspects of social communication and participation.

A severe threshold to services concerns specialist visits in private households and in inpatient care homes. There are virtually no specialist visits to households. A recent study showed that there is no adequate provision of specialist services in inpatient homes, in particular for gynecologists, eye doctors and ear nose and throat doctors which are virtually non-existent. Also dental care services in inpatient long term care homes are sometimes problematic (Hallauer J, Bienstein C, Lehr U, Rönsch H 2005). In an international comparative perspective it has to be mentioned that in Germany it is legally not possible to employ GPs in long term care homes (the only exception is the Federal State Berlin where there are exceptional rules). This makes it harder to provide frail elderly in homes with GP services and often leads to unnecessary hospital stays.

3.2.5 Geriatric services and training

In 2003, 171 hospitals (that is less than 10% of all acute hospitals) had wards for acute geriatric care providing a total of 9597 beds, and 97 hospitals provided 1446 places for geriatric day-care. Geriatric rehabilitation has been expanded in recent years leading to 74 inpatient institutions with 4146 beds and 46 ambulatory institutions with 695 places in 2003. Capacities varied substantially by Land. Three *Länder* did not provide any institution for geriatric rehabilitation, and two others did not provide ambulatory facilities for geriatric rehabilitation (Meinck et al. 2006).

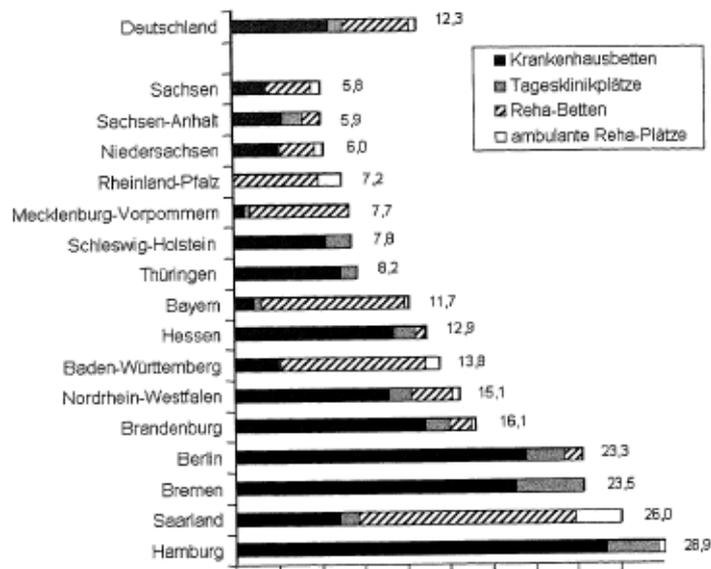
Geriatric care has been explicitly made a subject of the medical curriculum as an optional, yet not obligatory part of the cross-sectional study divisions in 2001. Most medical specialists can obtain an extra certificate in geriatric care since 1993, yet a sub-speciality geriatrics does only exist in the Land Brandenburg.

The 2000 federal reform of the training for elderly care-takers homogenized and modernized the training of competencies across the country, yet did not make geronto-psychiatric training obligatory.

For all health professions, training in the ambulatory setting and in care at home is still unduly limited although most health care and long-term care is actually in these settings. This affects the elderly in particular.

Figure 7. Geographic variations in geriatric treatment places per 100 000 inhabitants aged 65+ in hospitals (black), day clinics (grey), inpatient rehabilitation (dashed), and ambulatory rehabilitation (white) by Land, 2003 (data for inpatient rehabilitation from 2001)

Abb. 1 Geriatrische Versorgungsquoten und -kapazitäten in Krankenhäusern und Rehabilitationseinrichtungen pro 10 000 Einwohner 65 Jahre und älter getrennt nach Bundesländern und geriatrischen Strukturen, Stand: 2003*
 * Lediglich Daten der stationären Rehabilitationseinrichtungen mit Stand von 2001
 Quellen: Statistisches Bundesamt [6], Stier-Jarmer, Pientka, Stucki [7] und bei Landesministerien sowie Landesvertretungen des VdAK-AEV eingeholte Daten zu ambulanten geriatrischen Rehabilitationskapazitäten



Source: Meinck et al. 2006.

3.2.6 Age discrimination and quality of care

There is research on hospital expenses according to age. The results show that not chronological age but proximity of death is decisive for the cost intensity of acute hospital care. Hospital expenses in the last year of life exceed extremely those of previous years. With increasing age expenditure for non surviving patients drops almost linearly. Concerning the oldest old costs of treatment of patients who die and patients who survive are almost the same. Oldest old patients often receive less costly treatment than younger patients for the same conditions. This declining expenditure might explain health rationing. It is an empirical question if these results are peculiar for Germany; however, it rather seems that they can be observed in other countries as well (). The result that proximity to death is important for the cost intensity of care is in line with another study which shows that physician-patient contacts increase sharply with proximity to death ().

The Advisory Board for the Concerted Action on Health Care (reporting to the Federal Ministry of Health which transfers the commented report to the Federal Assembly) highlighted in 2001, that depression is under-recognized and under-treated in the elderly and that suicide among the elderly has not been sufficiently recognized (Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 2001). In 2004, the rate of elderly committing suicide was above the EU-15 average (23.3 versus 18.7 per 100 000) (WHO 2007). Similar findings on depression were also reported in the Federal Elderly Report 2002. In addition, the expert committee found a more widespread ageism in somatic as well as mental health care, particularly among the very old (Altenbericht 2002). Both advisory boards stated that there is age discrimination in the access to rehabilitation for the elderly, both for somatic as well as mental problems.

In addition, the health ministry's advisory board highlighted in 2007, that elderly are more at risk of patient safety incidents than younger age groups (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2007). Based on a systematic review of the Action Alliance for Patient Safety (a multi-stakeholder initiative with 130 mainly institutional members) elderly were also found to be most of risk of dying from a patient safety incident. Based upon routine data of pharmacological prescription in SHI, the advisory board estimated that about 15% of the elderly receive inappropriate medications (Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen 2007).

3.2.7 Policies

The Federal Elderly Plan is in place since 1992, support for informal care-takers, professional elderly care-takers, elderly care structures (also in new *Länder*), integration of elderly disabled, health in old age, need for help or care, concepts for help and care.

Therefore, with the health care reform 2007, geriatric rehabilitation was made a mandatory SHI benefit both for somatic and mental indications. Since April 2007, ambulatory geriatric rehabilitation has been made obligatory benefit of

SHI and shall be provided by mobile services to reach people at their place of living. The respective directive outlining eligibility criteria, type of services and conditions for their delivery has been published by the Federal Joint Committee.

Based on consultations and studies of expert groups, the federal associations of sickness funds have issued a tender (Europe-wide) in spring 2007 to reform the notion of “need for long-term care” in order to better reflect mental aspects and functional limitations.

The Charter of Rights for People in Need of Long-term Care and Assistance was developed by a multi-stakeholder committee led by the Federal Ministry of Family, Seniors, Women and Youth (BMFSFJ 2007). It basically summarizes existing rights from the various regulatory documents. The federal ministry published the charter in 2007 and distributed it to 27 000 providers and organizations involved in long-term care by the federal ministry in April 2007. In January 2008, stakeholders will evaluate first experiences with the implementation of the charter.

