MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE WITHIN THE FRAMEWORK OF SOCIAL SECURITY IN THE FEDERAL REPUBLIC OF GERMANY

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Belgium	(Soc. Sec. 1968/D.5)
Canada	(Soc. Sec. 1968/D.8)
Ecuador	(Soc. Sec. 1968/D.6)
Federal Republic of Germany	(Soc. Sec. 1968/D.7)
India	(Soc. Sec. 1968/D.1)
Poland	(Soc. Sec. 1968/D.2)
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United Kingdom	(Soc. Sec. 1968/D.3)

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NATIONAL MONOGRAPH ON THE ORGANISATION OF MEDICAL CARE UNDER THE SOCIAL INSURANCE SYSTEM

FEDERAL REPUBLIC OF GERMANY

A. Methods by which Members of the Population May Obtain (a) medical care in case of a morbid condition or of maternity, and (b) other personal health services

1. Statutory System

The German social sickness insurance system is a public institution based essentially on the statutory obligation to be insured which applies to all employed persons.

In addition to the compulsory insurance there is also voluntary insurance for persons who are not or have ceased to be covered by the obligation.

The scope of German social sickness insurance as regards persons is described under heading B.2 below. Its organisational structure may be described as the articulation of distinct units. This approach, which should be considered in the light of the history of sickness insurance in Germany, stems from the liberal idea of combining the principle of compulsory insurance with maximum freedom for the individual or group in establishing or choosing an insurance community. As a result, statutory provision is made for the following kinds of social sickness insurance institutions:

(1) local sickness funds;

(2) rural sickness funds;

(3) works sickness funds;

(4) guild sickness funds;

(5) substitute sickness funds for wage earners[1];

(6) substitute sickness funds for salaried employees[1];

(7) miners' sickness funds;

(8) seafarers' sickness fund.

Apart from the miners' and seafarers' funds, which are composed on an exclusively occupational basis, each employed person belongs, in principle, to the local sickness fund which is competent for his workplace or if there is no such institution, to the rural sickness fund. The latter, originally intended to serve as occupational

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[1] "The Insurance Code (1924) provided in Section 503 that the larger mutual insurance associations registered before 1 April 1909 could be authorised as "substitute sickness funds" for their respective districts and classes of members liable to insurance."

funds for agricultural workers, thus perform a twofold function: apart from their primary character they also have comprehensive scope in areas without local sickness funds. However, this is the case in only five small agricultural areas.

As already stated, the miners' and seafarers' sickness funds have a purely occupational composition. By statutory provision, all persons employed in mining or at sea have to enter these funds. Other compulsorily insurable persons cannot join them, each is a separate community for insurance against the special risks arising out of the character of the particular occupation.

A works sickness fund can be set up only for a particular establishment. Once it has been formed, all compulsorily insurable persons employed in that establishment must belong to it. If such a fund is dissolved or if the establishment ceases to exist, the employed persons concerned are directed to the local sickness fund which would, in principle, have been competent to insure them.

A guild sickness fund can be set up only for one or more handicraft guilds. Once it has been established, all compulsorily insurable persons in the particular guild, or one of the guilds which have formed a joint sickness fund, must belong to it. If the fund is dissolved, the members transfer to the competent local fund in the same way as those of an extinct works fund.

Membership of a substitute fund for wage earners, or of a substitute fund for salaried employees, depends on the free choice of the compulsorily insurable person, provided he belongs to the group of persons who can elect to take membership of a substitute fund. The following can so elect:

(a) in the case of a substitute fund for wage earners, any compulsorily insurable person belonging to an occupational group for which a wage earners' substitute fund has been set up;

(b) in the case of a substitute fund for salaried employees, any compulsorily insurable person whose activity is designated under insurance law as a "salaried employees' activity"

At present it is not permissible to set up substitute funds in addition to those which already exist.

2. Private Sickness Insurance

Private sickness insurance is individual and contractual insurance under private law. There are three types of insurance: full, partial and daily indemnity. For each of these types the insurance companies and associations offer a large number of tariffs, with a choice between a very low level of benefit and complete protection, which may be obtained by a combination or a cumulation of tariffs. In general the choice of tariff depends upon the financial possibilities of the person concerned. All the tariffs include different rates of contribution according to the age of the insured person at entry into insurance and sex. In principle contributions are reduced for children up to 21 years.

There are 93 insurance companies and several hundred small insurance associations. The latter generally operate on a local basis; their volume of contributions does not exceed 1 per cent. of the total volume of contributions for private insurance.

Private insurance is available to every person, even if he is covered by the statutory sickness insurance scheme. The number of insured persons does not emerge from the statistics on private sickness insurance, which show only the number of contracts, so that a person with several partial insurance contracts would be counted several times. At 30 June 1966, there were 6,640,000 full contracts, 8,990,000 partial contracts and 990,000 contracts for daily indemnities. The number of full insurance contracts corresponds to the result of an inquiry made in 1963, according to which 11.2 per cent. of the population were covered by private insurance.

5. Statistical Data on the Number of Persons Protected by the Various Schemes

More than 87 per cent. of the total population of the Federal Republic of Germany are protected in case of sickness by social sickness insurance. Further data on the subject will be found in the following statistical summary, ref. A.3, entitled "Members of Statutory Sickness Insurance and Insured Dependants on 1 September 1966".

Public employees are covered by their own statutory scheme, which reimburses part of the cost of medical care. In addition 58.4 per cent. of public employees are protected by the sickness insurance scheme, and 36.4 by private insurances; 5.2 per cent. are not insured.

It is not possible to indicate accurately the percentage of handicraftsmen, persons engaged in commerce and members of the liberal professions who are covered by sickness insurance.

7.1 per cent. of salaried employees are not covered by compulsory sickness insurance because their salaries exceed the ceiling for affiliation (10,800 D.M. per year). 5.3 per cent. are protected by private sickness insurance and 1.8 per cent. are not insured.

B. Summary of Provisions of Statutory Scheme

1. Contingencies Covered

Statutory sickness insurance provides for benefits in case of:

sickness (irrespective whether or not caused by an accident or an employment injury);

maternity;

death.

In principle, all the contingencies are covered for all the persons concerned; but in the case of voluntary members the benefits may be restricted by the rules of the particular fund either to medical care and hospitalisation or to the cash sickness benefit.

A.3

Members of Statutory Sickness Insurance and Insured Dependants on 1 September 1966

Type of Sickness Funds	1 No. of Funds	2 Compul. Memb.	3 Volun. Memb.	4 Pensioners	5 Aggreg. Memb. (2+3+4)	6 Protected Depend.	7 All Ins. Persons	8 Membership (Col.5) as % of Pop.	9 Insured Persons (Col.7) as % of Pop.
Local	401	9,624,134	1,954,366	3,848,248	15,426,748	According to a sample taken in 1963, there are 79 dependants for every 100 members.			
Rural	102	153,703	194,872	74,971	423,546				
Works	1,250	2,803,813	359,239	712,668	3,875,720				
Guild	177	1,105,629	117,982	90,519	1,314,130				
Seafarers'	1	54,855	10,371	7,592	72,818				
Miners'	8	469,462	34,839	772,026	1,276,327				
Substitute:									
Wage-earners	8	222,304	59,987	23,219	305,510				
Salaried employees	7	3,408,508	2,429,715	510,311	6,348,534				
TOTAL: 1966	1,954	17,842,408	5,161,371	6,039,554	29,043,333	22,944,233	51,987,566	48.6	87.0
at 1.9.65	1,971	16,845,838	6,063,091	5,903,428	28,812,357	22,761,762	51,574,119	48.6	87.1
at 1.9.64	1,979	17,132,291	5,574,740	5,774,176	28,481,207	22,500,154	50,981,361	48.6	87.0
at 1.9.63	1,998	17,363,301	5,130,685	5,689,698	28,183,684	22,265,110	50,448,794	48.7	87.2

2. Scope as regards Persons

Statutory sickness insurance covers:

(1) compulsory members,

(2) voluntary members, and

(3) dependants of the above groups, on fulfilment of certain conditions.

(1) Compulsory Members

The insurance extends in principle to all persons employed by others for remuneration, and also to apprentices even if unpaid. However, salaried employees are compulsorily insurable only if their regular annual earnings do not exceed 10,800 marks. Public officials, students, clergymen and persons whose employment is a spare-time occupation only, are not covered by the obligation. Furthermore, homeworkers, midwives, free-lance artists, teachers and educators and free-lance nurses (sick, confinement and infants' nursing) are insured only if their income from the free-lance activity does not exceed 10,800 marks a year.

The obligation to be insured extends also to any person drawing a pension from his own pension insurance, or having applied for such a pension, who was a member of a sickness insurance fund for not less than 52 weeks in the five years preceding his application.

The surviving dependants of the deceased insured persons are also insured if they receive or have applied for survivors' pensions. In the case of survivors of salaried employees who earned over 10,800 marks a year and were therefore not themselves insured, the insurance is conditional on the deceased's having been a member of a sickness fund for not less than 52 weeks in the previous five years.

Finally, all persons drawing unemployment benefit are, in principle, insured under the statutory scheme.

(2) Voluntary Members

There are two kinds of voluntary membership of statutory sickness insurance. First, persons who cease to be employed for remuneration or cease to draw unemployment benefit can continue to be insured on a voluntary footing ("continued insurance").

Second, persons who are excepted by some particular provision from the obligation to be insured, and also members of an employer's family who work in the undertaking, have the right to take up insurance on a voluntary footing ("voluntary entry"). The same right belongs to self-employed persons, not being compulsorily insurable, who regularly employ not more than two compulsorily insurable persons. Lastly, pensioners not fulfilling the conditions which would make them compulsorily insurable may insure on a voluntary footing. In the case of all the above groups, however, voluntary entry is dependent on the condition that the annual total income does not exceed 10,800 marks.

(3) Dependants

Every insured person, irrespective of the class of insured to which he belongs, is entitled to "family benefit" for his or her spouse if the latter is legally entitled to maintenance. An insured person's children, if entitled to maintenance, are also protected; the rules of the particular sickness fund may fix an age limit at which its obligation to provide benefit ceases. The rules may also declare other family members to be entitled to benefit: special conditions may be attached to such entitlement.