The federal government has published a draft reform on long-term care insurance recently which seeks to improve services for dementia, better coordinate services at the local level and provide more incentives to care for elderly at home. In addition, the contribution rate for the statutory long-term care insurance shall be increased by 0.3% to be shared equally by employees and employers. The (legally set) contribution rate for the statutory part (the private long-term care insurers set their own rates) has not been increased since the introduction of the social long-term care insurance. There was increasing consensus that this led to higher financial pressure on providers which in turn sought to lower costs by rationalizing processes, accelerating working schedules and employing less qualified staff. Due to large differences between the governing coalition partners, a profound reform of the financing of the long-term care insurance was not included, e.g. the coalition agreement included the intention to pool funds between statutory and private long-term care insurance.

Model projects on health and Social Care for the frail elderly. In 2000, the Federal Ministry for Family, Elderly, Women and Youth launched a programme

where it supported financially 20 model projects which developed new and innovative ways for supportive structures for health and social care in the following six areas:

- strategies and structures of integration of health and social care and new forms of case management,
- new approaches for assessing health and social care needs,
- consumer protection in the field of ambulatory care,
- strategies for the qualification for carers in particular carers for people with dementia,
- strengthening of care at home,
- mobilizing of civil society and creation of structures which facilitate the inclusion of the voluntary sector.

The programme lasted four years from 2000 to 2004, and many of these model projects kept on working until today (BMFSFJ 2004). However, a drawback of this programme seemed to be that there was no systematic evaluation which also included ideas for the diffusion of successful model projects. While some of these model projects appear to be successful, sustainable attempts were lacking to transfer these models to other locations.

3.3 Conclusions (vulnerable groups)

Elderly with disabilities, migrants and people with mental health problems are more likely to experience access barriers to health care than more advantaged groups, but do not necessarily experience disadvantages:

Elderly with disabilities are mainly affected by geographic barriers, organizational hurdles (limited home visits by specialists) and supply-side responsiveness (actual provision of sufficient services and safe products, ageism).

Migrants are mainly affected by barriers related to coverage (illegal immigrants) and benefits (asylum seekers, refugees), organizational hurdles involving

administrative competencies, but also by cost-related barriers, supply-side responsiveness and demand-side barriers.

People with mental health problems are mainly affected by cost-related barriers, organizational hurdles and supply-side responsiveness which interrelate with demand-side barriers). Research and political debate have hitherto largely ignored deficits in the access to somatic health care for people with mental health problems.

While, on average, their overall utilization of health care has been documented to be higher than in the general population, it is unclear whether utilization sufficiently meets their need. Yet, barriers tend to reinforce each other, particularly in socially vulnerable groups. There is broad consensus that some of the most disadvantaged in these three groups experience serious access barriers.

To overcome demand-side barriers and their interaction with supply-side barriers it seems important to recognize the structural aspect of them, provide training to providers and proactively address stigma and prejudices. Respecting deficits and acknowledging resources has been recognized as a key attitude in dealing with marginalized groups. The design and implementation of strategies is likely to work best when people of the respective groups are involved or even leading.

4 Country information for the case study on mental health

4.1 Introduction

This chapter focuses on schizophrenia, depression, personality disorders, and anxiety disorders. Barriers of access for people with substance-related disorders and learning disabilities are mentioned when barriers are obvious and substantial. Barriers of access for people with dementia and other organic brain disorders are discussed in section 3.2 on older people with functional limitations.

4.1.1 Legislation.

Access to health care and long-term care for people with mental health problems is regulated as part of general health care legislation at federal level which secures country-wide uniform regulation (Social Code Book V and XII). The Social Code Book V highlights that the special needs of disabled shall be paid specific attention (§2 SGB V), and that the needs of disabled due to mental health problem shall be paid special attention in the provision of ambulatory physician care (§72), allied health personnel services and medical rehabilitation (§27).

In addition, the rights of mentally disabled and somatically disabled were strengthened by the reform of the social code book IX on rehabilitation and participation, enacted in 2002. The Social Code Book IX regulates the access to medical, occupational and social rehabilitation and social participation for disabled and provides for improved cooperation among the various payers. It highlights (§10 SGB IX) that special needs of people with mental health problems at risk of disability and of disabled due to mental health problem shall be taken into account.

Legislation on social care and compulsory hospitalization for the people with mental health problems is performed at *Länder* level. 15 out of 16 *Länder* (except for Hesse) have specific mental health legislation in place. These regulate the responsibilities of the government and other actors in governing,

planning, financing and providing social services for people with mental health problems. In addition, the laws also define the duties and rights of individuals, professionals, justice and police in compulsory hospitalization as well as appeal mechanisms for the individual or his/her guardian (Bramesfeld et al., 2003).

The law on guardianship (*Betreuungsrecht*) provides for a modular approach to guardianship, separating the capacity to make decisions on medical interventions from decisions about where to live and decisions about spending money. A judge decides upon which family member, friend or professional is best suited to take decisions for the incapacitated individual. In case of need for grand medical interventions the decision-making is not (necessarily) left to the legal guardian but subject to decision-making of a judge after consultation with the treating physician, the guardian and family members. Decisions on guardianship shall be reviewed regularly depending on the expected duration of limited decision-making power.

The anti-discrimination law, which translates five EU directives relating to Art. 13 EC treaty into national law, was passed in 2006. The law states amongst others that disabled persons should not be discriminated and that disadvantages should be prevented or abolished (other criteria mentioned are age, gender, ethnic origin and race, religion, *Weltanschauung* and sexual identity). While the term 'disabled' includes people disabled due to mental health problem, there are no specific provisions for people with mental health problems, for example concerning their access general health services.

4.1.2 Policies

Policies for people with mental health problems continue to be based upon the principles of the Parliamentary Enquête Commission in 1975: the establishment of need-oriented ambulatory and complementary support structures in the every day life setting (*Lebensumfeld*), the decentralization and regionalization of inpatient care, the coordination and cooperation of all care providers (and payers), and the social and legal equalization of the people with mental health problems with the somatically ill.

In recent years, the outcomes of these policies were assessed and recommendations refined by the Federal Assembly (2000), the Federal Council's Conference of the Health Ministers of the *Länder* (2003, see annex), and a working group at the Federal Ministry of Health and Social Security (2004, see annex). All committees recommended to better coordinate health services within health care as well as between health and social care, to improve medical, occupational and social rehabilitation for people with mental health problems, and to shift rehabilitation to ambulatory settings, as well as to take special notice of children, youth and the elderly, especially those living in elderly homes and nursing homes. The Federal Council's working group on psychiatry (2003) also recommended to remove disadvantages for narcotic drug addicted persons compared to persons with other addictions and mental health problems.

Patients' rights from in civil and social law, for service and product liability regulations have been summarized in a guideline, which was compiled by a multi-stakeholder group and published by the federal ministries of justice and health in 2001. Similarly, another guideline focuses on the rights of people in need of long-term care and was published in 2006.

In addition, several single-issue policies and programmes relating to mental health have been established in recent years, mainly on a multi-stakeholder basis, to overcome the traditional separation of sectors and social security branches in the social insurance system (see also 4.1.3). For example, since 2004, the awareness, prevention, early recognition and treatment of depression has been adopted as the sixth priority area of the federal health target programme *gesundheitsziele.de* where the major stakeholders of health care and prevention are involved (www.gesundheitsziele.de). Another health target "growing up in health" includes a sub-target on stress reduction in children and youth. The federal health targets were actively disseminated to 2200 organizations by January 2005 (Philippi 2005). The evaluation concept for the health target on depression was approved by the programme's steering committee in July 2007.