3. Range of Benefits

(1) Medical Care

The sickness funds provide ambulatory general practitioner, specialist and dental care, the insured person remaining free to choose between the practitioners approved for these purposes. In case of hospitalisation, care is given as a rule by a specialist because, the hospitals being divided into departments on the basis of specialities, there is always a specialist in charge of the respective department.

(2) Pharmaceutical Supplies

The necessary supplies are prescribed by the practitioners acting for the fund. No list of proprietary preparations is maintained.

(3) Hospitalisation

This includes provision of medical care and maintenance in a hospital - i.e. in an institution which is calculated, as regards accommodation, medical equipment, staffing and methods of treatment, to bring about the desired cure.

(4) Dentures

Arrangements are made to provide insured persons with dentures; the funds participate in the cost. At present the pension insurance institutions also share in the cost in so far as their beneficiaries are concerned. There is a tendency towards assumption of the total cost by the sickness funds.

(5) In addition to medical practitioners, there are chiropracticians, masseurs, bath establishments, etc., who or which provide insured persons with care on behalf of the funds if an approved medical practitioner so orders.

Furthermore, some sickness funds offer a service in the shape of their own dispensaries staffed by physicians in their employment. Some funds also provide cures in their own rest homes or maintain radiological institutes, dental clinics, and offices for the issue of spectacles. However, as a rule no further such establishments may be set up at present.

(6) Some of the funds' obligations towards protected persons are met on a basis wider than that of the particular locality. This is done in the case of benefits which cannot be provided locally, or not with

due expectation of success. The services in question are performed by a department of the district wage earners' pension institution, which assumes responsibility for what are known as "sickness insurance joint services". According to the statutory provisions, the operation of sanatoria, curative, convalescent and similar establishments and the taking of preventive measures to protect health (mass innoculations, for instance) are classified as joint services.

4. Qualifying Conditions for Medical Care

Sickness Benefits

(1) The sickness insurance funds provide care (including medical treatment, dental treatment, pharmaceutical and medical supplies) on the following conditions:

(a) Members

The only condition for grant of benefit is membership. This applies to all kinds of insured persons.

(b) Dependants

Benefits are granted if:

the person from whose insurance the claim stems is a member of the fund, and

the patient is a dependant entitled to claim benefit under the rules, and

the patient has no statutory claim to the same or similar benefits from another source.

(2) The sickness funds may grant hospital care. This benefit is, in general, always allowed if medically necessary.

(a) Members: conditions as under (1)(a) above.

(b) Dependants: conditions as under (1)(b) above.

(3) Dentures

(a) Members:) The sickness funds pay a contribution
) to the cost of dentures, according to
(b) Dependants:) their own directives.

(4) Provision of major medical and surgical requirements, convalescent care, measures to prevent disease of particular members or dependants:

(a) Members:) The rules or directives of the particular
) sickness funds determine whether and to what
(b) Dependants:) extent the fund shall contribute to the cost.

Medical Care in Case of Maternity

In case of maternity, provision of benefit under sickness insurance depends on the condition that the mother (if she is a member of the fund) or the person from whose insurance the claim stems (if the mother is a dependant) must be able to show a total duration of ten months' insurance in the preceding two years, including six months in the preceding year.

"Family" maternity benefit is granted only to wives of insured persons, and to their daughters, step-daughters or adopted daughters if living in the household. A person entitled to maternity benefit as an insured person cannot claim it as a dependant.

The following benefits are provided:

(1) Medical care including examinations to ascertain pregnancy and pre-natal examinations (with laboratory tests).

It should be pointed out that pre-natal care is given even if the above-mentioned qualifying period of insurance has not been completed. It is given to the same extent to members and to dependants.

(2) Obstetrical assistance, pharmaceutical and medical supplies.

These are also given to the same extent to all persons entitled to maternity benefit.

5. Period of Protection after Cessation of Insurance

If the contingency (sickness) occurs within three weeks of a person's ceasing to engage in a compulsorily insurable occupation, or of ceasing to receive unemployment benefit, that person may claim the statutory sickness benefits, but not the additional benefits provided for in the rules of the fund - i.e. he may receive medical care and the cash benefit or hospitalisation - for a maximum of 29 weeks after cessation. The following conditions must also be fulfilled: the person must not have been employed (or self-employed) for gain since the cessation; he must be able to show a period of insurance of six weeks immediately preceding the cessation, or a total of 26 weeks' insurance during the past year; he must not be gainfully active when the contingency occurs.

6. Limitations in Duration of Benefits

Care in case of sickness is given to insured persons and their dependants, during membership, without other limit as regards time. It may continue for not more than 26 weeks after cessation of insurance, provided the sickness began during membership.

Hospitalisation

The cash sickness benefit or hospitalisation is also given without limit of time, except that in respect of the same sickness it may not be given for a total of more than 78 weeks in any three consecutive years; this maximum is not extended if the patient becomes affected by an additional disease. If the sickness starts

during membership, whereas the incapacity for work or need for hospitalisation starts after cessation of membership but during receipt of care, the person is entitled to the cash sickness benefit or hospitalisation for 78 weeks; the period of receipt of care then coincides with the period of receipt of the cash benefit (or hospitalisation) and so may in some circumstances exceed the above-mentioned limit of 26 weeks.

Extension of the period in special cases is not possible.

7. Provision for Cost-Sharing by Beneficiary

The beneficiary has to pay a charge at the pharmacy, optician's, etc., for each prescription handed in, irrespective of the number of medicaments prescribed thereon. The amount is 50 pfennig, save that it cannot exceed the value of what has been prescribed.

The following are however excused the charge: persons compulsorily insured as pensioners, and their dependants; voluntarily insured pensioners, and their dependants; members who are incapacitated, and their dependants, in respect of prescriptions made out after the tenth day of incapacity for work; persons suffering severe war disablement, and their dependants.

Statutory provision for reimbursement of the cost of pharmaceutical supplies is made in one case only: if an employer sends his employee abroad and the latter falls sick during the absence while remaining compulsorily insured, the employer has to make available, in the foreign country, such benefits as the sickness fund would normally provide and the fund reimburses the cost to him.

However, a form of reimbursement which has grown up in practice as a result of the increasing foreign holiday travel is applied more and more frequently: if a person insured with a German sickness fund goes to a country in which provision of benefits is not ensured under a social insurance convention, the cost of any medical care which becomes necessary during his absence, together with the cost of pharmaceutical supplies, is reimbursed up to an appropriate level - usually, up to the amount which the same care etc. would have cost at home.

8. Administration

(1) Administrative Organisation

The internal administrative organisation of the particular sickness funds is determined by their functions. There are no statutory provisions governing their internal organisation in detail (the term "internal organisation" being used in the sense of the articulation of the administrative machinery by which the business is conducted).

The sickness funds have constantly been distinguished by great flexibility and aptitude for adjustment as regards administrative organisation. This is particularly due to the fact that, according to the legal and practical situation of the moment, they

very often have acted, do act and - because they stand so close to the individual citizen - will continue to act as agents for the performance of functions with which they are not essentially concerned. The following may be quoted as instances of the non-essential functions which they carry out by delegation (the list is not exhaustive): collection of contributions to the wage-earners' and salaried employees' pension insurance institutions, and to unemployment insurance; transmittal of the said contributions to the insurance institutions concerned; care of war disabled for account of the Federal Republic, and obtaining reimbursement of the moneys so expended; application of the Maternity Protection Act for account of the Federal Republic, and obtaining reimbursement of that expenditure also; care - on account of the Federal Republic and Provinces - of persons who suffered from political persecution, and obtaining reimbursement of that expenditure; giving benefits on behalf of the pension insurance institutions, and obtaining reimbursement; giving benefits on behalf of accident insurance, and obtaining reimbursement.

It is evident that, having regard to the multiplicity of the duties to be performed, and the constant changes therein, a hard-and-fast administrative structure cannot be adopted; nor would that be possible having regard to the great differences in size between the individual funds.

But it should not be assumed that the administrative conduct of the sickness funds is free of all statutory control. On the contrary, there are strict rules on sickness insurance administration, issued by the federal authorities; but, mandatory though these rules may be, they merely regulate administrative action in general terms, according to objective principles which ensure its due reliability. The form of administrative organisation is left very much to the particular insurance institution.

Hitherto the internal organisation of the sickness funds has been determined largely by traditional ideas. However, the trend towards adoption of modern organisational methods, which inevitably followed the rapid spread of electronic data processing, has had its effect. A fair number of the big sickness funds already use electronic procedures, and smaller ones are considering pooling their administrative arrangements in order to be able to afford such procedures themselves. The ultimate visible objective - recognised and aimed at by the federation of sickness funds - is integrated processing of data within social insurance as a whole, including its partners in the widest sense, of which the State is one.

As was stated earlier, the inner organisational structure of the sickness funds is determined by the functions which they carry out: the uniformity of the functions to be performed by all the funds has inevitably led to uniform basic arrangements of internal organisation. This latter uniformity is reflected in the administrative articulation, which may be described as follows:

(a) Management

The current business of the fund is administered under the responsibility of the manager, a full-time officer chosen by the board. He is the official chief of all the other employees of the fund. A permanent deputy may be appointed to assist him, by decision of the board. The manager alone will not as a rule be able to do all the work classified as managerial, unless the fund is a very small one; so he appoints assistants who, with himself, make up a department, usually entitled "management" or something of the kind. Its duties include supervision of the staff, issue of service instructions, etc., co-operation with the organs representing insured persons, relations with the supervisory authority, the federations and the persons with whom the fund has a contractual relationship, the handling of questions of principle, personnel administration legal matters and internal administration (tele-communications, postal business, automobiles, procurement, duplication and other technical services).

(b) Finance and Accounts

In every sickness fund this branch of administration is a self-contained unit within the general organisational structure. The finance and accounts department deals with income and expenditure, and must always be able to indicate the financial situation of the fund, i.e. to say what moneys it has at its disposal at a given time, where they are and how they are invested.

It should be pointed out in this connection that the sickness funds are not free to invest their money as they please but are subject to strict statutory provisions, compliance with which is very closely supervised by the authorities. As sickness insurance covers short-term contingencies, which occur in a rhythm and intensity that cannot as a rule be foreseen, a sickness fund must always have cash readily available; and this means that the mass of its available resources can only be invested at short term. It is also required by statute to form a reserve on which it can always fall back in an emergency.