In addition, health target programs have been developed in seven *Länder* during the past decade (Stein 2005). Most of these include a health target on depression, while some have also integrated additional targets on improving the quality of care for people with mental health problems or reducing substance abuse (Philippi 2005). Some *Länder* have encouraged the development of health targets also at municipal level. Yet, North Rhine-Westfalia is the only land that provides a legal framework for “health conferences” at the *Land* level and at municipal level. A survey in North Rhine-Westfalia showed that many citizens approved of the idea of health targets, but that in fact, few of its citizens knew about the existence of the health conferences and the content of the health targets (Boschek, Kugler 2002).

While the federal health target on depression includes sub-targets on the prevention on suicide, an even broader multi-stakeholder coalition focuses specifically on the prevention of suicide. It includes representatives of the federal and *Länder* governments and the Federal Assembly as well as representatives of professions, providers, payers, people with mental health problems and their families. The coalition provides information to people at risk of suicide, to their families and the public as part of a national suicide prevention programme (which is currently being developed) (<http://www.suizidpraevention-deutschland.de>).

4.1.3 Plans and programmes.

Länder governments are formally responsible for planning and securing hospital care and social care. Planning for people with mental health problems is based upon the specific *Länder* legislation. Many *Länder*, however, have devolved responsibilities partly or largely to the regional level or the municipal level. Where responsibilities for planning institutional and community-based care have been integrated horizontally at a certain administrative level, either Land, region or municipality, care seems to be better coordinated and community-based care more developed than in *Länder*, where responsibilities are spread across multiple administrative levels (Bramesfeld et al. 2003).

To better coordinate care, 10 out of 16 *Länder* had community-psychiatric associations to coordinate care for people with mental health problems in 2000. However, participation was largely voluntary, a legal basis was provided by only 2 *Länder* (Gesundheitsministerkonferenz 2003). While most social care actors take part in these associations, only few sickness funds and other health care actors take part (Bramesfeld et al. 2003).

In 2003, the federal government issued an action plan “drugs and addiction”. The programme is led by the Narcotic Drug Commissioner of the Federal Government, based at the Federal Ministry of Health and Social Security. The commissioner monitors trends in drug use behaviour and care structures on an annual basis (“drug report”). In addition, there are various alcohol prevention and harm reduction programmes, led by the Federal Agency for Health Education and several multi-stakeholder organizations. Medium-sized and large-sized companies are obliged by law to provide an ombudsman on addiction to their employees who provides confidential advice and support.

The anti-stigma campaign “open doors” (of the World Psychiatric Association) was implemented in Germany by the Medical Society of Psychiatry, Psychotherapy and Neurology in cooperation with associations of people with mental health problems from 1999 and showed an improvement of attitudes and opinions in the general population of six large urban areas at a second evaluation in 2002 compared to 1999 (Gaebel 2004).

The competence-networks on depression and schizophrenia, funded by the Federal Ministry of Education and Research to help research translate into practice, have taken a leading role in initiating, supporting and evaluating public campaigns for raising awareness and reducing stigma of mental health problem (see below). In recent years, local alliances against depression have been set up by municipalities or psychiatrists in cooperation with a varying, yet broad set of stakeholders.

There is no specific programme to promote physical health among people with mental health problems currently. Yet, associations of psychiatrists and people with mental health problems are advocating that mental health problems should

be recognized as a condition that is eligible for SHI funding of group exercise which until now is only granted to persons with certain chronic somatic illnesses (see also organizational).

4.1.4 Health services

People with mental health problems are entitled to and largely use mainstream general health services. Special mobile services are provided in metropolitan areas for homeless people and for intravenous drug users. Forensic psychiatric patients are mainly taken care of by forensic psychiatrists and the prison's general physician.

Public health offices of municipalities provide social-psychiatric services including counselling, social work, home visits and crisis intervention, which are directed particularly at the most disadvantaged among the people with mental health problems. Psychiatrist medical officers may also exert hierarchical powers through compulsory hospitalization and are usually better qualified to do so in a patient-oriented way than are other physicians or the only (and rather traumatic) use of police forces (Busse et al. 2007; Priebe et al. 2003). Psychiatrists employed by social-psychiatric services are allowed to provide medical treatment in only four *Länder*. In the remaining *Länder*, medical treatment is solely the task of office-based physicians, of hospital outpatient clinics or hospitals (Bramsfeld et al. 2003).

A characteristic of German health care is the long-standing tradition of medical rehabilitation which is largely provided by inpatient institutions in the countryside and financed by several social security branches. Another typical feature of German health care is the strong-hold of psychosomatic medicine at university hospitals, in physician specialization (in conjunction with psychotherapy and/or internal medicine) and in rehabilitation centres. In fact, many former psychiatric hospitals were transformed into institutions for psychosomatic rehabilitation during the past decade (Busse et al. 2007). Psychosomatic medicine mainly cares for patients with anorexia, bulimia and somatoform functional disorders, while treatment for addiction is largely performed by psychiatric institutions.

Another pioneering feature, the trialog, was developed by the German community psychiatric movement during the 1980s. The equal trialog between people with mental health problems, their families/friends and (progressive) professionals in mental health and social care first surfaced publicly in a “psychosis seminar” in 1989 where people with mental health problems were invited as “experts of illness” to inform university students about the illness experience, communicate their needs for care and represent their civil rights. In 2004, about 130 psychosis seminars and forums operated on a triialogue basis. In meanwhile, triialogue takes also place within psychiatric institutions, in advocacy organizations, multi-stakeholder associations and at conferences (Bombosch et al. 2004).

Access to social care requires a means test (which involves family members to a certain degree) or needs to be paid out-of-pocket. The differing actors in the financing and provision of health and social care brings about interface problems with health care and (possibly unmet) demands for administrative efforts to access services.

4.1.5 Civic society

At federal level, several self-help organizations represent the interests of people with mental health problems, provide information to their constituency and help with capacity building of mutual support groups at local and regional level. This includes especially the Federal Alliance of Persons with Psychiatric Experiences (www.bpe-online.de) and the Federal Working Alliance for Family Members of Mentally Ill (www.psychiatrie-online.de). Their website presentation is co-financed by the Federal Ministry of Health and a publisher of books on mental health respectively. These two organizations are members of the German Disability Council which is one of the four organizations that was legitimated by the Federal Ministry of Health in 2003 to represent patients' interests in the Federal Joint Committee, the central decision-making body within SHI. The two organizations are also standing members of working groups of the Action for Mentally Ill (but not full members), a multi-stakeholder consortium of provider and professional organizations, payers, administrations and politicians which was founded in 1971 to improve the living conditions and

the care for people with mental health problems by writing reports, advocating policy and developing concepts for care and integration.

In addition, single-issue organizations like the Anonymous Alcoholics, other addiction self-help groups and associations for other mental health problems (phobias, compulsion disorders, eating disorders, depression etc.) are being active at federal level.

At regional and local level, an even broader variety of self-help groups exist for people with mental health problems. Some of them are linked to organizations at federal level and many simply focus on local mutual support. This includes anti-psychiatric organizations like the “Mads’ Offensive”, who still maintain a critical distance to hospitalization, compulsory treatment, authoritarian expert attitudes and pharmaceutical care.

Overall, self-help organizations for people with mental health problems are less in number and capacity than self-help organizations for physically ill or physically disabled. Of the about 40 000 to 60 000 health-related self-help groups (with about 3 million members) less than 5% are concerned with mental health problem predominantly. 282 contact centres support the establishment and sustainability of local and regional self-help groups. Their federal association, being another of the four legitimated organizations to represent patient interests in the Federal Joint Council, has taken on the responsibility to (co-)represent particularly vulnerable groups, who are not well represented in the self-help movement, including the people with mental health problems, though a formal policy has not been developed yet.

In recent years, additional multi-stakeholder forums have been set up at the initiative of university-based psychiatrists to better link research, practice and public awareness. These include the competence network on schizophrenia, the competence network on depression and the action alliance suicide prevention. Under the patronage of the Federal Minister of Health, the newly founded Action Alliance Mental Health shall coordinate and enforce the various initiatives against stigma and discrimination of people with mental health problems.

Initiatives of all these NGOs focus on access to appropriate mental care, legal protection against undesired compulsion, social participation or general issues of stigma and discrimination, but do not identify access to somatic health care as a special issue.

4.1.6 Public opinion

The federal assembly of elected representatives of the physician assemblies and medical chambers at *Länder* level issued a statement in May 2007 on people with mental and psychosomatic illness. Representatives criticized that people with psychosis are stigmatized of being particularly violent, that addiction and depression are regarded as self-inflicted disorders, and that parents of people with mental health problems children are faced with the generalist prejudice of being liable for misguided education. They criticized that stigma of people with mental health problems was associated with an undue low recognition of curability which was mirrored in the media, in the practices of private health insurers, private incapacity to work insurers and private life insurers as well as general society (Deutscher Ärztetag 2007).

Lay perception of mental health problem has been shown to differentiate by the level of severity and psychosocial disability, according to the diagnostic label, the involved treatment professions or institutions and the applied treatment methods (Gaebel et al. 2006). Stigma and knowledge about the curability or manageability of mental health problem improved in the general population over three years which has been associated with anti-stigma campaigns (Gaebel 2004).

The media provide a mixed picture on mental health problems. While discriminatory language is largely taboo²³, the perspective, selection and combination of aspects reported may preserve or foster prejudices. Yet, in recent years, media have also contributed to raising awareness about symptoms, severity and treatment options and prognosis of different mental diseases. Some high profile athletes, TV moderators have spoken out publicly

²³ Boulevard newspapers may use slang words like “crazy” for scandalizing or comic news though this is not necessarily understood as discriminatory but rather a rough talk among community members.

on their experience with burn-out, depressive episodes, panic attacks or addiction. Yet, usually, people with mental health problems have little voice in the media themselves as authors or interview partners.

4.1.7 Research

German researchers have taken part in the European Study of the Epidemiology of Mental Disorders (ESEMeD) (Alonso et al. 2004) and the WHO Mental Health study (Scott et al. 2007) which have, amongst others, highlighted the high level of co-existing mental and somatic disorders in the general population.

Any of the following research focuses on disease mechanisms, diagnosis and treatment of mental health problems, improvement on the quality and responsiveness of care, and/or public awareness but does not specifically consider health care for somatic co-morbidity in people with mental health problems.

The Federal Ministry of Education and Research is financing several research structures in mental health to improve cooperation between research and various health care settings: The German research networks on depression and suicide (1999-2008, www.kompetenznetz-depression.de), on schizophrenia (1999-2008, www.kompetenznetz-schizophrenie.de), on dementia (2002-2007, www.kompetenznetz-demenzen.de) and on (behavioural or cognitive) psychotherapy (2006-2009) for phobic and panic disorders, hyperkinetic syndrome and eating disorders.

Research includes repetitive surveys on stigma and effects on destigmatization campaigns related to schizophrenia and depression (Gaebel 2004) .

Following a complex intervention in the region of Nuremburg (based on family physician education, cooperation with self-help and non-medical multipliers, and public educational campaigns) in 2001 and 2002, the suicide rate decreased by 20% and was significantly lower than in a neighbouring control region. Awareness and knowledge increased significantly during the first 10

months in a representative population sample but not further until 2002 (Lehfeld et al. 2004).

Based on these experiences, additional regional alliances against depression have been set up, coordinated by the German Alliance against Depression which is part of the EU funded European Alliance against Depression since 2004.

The new health services research program of the Federal Ministry of Education and Research, the federal associations of sickness funds and the statutory retirement funds from 2007 sets out to identify barriers to shared decision-making in health care and good practice to improve participation in health care, particularly by making patient information more accessible to vulnerable groups (including people with mental health problems). The selection of successful research programs is expected to be announced in September 2007.

Barriers for payers and providers to secure socio-therapy and for severely mentally to utilize socio-therapy (see 4.4.2) are currently being evaluated by the Federal Joint Committee in cooperation with the medical review boards of sickness funds and provider associations. The report is expected to be completed in autumn 2007; a decision about its publication has not yet been taken.

4.2 Methods

Pubmed was searched by a variety of MESH terms and other search terms:

- Germany or Europe or European²⁴

Plus different combinations of:

²⁴ The following text exclusively reports findings from empirical studies which were performed in Germany.

- Mental disorder or mental health problem or emotional disorder or schizophrenia, depression or mania or bipolar disorder or personality disorders or anxiety disorders
- Physical or somatic or general health care or morbidity or co-morbidity or multi-morbidity or cardio-vascular disease or mortality or avoidable mortality
- utilization or health services utilization or delivery of health care services or provision or supply
- Access or barrier or hurdle or equity or inequality or variation
- Coverage or benefit or geographical or organizational or budget or waiting list or rationing or quality of care or health literacy or satisfaction or stigma or discrimination

Key-informants were contacted by telephone or mail and asked to provide relevant publications and/or personal experience. A list of key informants, their role or organizational affiliation and their website for further information is provided in the annex.

4.3 Access to general health care for people with mental health problems

4.3.1 Co-morbidity of mental and somatic disorders

Mental disorders are associated with excess mortality, both before the age of 65 (premature death) and beyond the age of 65. In 2002, mental disease ranked third in women and fourth in men as the (primary) cause of premature death and concerning indirect costs due to life years lost (Federal Statistical Office 2004). The most common reasons for this excess mortality have been

documented as being due to alcohol related complications, suicides and accidents.²⁵

Yet, somatic diseases also contribute substantially to the excess mortality of psychiatric hospital patients. In 4803 of 14 471 (33%) episodes of care in 7 hospitals with defined catchment area, somatic disease was diagnosed among patients admitted to psychiatric units. Most frequent somatic diagnoses concerned the heart and the circulatory system (8.4% of all episodes), the nervous system (5.3%) and metabolic and endocrine system (5.2%). In 4% of all episodes (n = 583) patients were transferred to a non-psychiatric unit. 190 deaths were recorded. Most deaths affected persons aged above 65 years, particularly with underlying organic mental health problems, while 18 deaths occurred below the age of 65 (Hewer et al. 2002). An earlier study on 14 195 episodes in 7 psychiatric hospitals with defined catchment areas found that 196 patients died compared to an expected 32 deaths among non-psychiatric hospital patients. Mortality during hospitalization was mainly due to natural causes (174) and to a smaller extent due to suicide (22). Roughly one half of the total 196 deaths were due to cardiovascular disorders and pneumonia. In patients with non-organic psychiatric syndromes, suicide was the most frequent cause of death (21 of 58 fatalities). Overall, standardized mortality risk was highest in organic mental health problem (SMR 7.55), followed by functional psychoses (SMR 4.55) and other disorders (alcoholism, neurotic and related disorders, SMR 3.25) (Hewer et al. 1995). In a later study, during 8927 episodes in 7 psychiatric hospitals with defined catchment area, 51 patients died, compared to 12 expected deaths in the general population. 20 died from suicide and 31 died from natural causes, mainly due to cardiovascular disorders (Hewer and Rössler 1997).