Lastly, in the finance and accounts department all income and expenditure are so recorded and documented that every change in the level of property of the fund can be checked without room for error. Income must be objectively classified according to its origin, and expenditure according to its purpose, so that the causes determining the financial position of the fund can be perceived at any time. The entries of receipts and spendings form the basis of advance estimates for the coming financial year and are summarised in the closed accounts for the past financial year, on which a report has to be made to the meeting of delegates.

(c) Contributions Department

Another department of every sickness fund is that which deals with contributions. Owing to the great volume of its work, this is almost always subdivided. The contributions department is required not only to collect the sickness insurance contributions, but also to collect and transmit the contributions to pension and unemployment insurance. Calculation of the contributions of compulsorily insured persons is done according to either the "wage class" or the "real earnings" system. Under the wage class system, usually employed in small undertakings, the sickness fund works out the sums and sends the firm a statement of account. The real earnings system is permitted in the case of larger undertakings, which have their own fully equipped wages offices: these calculate the sickness insurance contributions and set them out in a monthly statement which they have to render to the funds concerned. All undertakings are checked in turn by the sickness fund over a two-year period; for this purpose the fund maintains a "works control group" as a subdivision of its contributions department. Lastly, the contributions department also has the special function of compulsory collection of moneys owed (the sickness funds are, by statute, public executive authorities).

(d) Benefits Department

Every sickness fund has its benefits department which is equal in importance to the contributions department. It has to grant both the sickness insurance benefits and the benefits allowed on behalf of other insurance institutions (accident or pension insurance) or on behalf of the Federal Republic (medical treatment for war disabled and political victims, maternity assistance, etc.). Matters of restitution and recovery are usually handled by the benefits department as a special duty.

(e) Payments Control

The benefits department does not directly pay benefits, but merely states that an insured person is entitled. It makes out an order for payment, which is put into effect by the finance and accounts department or by a cashier's office attached to this. In the case of payments in kind the benefits department issues a form (cost recognition form for hospitalisation, authorisation for medical or surgical supplies, etc.). These papers are eventually returned by the services from which the insured persons have received the benefits in kind, with a bill to the fund for the cost insurred in each case. The bills are checked both mathematically and technically by the payments control department, which also makes out the orders for payment and sends them on to finance and accounts for settlement.

(f) Internal Audit

Lastly, there is an internal audit department. This, unlike all the other branches, does not handle any particular self-contained area of insurance administration. Instead, the internal audit department checks on the work of all the others, so as to ensure that they perform their particular functions rightly, in accordance with statutory provisions and the rules of the fund; it checks whether all receipts and expenditures have been correctly calculated and duly justified, whether any embezzlement or other improper acts have been committed, etc.; in fact, the main object of its work is to ensure administrative security. Lastly, this department is responsible for obtaining maximum efficiency in administrative procedures. Very big sickness funds have their own efficiency specialists.

(2) Participation in Management by the Parties concerned (Persons Protected or Contributors, Employers and Public Authorities)

Being organs of indirect government, the statutory sickness funds are self-administered corporations. The employers and the insured persons participate, without payment, in the management. The organs of each fund, namely the delegate meeting (comparable to a parliament) and the board ("top management") are composed of equal numbers of employers' and insured persons' representatives. These persons are chosen, at the "social elections", for membership of either of the two organs.

The substitute funds are an exception in that their organs are composed of insured persons' representatives only.

The delegate meeting is the organ responsible for filling in the framework set by social legislation, and particularly for determining the rules of the fund. It also has to make the estimates for the coming financial year and, at the end of the year, to approve the final accounts.

The board is responsible for the general conduct of the sickness fund. It has power to act on behalf of the fund and accordingly concludes the contracts with medical and dental practitioners, pharmacists, hospitals and other persons or institutions. It selects and appoints the full-time manager of the fund, appoints all other personnel and decides regarding their promotion and separation.

(3) Supervision by Public Authorities

Because the sickness funds are self-administered corporations, they are subject to supervision by the State. The supervision relates essentially to points of law - i.e. whether the fund gives effect to statutory provisions and to its own rules. In some cases the supervision also relates to the efficiency of the action taken by the fund.

9. Financing

Sickness insurance benefits are financed by means of contributions.

In the case of compulsorily insurable employed persons, the contributions are paid half by the employer and half by the insured. In principle, compulsorily insurable self-employed persons pay the whole contribution themselves. The same applies to voluntary members, except voluntarily insured pensioners, in whose case the pension insurance institution participates. In the case of compulsorily insured pensioners the pension insurance institution pays the whole contribution. Both the participation (for voluntarily insured pensioners) and the full amount of the contribution (for compulsorily insured pensioners) are additional to payment of the pension. The contributions of pension insurance institutions on behalf of pensioners do not cover the expenditure for this category of insured persons and it will increase from year to year. In 1965 the deficit for the local funds attained 26.1 per cent. of their expenditure. In the case of unemployed persons the contribution is paid by the unemployment insurance institution.

The sickness funds, as indirect organs of government, are in principle excused from payment of taxes - so far as regards the performance of their specific tasks, but not if they also engage in economic activity. The persons with whom the sickness funds have contractual arrangements (pharmacists, opticians, bandage-makers, etc.) are excused from turnover tax on goods supplied to the funds.

No provision is made for direct financial participation by the public authorities. There is provision for financial participation by the organisation which established the particular sickness fund, if the factors determining receipts have reached a certain level and there is nevertheless a shortfall: but the establishing organisations are not all public authorities - the local and rural funds are established by the local government authorities, the guild funds by the handicraft guilds and the works funds by the employers.

10. Right of Complaint

(1) Complaint of Refusal of Benefit

If benefit is refused, the insured person is entitled to take action to secure it. A communication stating the refusal is made to him, and he may contest this in a complaint to the social court.

(2) Complaint as to Quality or Quantity of Benefit

The sickness funds are required to ensure that care in case of sickness (medical care and pharmaceutical supplies) is provided as a benefit in kind. They employ medical practitioners, dentists, pharmacies, hospitals, etc. to provide the benefit. This brings the insured person into a private-law relationship with the practitioner or other agency. If the benefit provided by the latter is defective in quality or quantity, the insured person can take pro-

ceedings before a civil court to obtain a proper benefit. In addition he may apply to the sickness fund, which will attempt to induce the contracting agency to provide benefit of the proper standard.

Disputes before bodies dealing with claims concerning sickness insurance in 1966.

Claims not settled at the beginning of the reference period	1,358
Claims presented to the competent bodies in the reference period	7,370
Claims settled in the reference period	7,611
Claims not settled at the end of the reference period	1,117
Claims settled in the reference period:	
(a) Withdrawal of claim	730
(b) Decisions	
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C. Application of Statutory Scheme and Discussion of Experience and Problems

1. Ambulatory and Domiciliary General Practitioner Case

(1) Except for the miners' sickness funds, which are competent only for persons employed in mining undertakings, the statutory sickness insurance institutions (local, rural, works, guild and substitute funds) do not have their own clinics. In some cases, in areas where mining is concentrated such as the Ruhr, miners'

sickness funds have their own special hospitals, the main function of which is to provide in-patient care; for this purpose the miners' hospitals are accessible to persons due for benefit from other sickness funds also. Ambulatory care at such hospitals is of minor importance. Save in exceptional (emergency) cases, the out-patients' department of a miners' hospital is available to members of miners' sickness funds and their dependants only on the strength of orders by a miners' fund medical officer. Domiciliary care is not given as part of the out-patients' service: the miners' fund medical officers are competent to provide this. The out-patients' departments of the miners' hospitals are used, by order of a miners' fund medical officer, chiefly in cases in which the character of the particular morbid condition is such as to require special diagnostical or therapeutical measures which cannot be taken in normal practice but only by specialists attached to the hospitals or by means of the hospitals better material equipment, as the case may be.

The medical practitioners working at the miners' hospitals are either in course of training as specialists or already have specialist qualifications; it may be said, in any case, that because the hospitals are divided into specialist departments, the medical practitioners work as specialists there.

The question also arises whether the medical care given by way of ambulatory treatment at the hospitals is general practitioner care. Although, according to the professional codes of the federated provinces, the hospital medical practitioners who were still training as specialists on approval of the particular code could not immediately have started private practice as specialists, nevertheless - having regard to its special purpose - ambulatory care at a hospital can only exceptionally be regarded as general practitioner care; as a rule it is likely to be specialist care (see under 2.). In a purely legal sense and also in practice, from the standpoint of the beneficiary, it is indifferent whether such ambulatory care has to be classified as specialist or as general practitioner care.

The miners' funds cover only about 4.5 per cent. of all persons insured with statutory sickness funds. Members of this relatively small proportion are, again, only exceptionally treated by general practitioners in the out-patients' departments of hospitals belonging to the miners' funds: so that, although this item in the Model Plan may have theoretical importance, in terms of the medical-care system as a whole it involves no real problem.

(2) Similarly, ambulatory care given at hospitals not belonging to miners' funds (the overwhelming majority of the approximately 3,650 hospitals) is only a minor part of all ambulatory care given to persons insured against sickness. As this care is usually given by specialists, and so is not general practitioner care, further information about it will be found below under "2. Specialist Care ...".

(3) Medical care is given mainly by general practitioners in independent practice although a trend may be observed under which treatment by specialists is steadily increasing (cf. also under H 1 b).

On 31 December 1965 there were altogether 90,745 physicians in the Federal Republic. Of these 85,801 were engaged in their profession, namely 49,222 (57.37 per cent.) as general practitioners and 56,579 (42.63 per cent.) as specialists. Of the 85,801 active practitioners, 50,215 were in independent practice, 26,535 were employed by hospitals and 9,051 in administration.

The above figures mean that on 31 December 1965 there was one medical practitioner for every 691 members of the population. The ratio has developed as follows in the last few years.

	Active Medical Practitioners	Inhabitants per Practitioner
1960	79,350	703
1961	80,825	700
1962	82,097	697
1963	83,025	697
1964	84,203	696
1965	85,801	691

The fact of being established in independent practice is however not sufficient to enable the practitioner to give medical care, at the expense of a statutory sickness fund, to persons entitled to benefit from the fund and their dependants. Such practitioners require a special authorisation ("approval"). Most independent medical practitioners have this approval (cf G. c).

Of the 50,215 medical practitioners in independent practice on 31 December 1965, 43,765 were approved for sickness fund work, i.e. they were authorised to provide care for persons entitled to benefit from the local, rural, works and guild sickness funds, and their dependants, at the expense of the respective funds. The number has developed as follows in recent years:

	Number of Physicians Approved for Sickness Fund Practice
1960	42,144
1961	42,763
1962	43,284
1963	43,667
1964	43,647
1965	43,765

To be complete, it should be stated that medical practitioners who take part in the provision of care for persons insured against sickness under the statutory scheme do not thereby lose the right to treat persons not protected in this way, i.e. to engage in private practice.

In order that it may be understood under what provisions and in what legal form a medical practitioner who has been authorised to give care to persons protected by statutory sickness insurance is bound to the insurance scheme, the following information on the system of contracts is given in accordance with the Model Plan. The position differs as between the various kinds of sickness funds.

(a) Local, Rural, Works and Guild Funds

Under section 182 of the Insurance Code, the above funds (known as "Insurance Code funds") are required to provide medical care as a benefit in kind. According to section 368 in subsection 1 of the Code, the associations of sickness fund practitioners (regional associations of physicians engaged in sickness insurance work, having the status of corporations in public law) are required to give the medical care for which the funds are responsible and to take over from the sickness funds and their federations the guarantee that the benefits provided by the funds will correspond to statutory and contractual requirements. The Code provides further (in section 368g, subsection 1) that, within the framework of statutory provisions and of directives issued by the "Federal Committee" (an organ for joint self-administration composed of representatives of the practitioners and of the sickness funds), the provision of medical care by the sickness fund practitioners shall be regulated in written contracts between the practitioners' association and the funds and their federations. Within this statutory framework, the actual stipulations are determined at the local level by what are called "comprehensive contracts" (concluded between the particular sickness funds and the respective local associations of sickness fund practitioners) and at the federal level by "federal blanket contracts" which determine the general contents of the comprehensive contracts and are concluded between the federal organisations of practitioners and sickness funds respectively.

The federal blanket contracts can be supplemented, if regional conditions so require, by "provincial blanket contracts" between the practitioners' associations and the federations of sickness funds at the level of the particular province.

Excepting those at the provincial level, the above contracts must be brought into existence. If a contract respecting the provision of sickness insurance medical care is not concluded - or not in full - by negotiation, its contents have to be determined by an arbitration board. The boards are composed of representatives of the sickness funds and sickness fund practitioners in equal numbers with a neutral chairman; they are one of the organs for joint self-administration by the two parties. Hence, under the regulations governing the activity of sickness fund practitioners, there cannot be a contractual vacuum or a physicians' strike.

The contracts concluded by the practitioners' associations and by the Federal Association of Sickness Fund Practitioners are binding on all practitioners engaged in sickness fund work (section 368m, subsection 2 of the Insurance Code). Similarly, the rules of the provincial federations of sickness funds must provide that the contracts concluded by their federal organisations are binding on the particular local, rural, works and guild sickness funds concerned (section 414b subsection 2 of the Code).

It results from this system of contracts that there is no direct legal relationship between the individual practitioner and the particular sickness funds on behalf of which he is entitled to give medical care. A practitioner who wishes to attend sickness fund members enters, on the basis of a special authorisation, into a public-law relationship with the association of sickness fund practitioners. The resulting relationship is compulsory because the practitioner then has both the right and the obligation to take part in the provision of sickness insurance benefit (section 308a subsection 4 of the Code) and the contractual stipulations respecting provision of such benefit are binding on the practitioner.

The authorisation is given in respect of a particular place. The procedure is regulated in detail by a special "Approvals Order" and authorisation is decided by "approval committees" (joint organs for self-administration, composed of representatives of the practitioners and the funds). A practitioner wishing to be approved has to meet specific standards regarding his qualifications. Approval can be withdrawn in specified circumstances, for instance if a physician commits a gross breach of his obligations as a sickness fund practitioner. In order to ensure sufficient medical care, the Insurance Code formerly prescribed (in section 308a subsection 1) that as a rule one practitioner should be approved for every 500 members of sickness funds. However, by judgment of 23 March 1960 the Federal Constitutional Court declared the relevant provision of the Code to be unconstitutional and therefore null and void; so admittance to sickness fund practice is no longer subject to any numerical restriction (as regards the effect of this situation and related problems, see below under H.1). In urgent cases practitioners not approved for sickness insurance work may be called in by patients; such attendance is then considered to be sickness insurance benefit, i.e. the insured person does not become the practitioner's private patient.

In special circumstances, practitioners may be authorised, by decision of the approval committee, to take part in the provision of sickness fund benefit for periods of up to one year, in order to ensure sufficient medical care (particularly in an emergency), or to attend a restricted group of persons, or to provide specific medical services. However, this special form of medical attendance known as participation, is insignificant in terms of the over-all situation, for only 136 practitioners acted on such a footing in 1965. In addition about 2,000 chief physicians or chiefs of departments, of hospitals participated in sickness fund work in 1965 (see C2a).

(b) Substitute Funds

Whereas the associations of sickness fund practitioners are obliged to ensure provision of benefits on behalf of the "Insurance Code funds", there is no such obligation in respect of the substitute funds. According to section 368n subsection 1, last sentence of the Insurance Code, the practitioners' associations may take on further activities related to medical care, particularly on behalf of substitute funds. The relations between these funds and the practitioners are determined by contracts freely concluded with the practitioners' associations. Unlike those of the Insurance Code funds, the contracts concluded by the substitute funds are not subject to standards laid down in the Code; and as there is no obligation to have such contracts, there is also no statutory provision for arbitration to determine the contents of a contract, with binding force, if it has not been concluded by negotiation. The above situation also has the consequence that the Federal Association of Sickness Fund Practitioners, the body which controls conclusion of the contracts, can to a large extent determine their stipulations, thanks to its monopoly; so, again unlike the position regarding the Insurance Code funds, a contractual vacuum and a physicians' strike are possible here.

As in the case of the Insurance Code funds, there is no direct contractual relationship between the substitute sickness fund and the individual practitioner: the individual practitioners' relationship with the substitute fund is only through the Federal Association of Sickness Fund Practitioners.

There is no statutory provision for a regular approval procedure, with jointly manned committees, in the case of the substitute funds. By unilateral decision on the part of the Federal Association of Sickness Fund Practitioners, such practitioners engage in the work as have been approved in respect of the Insurance Code funds, or could be so approved, and have undertaken to discharge the duties set out in the contract. The right to take part in substitute fund practice applies to each physician personally and to the particular place or district for which it has been conferred. The persons entitled to benefit are the members of the substitute funds (with their dependants) whose annual income does not exceed the upper limit of compulsory pension insurance for salaried employees (now 1,800 marks a month). A practitioner not participating in substitute fund work can also be called upon in case of urgency.

(c) Miners' Funds

Section 204 of the Miners' Insurance Act empowers the miners' sickness funds to regulate their relations with medical practitioners according to local conditions, i.e. the provisions of the Insurance Code regarding sickness fund practice do not apply.

The miners' funds have chosen two methods of regulating their legal relations with medical practitioners:

(a) provision for medical care by means of contracts with the associations of sickness fund practitioners;

(b) the system of "miners' fund medical officers".

(a) The former system applies in respect of about 20 per cent. of all persons insured with miners' funds. It operates in areas where there are mines but the mining population (members of miners' sickness funds) is of low density, as in the Province of Hesse. In such areas the funds provide their membership with medical care by arranging for the physicians, etc. authorised to engage in sickness fund practice under the Insurance Code to take care of the miners and their families also. This arrangement is based on "comprehensive contracts" concluded by the miners' funds with the respective associations of sickness fund practitioners.

(b) The system of miners' fund medical officers is of greater practical importance. Where it applies, the area covered by a particular miners' sickness fund is divided into medical districts. In each such district a general practitioner acts as the family physician (he is often called the Sprengelarzt or "district doctor") for all the miners, pensioned miners and their dependants living there. Appointment to act in this capacity is usually made after the vacancy has been published by the joint organs of management of the fund, (i.e. without the participation of the medical practitioners or their organisations) and takes the form of a private contract of employment. There is no obligation to contract with all physicians willing to be approved; in this respect the practice differs from that of the insurance code funds. The miners' funds may restrict the numbers of "district doctors" according to local needs.

To sum up, it may be stated that a direct contractual link with the insurance fund - this was the condition for inclusion of general practitioner case here - exists only in the case of the miners' fund medical officers. There is some link with the fund in the other cases also, but it must be regarded as indirect because associations (or the Federal Association) of sickness fund practitioners intervene. The above full description should also contribute to an understanding of the information given under D.1 below.

(4) and (5) In principle, persons protected by the Insurance Code funds and substitute funds have free choice among the practitioners who are approved for or take part in the particular kind of sickness-fund practice. The same applies to persons protected by the miners' funds unless they are cared for under the medical officer system described above. Sickness fund practitioners and those engaging in substitute fund practice cannot, as a rule, refuse patients: they may only do so exceptionaly and for good reason.

However, freedom of choice is to some extent restricted. If, without mandatory cause, a patient applies to a physician other than one of the Insurance Code or substitute fund practitioners who are closest to hand, the insured person has to bear the additional costs: these would include, for instance, such displacement charges as a physician living at a considerable distance would not be able to collect from the sickness fund (he would only be able to collect a charge corresponding to the distance from the patient's home to the office of one of the two physicians nearest to the patient).

The insured person is required to prove his claim to medical care by presenting a sickness form to the physician (cf. under 13 below). One sickness form holds good for a single "case" which means all the care given by the same physician to the same patient in the same calendar quarter year. This method usually ties the insured person to the physician he has once chosen. Change of physician within a calendar quarter is permissible only exceptionally and for good reason, which must be stated.

The principle of free choice does not apply at all under the miners' fund medical officer system. As already stated, the "district doctor" has to give medical care to all the protected persons residing in his personal district. All insured persons, pensioners (of the miners' pension insurance) and their entitled dependants have to register at the office of the medical officer who is responsible for their care. To this extent their freedom of choice is restricted. An insured person or pensioner can only reregister with a "district doctor", (other than the one to whom he was allotted on the ground of residence) who lives within four kilometres - two-and-a-half miles of his home: this he may do at the "census" of the fund, held every spring and autumn, and the change will have effect on 1 April or 1 October; at other times such a reregistration is possible only in exceptional cases, when confidence between the physician and his patient has been broken down; the reregistration applies to an insured person's protected dependants as well as to himself.