In addition, several cross-sectional surveys in the general population found that mental health problems are often associated with other mental health problems as well as with somatic disorders. The Federal Interview and Examination Survey on Mental Health in 1998/1999 showed that the 12-month prevalence

²⁵ For a recent overview on morbidity and mortality from mental disease and chronic somatic disease see for example Hilfer et al. 2007.

for any DSM-IV study disorder²⁶ was 31% as reported by a representative population sample aged 16 to 65 (lifetime: 43%; 4-week: 20%). Co-morbidity of several mental health problems was high, ranking from 44% to 94% of people with any mental health problem. Poor somatic health status was found to be significantly correlated with single mental health problems and with several mental co-morbidities.²⁷

These findings on mental-physical co-morbidity have largely been analyzed and interpreted in the sense that mental co-morbidity should not be over-looked when treating somatic disease (and that there is a bigger role to play for psychotherapists, psychiatrists, other psychosocial care-takers and psychopharmaca). Vice versa, it could be argued that somatic conditions should not be overlooked when treating people with mental health problems. Given the early onset of mental health problems and chronic or recurring episodic nature, it is likely that mental health problems preceded the occurrence of physical disease. In any case, these epidemiological findings support clinical findings that bio-psycho-social multi-morbidity is common and that physical and mental problems tend to interact and often enhance each other, particularly when they are severe or several disabling disorders occur at the same time. Thus, providers of somatic health care as well as mental health care need to be prepared to meet the physical as well as mental problems in patients with multi-morbidity.

Excess mortality and morbidity of people with mental health problems from physical disease may, in part, be related to the low socio-economic status of the people with mental health problems, to direct disease influence (e.g. depression leads to increased risk of cardiovascular disease and worse outcome after myocardial infarction), to adverse drug effects, to unhealthy life-styles or other factors (Lederbogen 2007). The life style of 194 schizophrenia patients was

²⁶ Among the 4181 adults (18-65) interviewed, reported 12-month prevalence was 14.5% for anxiety disorders, 11.9% for affective disorders (8.3% for major depression), 11.0% for somatoform disorders, 8% for pain disorders 4.5% for addictive disorders (4.1% alcoholism), 2.6% for psychotic symptoms, 0.7% for compulsion disorders, and 0.3% for eating disorders. Of the 31.1% with at least one mental diagnosis, 60.5% had one mental health problem, 20.3% had 2 disorders, 9% had 3 disorders, and 10.3% had more than 3 mental health problems. Anxiety disorders were found in 11.5%, mood disorders in 14.5% (mainly depression) and somatoform syndromes in 13.0% of the interviewees (Wittchen et al. 2001).

²⁷ Further factors associated significantly with mental health problem were female gender (except for substance disorders), not being married, and low social class.

found to be less healthy compared to a general population sample from 1998/1999. They were more likely to have a supper snack, consume instant meals and calorie-reduced food, and ate healthy groceries more rarely. Though they drink less alcohol, a greater proportion currently smokes, smoking on average 4 cigarettes more per day. On workdays they spend less time with strenuous activities, and in leisure time a greater proportion is involved in no sports. Health habits were particularly disadvantageously affected by schizophrenia in connection with unemployment. The authors concluded that schizophrenia patients are an appropriate target group for public health interventions and health counselling on healthy diet and motivation to prepare their own meals, to quit smoking, and to exercise (Roick et al. 2007).

4.3.2 Evidence on the utilization of general health care

A linkage of data from the Federal Health Survey's part on mental health in 1998 (Wittchen et al. 1999) with utilization data from various representative population surveys (1998-2000) suggests that persons reporting psychological symptoms (Zerksen list) neither used health care less often nor more often than the general population. This applied to family physician care as well as ambulatory specialist care and acute hospital admissions (Andersen et al. 2003).

The statistical mean may well overshadow that some mental problems are indeed associated with underutilization, while others may be associated with above-average utilization of general health care. Yet, a sub-group analysis (of the under-utilizers of health care) was not performed. The surveys neither took into consideration certain social groups that are likely to under-utilize somatic primary and/or secondary health care like homeless people, people institutionalized due to mental health problem or long-term care needs, people living in the community without telephone. They neither mirror the access situation for children nor for elderly above 65 (see 3.2).

Previously unrecognized physical co-morbidity and physical morbidity presenting with psychiatric symptoms and is a common problem in patients admitted to psychiatric hospitals (Hewer 1992).

In the group of homeless people²⁸ more than two thirds have been repeatedly documented to suffer from single or multiple mental diseases (substance abuse predominates, but also schizophrenic and affective disorders and personality disorders) (Längle 2005) as well as from physical co-morbidity (Völlm et al. 2004; Kellinghaus 1999; Trabert 1995). These surveys also found an underutilization of general health care as well as mental health care. In 1994, a study in the city of Mainz found that more than 90% of homeless people urgently need medical treatment. The main health problems of the homeless were: cardiac disease or hypertension (52.5%), skin disease (scabies, lice, leg ulcers, abscesses, pyodermias) and acute infections (50%), lower respiratory tract (47.5%) and trauma (50%), followed by liver (30%), kidney (25%) and gastrointestinal diseases (20%) (Trabert 1995; Völlm et al. 2004). Hospitals and general practitioners are mainly contacted in case of emergencies. Targeted help-seeking behavior concerning the psychiatric or addictive symptoms was extremely rare (Kellinghaus 1999).

Besides these findings, there is (to my current knowledge) no study in Germany which is set out to assess access to general health care among people with mental health problems compared with non-people with mental health problems people.

4.4 Barriers in access to general health care for people with mental health problems

4.4.1 Gaps in coverage

SHI and SLTCI: There is no formal barrier for people with mental health problems to be SHI or SLTCI insured (except for the general exclusion of self-employed, civil servants, asylum seekers and illegal immigrants). While people with mental health problems are less likely to be employed in the official job market, SHI and SLTCI coverage also extends to those receiving incapacity to

²⁸ In 1999, about 200 000 people were homeless in Germany (0.24% of the population). Of these, 35 000 were living on the streets, while 165 000 were registered with homes for homeless people (Kellinghaus 1999).

work benefits or social assistance. This also extends to homeless people. Only, when they are eligible to social assistance but do not access it, they are not covered. This occurs relatively frequently among homeless people. Those who migrate between municipalities are covered by the municipality where they last were registered, or if this is more than three months ago, in the municipality where treatment is provided. In hospitals, social workers often help with formalities, yet support is weak in ambulatory health care.

Coverage gaps also emerge when the SHI-eligibility card has been lost or has expired, since some providers decline treatment beyond emergencies if the card is not submitted. For recipients of social assistance, the requirement to apply for a new card with the social assistance payer and related administrative interactions with the sickness fund prolong the time without a card, especially if there are waiting times to meet the responsible officer or the officer is not responsive to this request. These administrative requirements are often not known and difficult to comply with for people with mental health problems, particularly those with little professional support (Tom L, people with mental health problems living on his own). For those with professional guardianship for health care, contacting the guardian first may be a source of further delay.