A salaried employee of a mine undertaking is entitled, at the funds' census, to elect for private practitioner care. In that case he drops out of the miners' fund medical care system and receives benefit from the fund in the form of cost reimbursement. He chooses his own physician and becomes the latter's private patient.

Except under the miners' fund medical officer system, free choice among sickness fund practitioners applies, in principle, not only to ambulatory care (at the physician's office) but also to domiciliary care. A patient is entitled to the latter only if it would be impossible or unreasonable for him to go to the physician's office. He should, as a rule, not call for domiciliary care on a physician whose office is considerably further from the patient's home than the office of another physician: as regards additional costs to be borne by the insured person, see above. A physician may refuse to make a visit outside his usual practising area, unless the case is urgent and no physician living closer can be reached.

2. Specialist Care at Hospitals for In-Patients and Out-Patients and Specialist Care Outside Hospitals

(1) As stated under C.1(1), the only statutory sickness insurance institutions which maintain separate hospitals are some of the miners' funds: persons entitled to benefit can receive out-patient care at such a hospital by order of a miners' fund medical officer. As also stated, this is likely in most cases to be specialist care. However, the kind of medical care given is of no practical importance in terms of the system as a whole. Statistics cannot be given for lack of relevant data.

(2) Compared to the miners' hospitals, those belonging to public authorities or to private undertakings or persons give a greater volume of specialist out-patient care; but the bulk of such care is provided by specialists in independent practice. Comprehensive statistics cannot be given as with some exceptions the hospitals do not have the relevant numerical data.

The kinds of ambulatory treatment described below can be claimed by patients of the Insurance Code funds and substitute funds. The latter provide it under contracts concluded on a voluntary basis. Practice among the Insurance Code funds differs, as explained below.

(a) Participation of Principal Physicians at Hospitals in Sickness Fund Practice

As regards the insurance Code funds, section 368a subsection 8 of the Code provides that the chief physician of a hospital, or the chief of a separate specialist department of a hospital, whether he is a public official or a salaried employee, must at his request be authorised by the approvals committee to participate in the care of sickness fund patients, on referral by a fund practitioner, for the duration of his employment at the hospital. While and in so far as they participate, such persons have the same rights and duties as sickness fund practitioners. The Approvals Order states specifically (in section 29, subsection 2) that a chief physician or chief of department may participate only in the ambulatory care of sickness fund patients: this makes it clear that his participation can not be extended to the in-patient care of sickness fund patients. (As regards in-patient care by physicians in independent practice, see under C.4.) According to the Approvals Order, the participation of chief physicians and chiefs of departments extends to the following acts:

(1) examination for diagnosis;

(2) consultation with a sickness fund practitioner in course of treatment;

(3) use of special methods of examination and treatment, particularly medico-technical methods (see under (b) below);

(4) ambulatory convalescent treatment following in-patient care, in agreement with the sickness fund practitioner concerned.

The approval committee may restrict participation to some of the above-mentioned medical acts. In certain circumstances such an authorisation may be rescinded (for instance, if the conditions which gave rise to the participation no longer apply).

On 3 December 1964, 1,880 chief physicians and chiefs of departments of hospitals were participating in sickness fund practice (1,987 in 1965). As the total number of authorised sickness fund physicians stood at 43,647 in 1966 and 43,765 in 1965, the percentage of chiefs was 4.31 in the former year and 4.54 in the latter.[1]

There are no data to indicate the specialities concerned. Such participation does not raise any particular problems, but the following point of difference from full engagement in sickness fund practice may be noted. Whereas, in accordance with the judgment of the Federal Constitutional Court mentioned under C.1(3)a, the access of physicians in independent practice to sickness fund work is effectively unlimited, irrespective of the need for their services, "participation" needs to be authorised only if it is necessary with a view to ensuring sufficient medical care. The Constitutional Court decided, by judgment of 23 July 1963, that the relevant provision of section 368a, subsection 1 of the Insurance Code is consistent with the Constitution.

(b) Use of Certain Technical Methods in Hospitals

Medical care of sickness fund patients includes also the use of medico-technical methods of examination and treatment (which can also be used on instructions by the chief physicians and chiefs of departments as part of their "participation" - see preceding section (a)). The top-level organisations of sickness fund practitioners and of local, rural, works and guild sickness funds agreed, on 22 November 1944, as to which "medico-technical benefits" (ärztliche Sachleistungen) should be classified as permissible. They are as follows:

röntgen examinations and treatments;

radium irradiation;

electro-cardiograms laboratory examinations;

diathermic and short-wave treatments;

electrical shock treatment;

high frequency treatment;

galvanism and faradism;

four-cell electrical treatment (four-cell bath);

irradiation with artificial sunlight or quartz lamp;

sollux, red ray, arc light and similar irradiations;

electrothermal treatments - full or partial, hot-air treatments - full or partial, steam bath, etc.;

[1] Date from KBV-Statistik 1966.

medico-mechanical treatments;

massage;

gymnastics (including respiratory and infants' gymnastics).

The characteristic feature of medico-technical methods is that the physician uses some apparatus or other material means. If the success of the treatment depends essentially on the personal activity of the physician, and the effect of the apparatus is therefore less important, the whole treatment counts as medical. Classification of a particular technical method as medico-technical means that the insured person is entitled to it to the same extent as other medical treatments. Medico-technical benefits include also services rendered by a person assisting the physician (such as a masseur employed by a medical practitioner or hospital) in which case the physician must at least give personal supervision and guidance.

Of course, sickness fund physicians in independent practice also may use medico-technical methods if they have the right equipment and the necessary training. For completeness, however, it should be noted here that the regulations for the use of röntgen therapy have been tightened up. Under Clause 15 of the Federal Blanket Agreement for Physicians - see C.1(3) - röntgen methods may be used in sickness fund practice only by those physicians who provide the competent association of sickness fund practitioners with evidence that satisfactory equipment is available to them. Directives regarding the standards to be met by röntgen equipment are issued by the Federal Association of Sickness Fund Practitioners. Authorisation to use röntgen therapy is given only (apart from specialists in röntgen and irradiation treatment) to practitioners who show that they fulfil the special requirements. The authorisation can be restricted to the use of specified röntgen procedures.

Some sickness funds have their own premises, in which medico-technical and other procedures are applied - radiological institutes, light treatment institutes, medicinal baths, etc. However, these are relatively unimportant.

(c) Treatment at University Polyclinics

For purposes of medical research and training, university hospitals maintain polyclinics, i.e. departments intended exlusively for ambulatory treatment. Such university polyclinics are entitled to take part in the care of sickness fund patients. The Insurance Code provides, in section 368n, subsection 2, that the associations of sickness fund practitioners shall conclude contracts with the universities, under which the polyclinics will undertake the examination and treatment of insured persons to the extent required by performance of their research and training functions.

The participation of the polyclinics is regulated by the respective contracts. As these provide that the polyclinics shall be used by sickness fund patients only on referral by an Insurance Fund or substitute fund practitioner, there is a danger that students and young doctors of medicine may encounter only patients with serious affections and never come across those with slighter symptoms such as will be encountered later in independent practice. Another problem is the absence of any provision requiring relevant contracts to be concluded between the medical associations and the universities

if such a contract does not come into existence the polyclinic concerned cannot perform its function. In one province of the Federal Republic such a situation has prevailed for years: the respective association of sickness fund practitioners refuses to conclude the contract, evidently because it fears loss of fees for its members.

Statistics on the extent of treatment at university clinics cannot be given, as no relevant data are available.

(3) The kinds of ambulatory specialist care at hospitals (or by hospital physicians) which have been described above are really of secondary importance. Most specialist treatment is given outside the hospitals, i.e. by specialists in independent practice. Recognition of the quality of specialist is conferred by the provincial Chambers of Physicians: the periods of training required are prescribed in the professional rules, or rules regarding medical specialities, issued by the said Chambers. Establishment of a physician as specialist involves the obligation to confine himself to his speciality.

For a specialist to be able to take part in the care of sickness fund patients, he must go through the same procedure as is described under C.1(3) regarding general practitioners, except that the registration systems used by the miners' funds (see below) does not apply.

As regards the problems arising out of the present steady increase in the number of specialists, see under H.1.b.

The total number of specialists authorised to engage in sickness fund practice at the end of 1964 and 1965 breaks down into the various specialities as follows[1]:

	31.12.64	31.12.65
All specialists authorised ...	17,515	17,821
Speciality	per cent.	
Internal Medicine	21.3	21.7
Gynaecologists	12.5	12.5
Ophtholmologists	10.5	10.5
Ear, Nose and Throat Specialists	10.6	10.4
Pediatricians	9.2	9.2
Surgeons	7.0	7.4
Dermatologists	7.5	7.4
Orthopaedists	5.0	5.2
Radiologists	4.5	4.5

[1] Data from KBV Statistik 1966.

Neurologists	4.4	4.4
Chest Specialists	3.4	3.3
Urologists	2.4	2.4
Laboratory Physicians	0.8	0.8
Diseases of the Mouth and Jaw	0.2	0.2
Anaesthetists	0.1	0.1

Under the medical system of the miners' funds, in addition to general practitioners (the "district doctors"), specialists of the various kinds are authorised to give treatment as such. As a rule a specialist can be called in only on referral by the "district doctor"; once this is made, there is free choice of the specialist.

Whereas the miners' funds permit recourse to a specialist only on referral by the general practitioner, there is no such restriction on recourse to specialists by patients of the Insurance Code and substitute funds: they may visit any specialist they please; but as they cannot have more than one sickness form in each quarter-year - see C.1(4) and (5) - this freedom may only be exercised if a general practitioner has not already been called in. If so, the patient can reach a specialist only on referral by the general practitioner. Referral is also possible from one specialist to another; so is referral from a specialist to a general practitioner; but referral to another sickness fund physician of the same speciality is permissible only in highly exceptional circumstances.

3. Pharmaceutical Supplies

According to section 1, subsection 1, of the Pharmacies Act of 20 August 1960, due provision of the population with medicaments is in the public interest and the pharmacies have chief responsibility for it. Any person wishing to undertake the business of a pharmacist must apply for a permit to the authority which is competent according to the law of the particular province. The permit has to be given on request if the applicant fulfils certain conditions which are set out at length in the Act (section 2). The holder of a permit is required to conduct the pharmacy himself on his own responsibility.

Section 28, subsection 1, of the Medicaments Act of 16 May 1961 provides that, apart from certain exceptions, pharmaceutical supplies in retail trade may be stocked, offered for sale and delivered in pharmacies only. Pharmacists may deliver such supplies, for account of social sickness insurance, only on receipt of a medical prescription. Subsection 3 of the same section adds that, on prescription by a person qualified to practise medicine, pharmaceutical supplies may be delivered in pharmacies only. Pharmacists thus have, by statutory provision, a monopoly as regards supplying medicaments to persons protected by sickness insurance.

Medical practitioners need some pharmaceutical products in their own practice - consultation requirements, as they are called. These can usually be drawn directly from the pharmacies, on the basis of

of multiple orders, by agreement with the insurance institutions and at their expense.

(1) As a rule the pharmacy is operated by the titular pharmacist, the "natural person" in the legal sense to whom the permit to have a pharmacist's business has been given in accordance with the Pharmacist Act. The bigger hospitals have their own pharmacies, but these provide medicaments only for persons undergoing treatment in the hospital: such pharmacies are not accessible to the general public; they must as a rule be staffed by at least one qualified pharmacist. Hospitals which do not have their own pharmacies must draw the supplies they need for their patients from public pharmacies; direct procurement from the manufacturer is not permitted.

The pharmaceutical supplies required for in-patients are for account of the sickness fund concerned, but as a rule the cost of each particular issue is not charged directly to the fund (though this is done in some circumstances, for instance in respect of particularly expensive medicaments, according to rules which vary from one province to another). Instead, these costs are included in the daily over-all charge per patient, made to the fund and covering all hospitalisation services - medical care, nursing, board, lodging, etc.

The number of hospital pharmacies has progressed as follows in the last years[1]:

	1	2	3	4
Year	All Pharmacies (2 and 3 together)	Hospital Pharmacies[2]	Other Pharmacies	2 as per cent. of 1
1960	9,171	242	8,929	2.64
1961	9,510	248	9,262	2.61
1962	9,792	248	9,544	2.53
1963	9,995	253	9,742	2.53
1964	10,228	262	9,966	2.56

For comparison, the number of hospitals may also be given:

	1	2	3
Year	Hospitals	Hospital Pharmacies[2]	2 as per cent. of 1
1960	3,604	242	6.71
1961	3,627	248	6.84
1962	3,651	248	6.79
1963	3,644	253	6.94
1964	3,633	262	7.21

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[1] Source: Statistisches Bundesamt: Statistisches Jahrbuch für die Bundesrepublik Deutschland: 1955, p. 79; 1957, p. 78; 1959, p. 72; 1961, p. 88; 1963, p. 80; 1965, p. 88.

[2] In charge of a pharmacist.

(2) The figures given in the preceding section show the bulk of pharmaceutical supplies reach the population through pharmacists in independent business. Pharmacists who wish to take part in supplying products to persons entitled to benefit under statutory sickness insurance require an "authority to supply" for the above purpose; it is made out in the name of the pharmacist in person. Particulars regarding this authority, the procedure, the points to be remembered in accounting with the sickness funds, etc. are in general regulated at the provincial level by special supply contracts between the provincial organisations of pharmacists and of sickness funds respectively. The right to participate in supplying the insured population can only be refused (or withdrawn) for a very good reason relating to the pharmacist personally: so practically all pharmacists participate in this operation. Although each contract holds good in one province only, the pharmacists generally apply the same conditions to patients of sickness insurance institutions established outside the particular province.

The sickness insurance institutions, or even the public authorities, have no practical possibility of directing the establishment of pharmacists in business or of keeping the number of pharmacies down to the level which would correspond to the need - i.e. to satisfactory conditions of supply. By judgment of 11 June 1958 the Federal Constitutional Court found that a limitation of freedom to go into business as a pharmacist is incompatible with the onstitution and therefore cannot be allowed. The result of this "liberalisation judgment" was a sharp increase in the number of pharmacies, as the following figures show:

Number of Pharmacies

Year	In Absolute Figures	Per 10,000 Inhabitants
1960	9,171	1.7
1961	9,510	1.7
1962	9,792	1.7
1963	9,995	1.7
1964	10,228	1.7

According to pharmacists, the yield of a pharmacy has declined, despite higher turnovers. The pharmacists' professional organisations therefore call for measures which would ensure a better expectation of income for their members. Some pharmacists believe that this should be done by reintroducing as far as possible the restriction on freedom to set up business. Others think that it would be advisable to modify the "medicament tariffs", which prescribe either the retail prices for pharmaceutical supplies or the amounts which the pharmacist may add to wholesale prices.

The first question (restriction of freedom to set up business) does not directly affect the sickness funds. In the interest of satisfactory supply they are concerned to see a sufficient number of pharmacists in operation; but this was already the case before the constitutional judgment of 1958. However, the funds are directly concerned to ensure that any modification of the retailer's price differentials shall not lead to still more disproportionately high expenditure for themselves. The Medicaments Act provides, in

section 37, that the prices and price differentials indicated in the tariffs for pharmaceutical products shall be so determined that regard is had to the justified interests of the consumers, inter alia, which may be taken to include the sickness funds' ability to pay.

In addition, there are several other problems, the most important of which may be mentioned here.

Nowadays the great majority of pharmaceutical products are made under factory conditions: these are the "proprietary preparations". The manufacturers are not restricted as regards the prices they fix, or as regards what specialities they produce. Often there is no real need for more kinds of medicaments, yet every year a large number of new preparations come on to the market. As a physician may prescribe for account of the sickness fund practically any of the (about) 60,000 preparations now available (excepting a few, the curative effect of which is not sufficiently known), massive advertising and promotion ensure that particular preparations are actually prescribed. So many are offered that the physician cannot check them all; he is therefore hardly in a position to prescribe only those at the lowest price (composition and effect being equal), although he is theoretically required to do this in accordance with the principle of economy governing sickness insurance. Legal judgments at the highest level have recently permitted the sickness insurance institutions to assist medical practitioners in this regard by indicating comparative prices.

According to the Deutsche Apotheker-Zeitung, 1964, p. 1299, there are about 60,000 proprietary pharmaceutical preparations on the market in Germany and only the following numbers in some other countries:

Switzerland	20,000 - 30,000
Italy	25,000
Spain	20,000
France	16,000
Belgium	10,000
Austria	6,500
Netherlands	4,000
Sweden	3,500
Denmark	1,600

(3) Free choice is allowed among the pharmacies permitted to supply insured persons. As already stated, this applies also to pharmacies outside the province, with which the particular fund has no direct contractual relationship. From the insured persons' standpoint it should be stated that in general the supply of pharmaceutical products is satisfactory. By local arrangements, certain pharmacies undertake to be "on duty" in turn, so that medicaments can be obtained at any time, even outside normal hours of business.

4. In-Patient Care in Hospitals

(Including other medical establishments) belonging to (a) the body administering the scheme or (b) the public authorities or private bodies or undertakings with which the scheme has contracted for care and/or beds.

Medical establishments belonging to statutory sickness insurance institutions exist in exceptional cases only. Some of the miners' sick funds maintain their own hospitals, particularly in mining areas, but even these provide in-patient care to sickness insurance patients who are not protected by the miners' funds. The bulk of the in-patient care is provided in:

(a) hospitals belonging to public authorities (provinces, districts, municipalities);

(b) public non-profit hospitals belonging to religious associations, the German Red Cross, workers' welfare organisations; and

(c) a few small privately operated hospitals.

(1) In-patient care by the patient's personal physician (general practitioner or specialist) occurs mainly in small hospitals, where it would be uneconomic to appoint staff for the treatment of in-patients only. Such hospitals are known as Belegkliniken[1], the practitioners as Belegärzte, and a corresponding term is used for the whole system of in-patient treatment by physicians not on the staff of the hospital. The same system is employed occasionally also in larger hospitals where the patients are attended mainly by staff physicians: a few beds may be kept free to be filled by physicians in independent practice specialising in, usually, the diseases of particular organs, such as the eyes, the ears, nose and throat, etc.

In-patient care of this kind, by physicians not on the staff of the hospital, is one of the benefits provided on behalf of the Insurance Code sickness funds (local, rural, works and guild funds). One contract defines the circumstances in which a fund practitioner can be permitted to give in-patient treatment. It states that in-patient work shall not be his main activity; it must be of minor importance as compared with the ambulatory care he gives on behalf of the fund. As a rule a sickness fund practitioner may not give in-patient care to more than 20 hospital patients at a time, or up to 25 in exceptional cases. This care is paid for, not by the hospital but by the sickness fund, via the competent association of sickness fund practitioners; i.e. it does not form part of the inclusive daily charge made for hospitalisation.

In addition to medical attendance, "in-patient care" includes maintenance, nursing, provision of medicaments, etc. Such care can be given only as a whole; medical care alone cannot be taken over by the hospital. Apart from the payment of non-staff physicians

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[1] Approximately "bespoke hospitals".

giving in-patient treatment in the "bespoke" hospitals, the relations between these hospitals and the sickness funds are governed by the same principles as in the case of hospitals with a staff of physicians in their employment (see below under (2)).

The substitute funds, too, use the "bespoke" system. It also occurs in the case of miners' fund patients not treated under the "miners' fund medical officer" system (it is exceptional for miners' fund medical officers to have "bespoke" beds in hospitals belonging to the miners' funds).

The following table[1] shows the extent of in-patient care by non-staff physicians.

Physicians giving In-Patient Care

Year	Staff Physicians		Non-Staff Physicians	
	Total	Per 1000 Regular Beds	Total	Per 1000 Regular Beds
1962	24,270	40	7,546	12
1963	24,957	41	7,573	12
1964	25,778	42	7,247	12

On 31 December 1964 there were altogether, in the Federal Republic including West Berlin, 788 "bespoke" medical establishments with a total of 67,719 regular beds, making 21.8 per cent. of all medical establishments and 10.93 per cent. of all regular beds (see also below under (2)).