Governmental subsidy and compensation schemes: Once people have obtained the permanent status as civil servants, judges, police or military officers or other employees with quasi civil servant status (former civil servants of the train, post or statutory insurance branches), people with mental health problems people formally have the same coverage as others. Though public employees seek to fulfil employment quota for severely disabled, mental disease assessed in the obligatory entry health examination may be a cause for denying a permanent civil servant status. For limitations in access to complementary PHI see the section on *PHI* below.

Governmental schemes for asylum seekers, refugees and illegal immigrants: People with mental health problems asylum seekers, refugees or illegal migrants formally have the same rights as others. Yet, their capacity to fulfil the administrative requirements to apply for funding or filing an objection to denials at the first instance, may be more limited. In asylum seekers,

psychological trauma from torture or rape, which is not clearly stated at the first hearing, is not recognized as a reason for asylum. They are therefore more likely not to be acknowledged for their main reason of seeking asylum than non-traumatized or non-people with mental health problems applicants and thereby less likely to access full entitlement to health care.

PHI: Persons with current or previous mental health problems are disadvantaged in obtaining substitutive, complementary or supplementary PHI coverage compared to physically ill, since any utilization of psychotherapy or psychiatric care in the past five years may lead to an increase of their entry premium, while for somatic problems a three year period is usually taken as a measure in the obligatory (self-reported) health assessment at entry. PHI coverage for mental service is more expensive for these applicants or may be left out from the contracted benefit basket. This may induce people with mental health problems to prefer non-insurance or under-insurance. Particularly affected are those ineligible for SHI (seeking substitutive PHI) and civil servants (who seek complementary PHI for 20% to 50% of their health care costs. The unequal treatment of people with mental health problems versus somatically ill is currently under debate as part of a reform of the private insurance law (whose fundamentals date back to the 1910s).

4.4.2 Scope of the health basket.

SHI: People with mental health problems are generally entitled to the same benefits as other insured. Also refinements of the legal basket by the Federal Joint Council or the federal associations of sickness funds recognize services for people with mental health problems, e.g. self-help groups to be supported. Yet overall, the SHI benefit basket is more tailored at meeting the needs of the physically ill or those with minor mental ailments. For example, exercise training is available only to people with specific chronic somatic disease but not to chronic mental health problem. The assembly of German physician representatives demanded in 2007 to abolish this disadvantage. However, improvements have been introduced in recent years. For example, home nursing care focused on somatic needs and somatic medical care or basic care services. Since 2004, ambulatory psychiatric nursing has improved home care

for people with mental health problems substantially, providing mainly psychosocial support but also somatic nursing if required (e.g. in case of flu which partly turned into a crisis situation for socially isolated people with mental health problems and led to hospitalization. This type of care reaches those who access care by a psychiatrist.

Another type of benefit, socio-therapeutic care, was introduced in 2004 to help those severely people with mental health problems who do not access care at all or insufficiently to obtain access with the coordination of a social worker. Socio-therapeutic benefits are mainly targeted at access to mental health care but could also include general health care, particularly to reduce unnecessary hospitalization and related disruption of everyday life for people with mental health problems. However, uptake has yet been low. Sickness funds have accredited providers in only few *Länder*, partly since existing providers do not fulfill the high requirements for structural quality and qualification. Also, psychiatrists continue to lead the coordination of this type of (time-limited) benefit, though their acceptance may be low among non-utilizers. In addition, eligibility criteria for potential users of socio-therapy, that medical review boards of sickness funds are to apply, are narrow. The respective directive of the Federal Joint Committee is therefore currently under revision. The 2007 health reform also demands now that providers of socio-therapeutic care are to be consulted in the process.

The uptake of other benefits seems partly to be low in people with mental health problems: An estimated 1% to 2% of people with alcohol dependency take part in medical rehabilitation. On average, it still takes 13 years from the onset of the disorder to apply for rehabilitation, which often takes place upon the pressure of the employer, the family or legal sanctions. 70% of people with alcohol dependence have contact to a family physician (which is less than the average population with about 95%). Yet, family physicians were found to have too little expertise in recognizing and starting treatment, and too little belief in the efficacy of treatment and the self-efficacy of their patients. Yet, 17% of applicants do not turn up to rehabilitation (Köhler 2007; Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 2001).

SLTCI: Demented people and people with mental health problems elderly have more difficulties in being assessed as eligible to long-term care benefits. This is due to the dominance of somatic criteria in the needs assessment guidelines which are the same for statutory and private insurers. Also, the group of ageing people with mental health problems and the group of ageing mentally disabled have not been recognized by policy-makers as target groups whose needs have not been adequately met by the current long-term care insurance arrangements. Despite some lobbying from the influential body Aktion Psychisch Kranke, they have not been included in the 2007 draft reform document on long-term care insurance. Yet, indirectly, they may profit from the reform which sets out to improve benefits for demented people. They may also profit from the redefinition of need criteria which are partly being developed, funded by the associations of sickness funds/long-term care funds.

PHI: Once contracted, people with mental health problems are entitled to the same benefits as others with the same type of contract. Yet, many insurance policies do not automatically cover psychotherapy. An additional coverage of this kind of treatment requires additional premiums. Other, more social types of benefits covered by SHI like household support, that enables ill people to stay at home during an acute illness, are generally not covered by PHI. Also, services that were developed recently in SHI to better meet the needs of people with mental health problems, like psychiatric home nursing or socio-therapy are not covered by PHI contracts.²⁹

The general PHI regulation of having to pay in advance and claim back expenditures from the insurer poses a burden on those with low income or little capacity to save money and perform administrative procedures. This has partly been relaxed by the insurers practice to accept bills directly from providers, especially from hospitals.

²⁹ Persons covered by private daily allowance during hospital stays may take hospitalization as an additional source of income. This works better for people with mental health problems than for physically ill, since the duration of hospitalization in psychosomatic institutions and psychiatric institutions is usually longer and less invasive. Though this may be regarded as "moral hazard", the use of hospitalization is an expression of the limited income opportunities in the common or sheltered job market and of the lack of an integration flexible or comprehensive continuous ambulatory care, that can be intensified in times of mental, social or physical (flue etc.) crisis.

4.4.3 Cost-related barriers

SHI: Since most people with chronic mental health problem are poor, co-payments to health care pose a serious problem. This is aggravated by the need for long-term care medication which requires the largest amount of co-payments. Also, those services targeted at mental needs like ambulatory psychiatric nursing, socio-therapy, acute hospital care, medical rehabilitation or transport to day-clinics at hospitals all require relatively high co-payments on a daily basis. People with mental health problems tend to be less able than other SHI insured to fulfil the administrative competencies required to collect receipts and apply for co-payment exemption. This applies especially for the severely people with mental health problems living in the community without regular source of social care and related support for administration and pocket-money management. Also, people with addiction face particular problems in saving money for eventualities like co-payments. For institutionalized people with mental health problems (and elderly) a simplified procedure has been agreed, with dwellers receiving a monthly deduction from their pocket money.³⁰

PHI: Similar to somatically ill, people with mental health problems experience higher increases in their premiums than their healthy peers once they are PHI insured. Yet, since mental health problem often starts earlier in life than somatic illness (esp. schizophrenia), people with mental health problems are indirectly disadvantaged by the current regulation that access to a standard tariff (with a maximum premium and a guaranteed benefit basket as in SHI) is only available from age 55. In the first half of 2008, all PHI insured will be eligible to change to the basic tariff regardless of age and illness severity. This requires health insurance literacy which tends to be less prevalent among people with mental health problems (see 4.4.6).