(2) As the above review shows, the bulk of in-patient care is given at hospitals with their own staff physicians. Since it makes no difference to the treatment whether the in-patient care was given in a "bespoke" hospital or in one with its own medical staff, no distinction of that kind is shown in the following tables.[2] Such a course seems justified in order to give a general picture of the extent to which provision is made for all necessary in-patient care and not only for that part of the population which is protected by statutory sickness insurance.

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[1] KBV-Statistik 1966 (federal territory including West Berlin and the Saar).

[2] Wirtschaft und Statistik, No. 2, February 1966.

Table 1

Hospital Accommodation, by Status of Hospital

Status of Hospital	Number of Hospitals		Number of Regular Beds		Regular Beds Per Cent.		
	1964	1963	1964	1963	1964	1963	1938[1]
Publicly owned, including municipal	1,375	1,389	341,708	340,631	55.2	55.3	62.6
	813	-	153,955	-	24.9	-	-
Other non-profit hospita hospitals	1,290	1,297	227,890	227,257	36.8	36.9	31.4
Private hospitals	968	958	49,790	47,797	8.0	7.8	6.0
Total	3,633	3,644	619,388	615,685	100.0	100.0	100.0

1 Reich territory as at 31 December 1937.

Table 2

Hospital Accommodation in Relation to Population

Year	Number of Hospitals	Number of Regular Beds	Regular Beds Per 10,000 Inhabitants
	All Hospitals		
1938[1]	4,673	367,090	93.5
1952)	3,288	502,547	104.9
1953) [2]	3,306	513,104	105.9
1954)	3,325	524,196	107.1
1955)	3,396	539,334	106.8
1956)	3,403	546,593	107.0
1957) [3]	3,405	553,725	106.9
1958)	3,440	558,792	106.5
1959)	3,461	567,266	106.9
1960	3,604	583,513	104.6
1961	3,627	594,642	105.1
1962	3,651	604,932[4]	105.7
1963	3,644	615,685	106.4
1964	3,633[5]	619,388	105.7
	Hospitals for Acute Cases		
1960	-	406,022	72.8
1961	-	413,927	73.1
1962	-	425,519	74.3
1963	-	418,341	72.3
1964	-	417,816	71.3

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[1] Reich Territory as at 31 December 1937.

[2] Federal territory without Saar and Berlin.

[3] Federal territory without Berlin.

[4] In North Rhine-Westphalia, includes 8,702 beds for new-born children.

[5] In Bavaria, includes 24 hospitals without regular beds.

Table 3

Hospital Accommodation, by Purpose of Hospital

Purpose of Hospital	Number of Hospitals		Number of Regular Beds	
	1964	1963	1964	1963
General hospitals ...	1,830	1,856	360,294	359,636
without separate specialist departments ...	646	699	36,001	41,962
with separate specialist depts	1,184	1,157	324,293	317,674
Hs. for internal diseases	140	152	14,178	14,761
Hs. for infectious diseases	4	3	122	126
Infants' and childrens' hospitals	85	84	12,822	12,593
Surgical hospitals	169	170	10,645	11,601
Hs. for accident cases	9	-	1,829	-
Orthopaedic hospitals	36	35	4,207	4,352
Gynaecological and maternity hs.	178	176	8,657	8,650
Maternity homes	32	36	314	360
Hs. for throat, nose and ear diseases	40	43	1,050	1,068
Hs. for eye diseases	37	38	1,667	1,658
Hs. for skin and venereal diseases	12	13	1,492	1,600
Hs. for röntgen and irradiation therapy	8	9	410	425
Tuberculosis hospitals:				
mainly for adults ...	204	216	31,582	32,852
for children ...	28	29	4,120	4,243
Psychiatric hospitals (incl. establishments for therapy and care[1])	154	141	100,768	98,259
Neurological hospitals	10	19	938	1,702
Hospitals for neuro-surgery	1	1	51	52
Mental hospitals	7	7	564	581
Hospitals for rheumatic cases	9	-	2,150	-
Rehabilitation hospitals	11	-	1,681	-
Other specialised hospitals	23	38	3,257	6,622
Hospitals for chronic patients and geriatric hospitals	60	54	9,488	8,825
"Cure" hospitals	504	481	44,624	43,218
Hospitals (or sickness depts.) in prisons	42	43	2,478	2,501
All hospitals,	3,633[2]	3,644	619,388	615,685
("bespoke" hospitals included)	788	846	67,719	50,540

[1] Including neurological hospitals in North Rhine-Westphalia, Hesse and West Berlin.

[2] In Bavaria, includes 24 hospitals without regular beds.

Table 4

Extent of Occupation of Beds and Duration of Stay

Year	All Hospitals	Publicly Owned Hospitals	Other Non-Profit Hospitals	Private Hospitals
Average occupation of beds (No. of days per regular bed per year)				
		All Hospitals		
1934)[1]	278.9	293.2	283.6	217.3
1938)[1]	303.4	-	-	-
1957)	326.7	333.0	321.3	305.0
1958)[2]	327.6	334.2	321.8	306.1
1959)	329.0	335.3	323.7	306.7
1960	340.3	342.4	343.2	309.6
1961	339.2	341.1	342.6	307.6
1962	336.4	337.7	337.7	321.3
1963	334.0	336.4	334.7	314.0
1964	335.7	340.0	333.9	314.8
		Hospitals for Acute Cases		
1960	336.5	331.8	345.4	311.1
1961	332.9	329.0	341.4	302.0
1962	320.8	318.7	324.9	307.7
1963	325.1	320.9	331.9	312.2
1964	326.3	323.3	331.0	316.6
	Percentage Occupation of Beds - All Hospitals			
1934)[1]	76.4	80.3	72.2	59.5
1938)[1]	83.1	-	-	-
1957)	89.5	91.2	88.0	83.6
1958)[2]	89.8	91.6	88.2	83.9
1959)	90.1	91.8	88.7	84.0
1960	93.2	93.8	94.0	84.8
1961	92.9	93.5	93.9	84.3
1962	92.2	92.5	92.5	88.0
1963	91.5	92.2	91.7	86.1
1964	92.0	93.2	91.5	86.2
		Hospitals for Acute Cases		
1960	92.2	90.9	94.6	85.2
1961	91.2	90.1	93.5	82.8

[1] Reich territory as at 31 December 1937.

[2] Federal territory without Berlin.

Table 4

Extent of Occupation of Beds and Duration of Stay (continued)

Year	All Hospitals	Publicly Owned Hospitals	Other Non-Profit Hospitals	Private Hospitals
Average occupation of beds (No. of days per regular bed per year)				
	Hospitals for Acute Cases			
1962	87.9	87.3	89.0	84.3
1963	89.1	87.9	90.9	85.6
1964	89.4	88.6	90.7	86.7
	Average Duration of In-Patients' Stay (days)[3]			
	All Hospitals			
1934) 1938)[1]	40.0 36.2	43.5 -	37.4 -	24.5 -
1957)	29.1	31.4	26.7	25.5
1958)[2]	28.8	31.1	26.5	25.5
1959)	28.4	30.7	28.3	24.5
1960	28.7	30.9	26.6	24.9
1961	28.6	30.8	26.6	24.6
1962	28.7	30.8	26.5	25.9
1963	28.2	30.3	26.2	25.4
1964	27.7	29.7	25.5	25.2
	Hospitals for Acute Cases			
1960	21.6	21.6	22.1	17.0
1961	21.4	21.5	22.0	16.4
1962	21.3	21.3	21.8	16.8
1963	20.7	20.8	21.3	16.1
1964	20.2	20.3	20.7	16.0

[1] Reich territory as at 31 December 1937.

[2] Federal territory without Berlin.

[3] Calculated by means of the following formula: total number of days' care given, multiplied by two, divided by sum of number of patients at beginning of period and number at the end of period.

Table 5. Number of Patients, Number of Days' Care, Duration of Stay

Year	Patients		Days' Care Given		Average Duration of Stay[1] (in days)
	Thousands	1960=100	Millions	1960=100	
	All Hospitals				
1956	6,725	91	190.1	96	30.1
1958	7,060	96	193.9	98	29.2
1960	7,350	100	198.6	100	28.7
1961	7,481	102	201.7	102	28.6
1962	7,533	102	203.5	102	28.7
1963	7,718	105	205.7	104	28.2
1964	7,953	108	207.9	105	27.7
	Hospitals for Acute Cases				
1960	6,620	100	136.6	100	21.6
1961	6,720	102	137.8	101	21.4
1962	6,703	101	136.5	100	21.3
1963	6,833	103	136.0	100	20.7
1964	7,017	106	136.3	100	20.2

[1] Calculated by means of the following formula: total number of days' care given, multiplied by two, divided by sum of number of patients at beginning of period and number at end of period.

Table 6. Physicians and Certain Groups of Para-Medical Personnel Employed in Hospitals

Occupation	Number		Increase (+) or Decrease (-) 1963 to 1964	
	1964	1963	Number	Per Cent.
Specialist Physicians	19,735	19,439	+ 296	+ 1.5
Physicians acting as General Practitioners	13,777	13,358	+ 419	+ 3.1
All Physicians	33,547[1,2]	32,797	+ 750	+ 2.3
Incl. staff physicians	25,778	24,957	+ 821	+ 3.3
Sick Nurses (female)	77,313[3]	76,437	+ 876	+ 1.1
Sick Nurses (male)	11,554	11,100	+ 454	+ 4.1
Children's sick nurses	10,917	10,694	+ 223	+ 2.1
Midwives	5,494	5,411	+ 83	+ 1.5
" on staff	2,140	2,036	+ 104	+ 5.1
" in indep. practice	3,354	3,375	- 21	- 0.6
Other personnel providing care	29,174	25,959	+ 3,215	+ 12.4
Pharmacists	534	512	+ 22	+ 4.3
Medico-Technical Assistants	10,006	9,745	+ 261	+ 2.7

[1] Also: in Schleswig-Holstein 24 contractual physicians, one visiting physician; in Hamburg, 40 consultants; in Bremen, 4 contractual physicians; in West Berlin, 35 part-time physicians.

[2] Includes 35 visiting physicians in Hamburg.

[3] Includes 26 part-time female nurses in Bremen.