4.4.4 Geographical barriers

Although exact data are not available, the vast amount of patients affected by mental health problems, particularly depression and dementia, is seen by

³⁰ while sickness funds receive an advance payment of the expected co-payment at the beginning of the year which is later to be paid back in case co-payments have not fully being used

general practitioners. In 2002, 1.9 million patients were seen by 4 800 SHI-affiliated psychiatrists (Ärzte für Psychiatrie u. Psychotherapie/Nervenärzte) per quarter and 520 000 patients were seen by 15 000 SHI-affiliated psychological psychotherapists or physicians for psychotherapeutic medicine per quarter (Melchinger 2003). Their number has increased substantially during the last decade. Yet, rural/urban differences are pronounced for the density of psychiatrists, but even more so for psychotherapists. The most unequal distribution is found for youth psychiatrists and psychotherapists (with little activity in the eastern part where the per capita premiums for SHI insureds are lower than in more affluent areas of the west, and where few people have PHI insurance which can create additional income).

In general, access to mental health care providers who may simplify also access to somatic care, has improved substantially since 1975. While the number of hospital beds and average length of stay decreased, the number of psychiatrists providing care in ambulatory care quadrupled between 1975 and 2000, the number of psychotherapists increased even more (Gesundheitsministerkonferenz 2003). But also the places for supported housing doubled from 1992 until 1996 from 8.9 to 17.9 per 100 000 inhabitants (Priebe et al. 2005). The number of contact centres increased from 406 in 1990 to 801 in 2000. The number of day structure centres increased from a very low number of 27 in 1990 to 152 in 2000, their places from 441 to 2425 (i. e. 34 030 inhabitants per place in 2000).

Access to somatic health care tends to be better for people with mental health problems who are integrated in social work contexts or health care contexts on a regular basis. However, in severely people with mental health problems, much depends upon their care-taker's and their family physician's responsiveness and awareness. Though most homes have been located in communities, a few former hospitals outside the communities continue to function as homes. Though these homes are accessible to public transport (esp. busses), the geographic distance may pose a barrier to easy access to ambulatory somatic care. Day centres and sheltered work-places are usually located in municipalities. Access to vocational rehabilitation and comprehensive social

integration is still considered insufficiently developed. Due to unclear responsibilities of the various funders, the number of places of comprehensive vocational rehabilitation for people with mental health problems have increased only to a small degree from 995 in 1990 to 1533 in 2000. 6 *Länder* did not provide any places for comprehensive vocational rehabilitation at all.

Following the dehospitalization since the 1970s, most institutionalized people with mental health problems live in long-stay homes³¹ (25-70%, varying by severity of disorder and geographic region) rather than psychiatric hospitals. In 2000, places in homes for people with mental health problems varied between one place per 333 inhabitants in Sachsen-Anhalt and 8628 in Berlin. In comparison, less people lived in sheltered living-communities, the respective ratio ranged between 967 in Bremen and 6365 in Mecklenburg-Pomerania (Gesundheitsministerkonferenz 2003).

Geographic hurdles probably affect people with mental health problems children and severely people with mental health problems when their care-takers are not responsive to their needs or do not have the time, money or endurance to support them with often long-term treatments. Also, travelling by public transport poses substantial challenges to people with mental health problems with anxieties, paranoia and motivation deficits. Also, people with mental health problems with bad experiences in discrimination may be more hesitant also to use the closed public spaces of public transport facilities.

4.4.5 Organisational barriers and supply-side responsiveness.

Despite the reduction in psychiatric beds and length of stay, allocation of resources for mental health problems still has a strong focus on hospital care and relatively large institutional settings. Such traditions of resource allocation are difficult to change at short hand, and contribute to influencing attitudes of the public, health care staff and patients. According to the Federal Cost of Diseases Account, €22.4 billion or €272 per inhabitant were spent on mental

³¹ In 2000 the overall number of homes for people with mental health problems was reported at 1180 providing 36,718 beds, that is 2248 inhabitants per place. Although the size of homes has been decreased in the last decades, the average home still has 36.7 beds.

diseases (ICD-10, F0-99) in 2002. Expenditure on mental health accounted for 10% of total expenditures on health. While 54% of total expenditures were spent on ambulatory care, for mental diseases this rate is only 27% (€6.1 billion). Nearly two thirds of the expenditures on mental diseases (€13.6 billion) were spent on institutional care (long-term care and acute inpatient care) (€13.6 billion, 61%), €6.1 billion on ambulatory care (27%), and €2.7 billion on other type of services including administration (€1.5). This reflects especially the spending on dementia with a high share of institutional long-term care, but shows also that spending on other mental health problems also holds a hospital focus. Other than depression, spending on rehabilitation in schizophrenia is low.³² The national data do not provide information about the specialities accessed in the various sectors.

When the prospective case payment (German DRG) was introduced in acute somatic inpatient care, while per diems were maintained in psychiatry and psychosomatic, it was commonly expected that in-hospital referrals to psychiatric wards would increase (especially when length of stay was above the target duration of the DRG. While this referral practice is being observed it has not become wide-spread, also due to specific coding controls.

Lack of clinical guidance may pose a barrier to the actual provision of benefits: There are clinical guidelines for common mental health problems and for common somatic disorders, yet there are no clinical guidelines on the joint management of somatic disease in people with mental health problems. The payers of rehabilitation have jointly developed guidelines for rehabilitation in their institution. Of the five currently available, four concern different somatic diseases and one concerns depression, which includes a thorough somatic check-up and several health promotion activities and health education. Currently, a multi-stakeholder group develops a draft programme for a potential disease management program on depression. All current disease management programs are concerned with chronic somatic diseases. There is no data, to

³² Concerning the living context, municipal welfare offices, spent €40 per inhabitant on the care for people with mental health problems. 7% of these expenditures were spent on psychiatric hospitals, 32% on long-term care institutions and 16% on transitional institutions. Another 18% were spent on sheltered living (incl. cash subsistence), 6% for ambulatory addiction counselling or support and 12% for various sorts of sheltered occupation (Melchinger 2003). These data show the comparably high priority of living in homes over sheltered living conditions.

which degree SHI insured people with mental health problems take part in any of these managed care programs.

Most benefits which are shaped for the needs of people with mental health problems focus on mental aspects, though they provide space for somatic interventions, e.g. psychiatric nursing, socio-therapeutic care, day centres with health promotion activities. Still, there is non explicit policy or programme on this.

Institutional settings may promote or hinder somato-mental care. Most psychiatric beds are integrated in acute hospitals, which provides the structural opportunity for interdisciplinary consultation and timely referral. A more detailed study of the actual facilities in the 1990s showed, that of 81 hospitals providing psychiatric beds, the majority had an internal medicine ward and provided consultations to psychiatric wards on a regular basis. Diagnostic equipment for internal disease was available to psychiatric patients. However, structural deficits in the care of medical co-morbidity in clinical psychiatry were observed in many hospitals to a varying degree (Hewer et al. 1998).

Psychiatric hospitals and wards often have a lower standard in amenities than somatic hospitals and/or wards, especially concerning access to telephone, privacy and space for social support.

Training structures may deeply influence the competencies, attitudes and interests of health personnel for a long period. Other than in many EU countries, German training of physicians does not include a generalist phase for junior doctors during the first year after medical studies, where e.g. 4 months of internal medicine, 4 months of surgery and 4 months of another subject would have to be done before the chosen speciality training starts. Psychiatrists in Germany train for 5 years of which 1 needs to be done in neurology, and 6 months can be done in other somatic specialities or general practice. Similar arrangements are made for psychotherapists, while psychosomatic specialists undergo several years of internist training. On the other hand, the five-year-training of family physicians may include 6 months of psychiatric/psychosomatic practice but does not require any experience in mental health contexts. In

addition, the training requires a course-based training on psychosocial knowledge and psychosocial supervision (“Balint”), which may simplify also the somatic care for people with mental health problems. Still, the strict mono-speciality structure of physician qualifications does not adequately reflect the co-morbidity with mental and somatic diseases.

Also, staff of rescue and emergency services are often not trained sufficiently to adequately meet the needs of emergency patients, although mental problems are found in 30% of their patients. Although psychiatric aspects gain increasing importance in nursing and elderly care taking, the federal elderly care taker curriculum does not make any experience in psychiatric settings mandatory, despite the high rate of demented people.

Yet, changing the training in somatic disorders in people with mental health problems is currently not high on the agenda for physicians or other health professionals. The introduction of the physician speciality psychosomatic medicine somehow seems to fill the gap, yet these subspecialists (often with internist basic training) are primarily concerned with eating disorders and somatoform disorders.

In addition, people with severe mental health problems, particularly when they are socially marginalized, report to avoid physician surgeries and partly emergency rooms due to unwelcoming and derogative behaviour of staff (Trabert 1998; Bramesfeld et al. 2007). They also report an easy escalation of conflicts which may have led to a denial of services or the use of force (Lauf 2007; Bundesverband der Psychiatrieerfahrenen 2007; Bramesfeld 2007). Yet, health care personnel is often not trained in de-escalating conflicts.

4.4.6 Demand-side barriers, user attitudes and health (care) literacy.

People with depression and schizophrenia express preferences for shared-decision making with physicians to a similar degree as the average mixed patient samples in family physician practices (Loh et al. 2005). Yet, they often do not feel taken serious. In particular, providers often seem to interpret

physical complaints as part of their disease (itching in diabetes) or as adverse effects of their psycho-pharmacotherapy (Bundesverband Psychiatrie-Erfahrene 2007; Bramesfeld et al. 2006).

The most important demand-side barriers to general health care for people with mental health problems are anxiety and shame, negative experiences (in health care or with “other authorities”) and lack of capacity to choose alternatives of more appropriate care or to make the best of their entitlements (“health care literacy”). Also, lack of sufficient social support to exert health care literacy or the discrimination of their care-takers also be considered.

Since anxiety is often part of mental health problem or a common co-morbidity, they are at increased risk also to be more vulnerable to fears of health care interventions, professionals and institutions which are generally prevalent in the general population. Health care related fears include fear of treatment (dental care, interrogations with personal/intimate questions), (paranoic) fear of intoxication (drugs) and loss of the body’s integrity (invasive interventions), fear of having to fit in care structures and not meeting the social control requirements (as e.g. in waiting rooms, rehabilitation or prevention in group-settings), fear of not having access to addiction substances during inpatient stays (Bramesfeld et al. 2007; Adam 2007; Kott 2007; Lauf 2007; Scholz 2007; Bramesfeld 2007).

In particular, homeless persons are often found not to consult physician surgeries at all or to seek medical care with late disease stages. Many are afraid of large institutions; and many are perceived in some sense to be “undesirable” as patients (Trabert 1997).

Bad experiences in health care settings following conflicts or discrimination make it more difficult for some people with mental health problems to seek somatic care in time. The experience of involuntary admission and treatment may add to the scepticism against the patient friendliness of the “medical system”, although not all perceive involuntary care as negative ex-post. A recent study found that the number of compulsory admissions increased in Germany from 114.4 per 100 000 in 1992 to 190.5 per 100 000 in 2001. Their

number appeared to be substantially higher in Germany than in other European countries, a finding which however requires further investigation since the comparability of data appeared unclear (Priebe et al. 2005).

There is little patient information that targets people with mental health problems concerning their somatic health needs.

Reports of the key-informants suggest that people with mental health problems are less likely to access somatic health care when they live on their own than when they live and/or work in sheltered institutions where staff may support them if required. However, for institutionalized people with severe mental health problems, health promoting exercise and diet as well as access to somatic care very much depends upon the mental institution's staff responsiveness and training.

4.4.7 Policies

The somatic needs of people with mental health problems are being recognized in as far as acute psychiatric departments have largely been integrated into acute multi-disciplinary hospitals, where consultation services are easily accessible. Yet, the focus of the political debate otherwise has been on the access to good quality mental health care and mental social care. Policies, campaigns and scientific reports have focused on the need to diagnose mental morbidity and comorbidity in people presenting somatic problems rather than in somatic comorbidity of mentally ill people.

An expansion of SHI benefits has provided some potentials for supporting better access to somatic care through sociotherapeutic care (since 2000) and psychiatric nursing care (since 2003), although both types of benefits have been focused on mental health service delivery rather than somatic care. The barriers to the actual contracting, provision and utilization of sociotherapy are currently under revision in the Federal Joint Committee. The better recognition of access to somatic care has been recommended by several stakeholders reviewed but is still being discussed.

The draft reform of the social long-term care insurance, which shall get into force in July 2008, includes an improvement of benefits for demented people. In severe cases they may receive up to 2400€ more than under the current regulations. In addition to improving resources for general long-term care, specific low-threshold care structures shall be expanded to better meet the need of demented people. In addition, case management shall be expanded and the local coordination of services for the elderly and the disabled.

The German Society for Psychiatry, Psychotherapy and Neurology lobbies for the recognition for SHI funding for exercise courses for people with chronic mental health problems. The societies for gerontopsychiatry and geriatrics are strengthening their efforts to integrate palliative geriatrics and end-of-life-care into the medical training and professional development.

The competence networks on schizophrenia, suicide and depression have been developed into a research network on mental health problems in 2007. One of the current four projects focusses on barriers to health care access among socially marginalized people with mental health problems (Bramsfeld 2007):

In addition to improving care, the federal government has launched a large research program in October 2007 to foster research on basic science as well as clinical care and health services research. The network of participating institutions shall be built around university departments and clinics that are already active in the field, the core of the network being subject to a tender.

4.5 Conclusions

Access to somatic care for people with mental health problems has not been a focus in Germany, neither in the scientific nor in the political debate.

People with mental health problems are mainly affected by cost-related barriers, organizational hurdles and supply-side responsiveness which interrelate with demand-side barriers. Research and political debate have hitherto largely ignored deficits in the access to somatic health care for people with mental health problems.

While, on average, their overall utilization of health care has been documented to be higher than in the general population, it is unclear whether utilization sufficiently meets their need. Yet, barriers tend to reinforce each other, particularly in socially vulnerable groups. There is broad consensus that some of the most disadvantaged in these three groups experience serious access barriers.

To overcome demand-side barriers and their interaction with supply-side barriers it seems important to recognize the structural aspect of them, provide training to providers and proactively address stigma and prejudices. Respecting deficits and acknowledging resources has been recognized as a key attitude in dealing with marginalized groups. The design and implementation of strategies is likely to work best when people of the respective groups are involved or even leading.

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