(3) As a rule, the beneficiary has free choice of hospital. However, the sickness fund can refuse to pay the costs if the chosen hospital does not ensure adequate and appropriate treatment under proper conditions. There is no provision that written contracts stating precisely how in-patient care is to be given must be concluded between hospitals and sickness funds; such contracts seldom exist, so relations are to a large extent unregulated. The contract - if any - consists mostly of not more than this: being informed of the conditions regarding admittance to and costs at the hospital, the fund makes out a statement of liability for the costs in each particular case, after a physician has certified the necessity for hospital (in-patient) care. The Federal Union of Sickness Funds and the German Hospitals Association (the top-level organisation of hospitals) have proposed that a system of contracts should be set up, with a federal blanket contract, provincial blanket contracts and local hospital contracts similar to those prescribed for ambulatory treatment on behalf of the sickness funds; this would be part of new legislation on sickness insurance.

By accepting liability, the fund undertakes to pay the cost of in-patient care (third class) in the particular case.

5. Dental Care

Any person in the Federal Republic of Germany or in West Berlin wishing to engage permanently in dental therapy, requires a certificate. The Dentistry Act of 31 March 1952 (BG Bl. I, p. 221) defines dental therapy as "the determination and treatment, as a profession and based on scientific dental knowledge, of diseases of the teeth, mouth and jaw". "Disease", in this connection, means any abnormal phenomenon of the teeth, mouth or jaw, including any anomaly in the position of the teeth and any deficiency (missing teeth). So dentistry extends to the whole area of the teeth, mouth and jaw.

(1) As in the case of medical care (cf. under C.1(3)), the bulk of the dental care of the population is given in the form of ambulatory treatment by dentists in independent practice. Ambulatory dental treatment in hospitals or by dentists employed at hospitals plays a relatively minor part. On 31 December 1965, out of a total of 31,660 dentists engaged in their profession, 458 or 1.5 per cent. were on the staff of hospitals.[1] Most such treatment would be at university clinics (cf. under C.2(2)c). Dentists can take part in the care given at these clinics (cf. C.2(2)a) but seldom do so.

(2) Dentists on the staff of hospitals are available mostly to provide care for in-patients. Staff arrangements for the care of diseases in the teeth, mouth and jaw area fall under the description of in-patient care given in C.4 above; to which reference may be made.

(3) On 31 December 1965, out of a total of 31,660 dentists engaged in their profession, 29,241 were established in independent practice; the latter group employed a further 1,151 dentists as assistants.[2] The ratio is thus one dentist to 1,873 inhabitants. The figure has moved as shown in the table on p. 41 in recent years.

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[1] Data from Wirtschaft und Statistik, No. 11/1966, p. 689.

[2] Ibid.

Year	Active Dentists	Inhabitants per Dentist
1960	32,509	1,716
1961	32,979	1,716
1962	32,649	1,753
1963	32,364	1,788
1964	32,047	1,828
1965	31,660	1,873

The number of dentists approved for sickness fund practice was:

- 28,673 in 1960
- 28,593 in 1961
- 28,664 in 1962
- 28,478 in 1963 and
- 28,272 on 30 June 1964.

In principle, dentists too may give care to sickness insurance patients only after special approval.

As regards the statutory basis and the contracts, reference may be made to C.1(3); the situation is essentially the same for dentists.

(a) Local, Rural, Works and Guild Sickness Funds ("Insurance Code Funds")

The Insurance Code funds and their federations are the contractual partners of the Federal Association and local and provincial associations of sickness fund dentists. According to section 368n subsection 1 of the Insurance Code, the associations of sickness fund dentists have to ensure provision of dental care to sickness fund patients. In order that the volume of care might be sufficient the Insurance Code formerly provided, in section 368a subsection 1, that in principle one dentist should be authorised for every 900 members. This rule (like that relating to physicians) was declared unconstitutional and therefore void, by judgment of the Federal Constitutional Court dated 8 February 1961.

However, there is a difference of principle, which also has practical importance, from the position on the medical side. In dental care, a distinction must be made between diagnosis, conservation of the teeth and surgery on the one hand and, the provision of dentures (i.e. replacements for natural teeth) on the other. According to the balance of legal opinion up to the present, the provision and fitting of dentures are not part of sickness fund care; nor do the duties involved by approval for sickness fund practice include the provision of dentures. Furthermore, there is no compulsion to conclude a contract, so that as regards dentures the dentists' associations are not obliged to negotiate with the sickness funds nor their federations. In some areas the associations of sickness fund dentists refuse, as a matter of principle, to conclude contracts regarding charges for dentures; in others the contracts which do exist relate to a few basic services only. Consequently, the provision of dentures is either not regulated, or is insufficiently regulated, on a contractual basis. Patients

protected by the Insurance Code funds count as private patients in respect either of all denture work or of all such work as is not covered by the contracts. This in its turn means that the dentists are subject to no restriction regarding the fees which they can ask. Cases are constantly reported in which the dentists use that freedom excessively and so place a great burden on insured persons.

The federal organisations of Insurance Code funds have long sought to improve the situation just described, but their efforts have so far been baffled by the resistance of the associations of insurance dentists, which refuse to make comprehensive settlement. The sickness fund organisations will therefore try to obtain a statutory amendment (as part of a Sickness Insurance Amending Act) by which the provision of dentures would be included in dental car to be given on behalf of the sickness funds; consequently there would be an obligation to conclude contracts on the provision of dentures as on medical and on other dental care.

(b) Substitute Funds

In the case of the substitute funds, the conditions reviewed under C(1)3b as regards medical care apply also, in general, to the whole field of dental care. Conservation of the teeth, dental surgery and also the provision of dentures are governed by contracts concluded on a voluntary basis: the situation regarding dentures is, in principle, unsatisfactorily regulated, as in the case of the insurance code funds.

(c) Miners' Funds

The relations of the miners' sickness funds with the dentists are governed on the same principles as their relations with the physicians (see under C.1(3)c). In the case of dental care also, two systems have developed:

(a) care based on contracts with the associations of sickness fund dentists (dental care by dentists authorised to engage in sickness fund practice; as regards the provision of dentures, the same problems arise as for the Insurance Code funds);

(b) care by "miners' fund dentists", i.e. dentists who have concluded individual contracts of employment with the miners' funds.

(4) Occasionally, sickness funds maintain their own dental clinics, at which ambulatory dental care is given, including the provision of dentures. However, this kind of dental care plays a relatively minor part.

(5) Persons entitled to benefit under social sickness insurance and their dependants can in principle choose freely among the dentists providing care for such persons. The same rules and practices apply, including certain restrictions on freedom of choice as in the case of medical care (see C.1(4) and (5) above.

6. Medical Care by Members of Professions Allied to That of Medicine

In the Federal Republic of Germany, persons not holding certificates as physicians or dentists are in principle permitted to engage in therapeutics if they fulfil specific conditions which are laid down in the Uncertificated Practitioners' Act (Heilpraktikergesetz). Therapeutics in that sense (Heilkunde) is defined as any occupational or commercial activity directed towards determining or alleviating diseases, ailments or physical injuries in human beings. However, it cannot be exercised on behalf of social sickness insurance. Under section 122 of the Insurance Code, medical and dental treatment shall be given by qualified medical practitioners and dentists. Medical treatment in this sense includes not only acts by the physician in person, but also those performed by his assistants, provided the latter acts are such as a physician, in accordance with the rules of medical science, may leave to non-medical personnel (consulting room assistant, medico-technical assistant) and provided the physician directs and supervises them on his responsibility. The above applies, for instance, to application of the hypodermic syringe by an assistant during consultation, blood testing by a medico-technical assistant, massage by a salaried masseur working under the physician's direction. There is, therefore, no provision under social sickness insurance for medical treatment by members of professions allied to that of medicine.

Finally, all acts of sick nursing belong to therapeutics in the sense that they affect diseases, ailments or physical injuries (the same is true, of course, of many other services, such as hospitalisation itself, but that is not important in the present connection). For instance, an insured person may be entitled to spectacles in order to correct a visual defect. In order that such benefits may be provided, the sickness funds have to conclude contracts with members of occupations which may be described as "allied" to the medical profession in the widest sense.

There are no statutory provisions requiring the funds to conclude contracts with the members of these occupations or professions; even for the Insurance Code funds the Code lays down no rules as it does for medical and dental care. So all the contracts rest on a voluntary basis. Mostly, they are entered into by particular insurance institutions, but often the respective organisations at the provincial level are the contracting parties. Because of the benefits which protected persons may claim under statutory provisions, there are contracts with members of the following occupations: masseurs, remedial gymnasts, orthopaedic mechanics, bandage makers, opticians, suppliers of hearing aids and glass (etc.) eyes, as well as with medicinal bath establishments. The subject matter of such contracts, as a rule, is the prices for the particular benefits, dates of delivery, etc. Generally the terms of a contract are applied also to beneficiaries of funds established in other provinces and so not parties to it.

Occasionally the sickness funds have their own establishments where, for instance, baths or massage are given on medical prescription; and a few funds have their own services for the issue of spectacles. However, such benefits are of minor importance.

Midwives have a special position in this regard. According to the Midwives Act, they are required at all times to assist women in pregnancy or confinement or women lying-in and new born children, in so far as no restrictions are imposed by their official instructions. The benefits which sickness funds must provide include necessary assistance by a midwife. There are no contracts with the midwives or their associations; nor are such contracts needed, for the extent to which midwives are required to give assistance is already set out in the Midwives Act and the instructions for midwives. The same applies to the fees which the sickness funds have to pay to midwives for their assistance: these are fixed in mandatory rules laid down by the Federal Ministry of Health.

7. Personal Health Services Other Than Therapeutic Medical Care

The sickness funds not only provide for therapeutic benefits in the widest sense, intended to remedy or alleviate a morbid condition. They also provide for prophylactic measures, consisting mainly of action to prevent sickness for particular members and their dependants, in addition, of course, to pre-natal medical care, which has been added by statute to the responsibilities of sickness fund practitioners.

A sickness fund can allow an insured person, or an insured person's dependant, a personal health service in the form of a "rest cure", or may make a contribution to the cost of such a benefit. Some sickness funds have their own rest homes. As a rule, however, the funds pass the cost, or part of the cost, directly to the insured person or the rest home (with which the price will have been negotiated), or to the charitable institution (German Red Cross, religious or welfare organisation) which provides the service.

The sickness funds also sometimes contribute to the cost of "mother-and-child" rest cures as part of special medical welfare schemes run by local authorities, religious or welfare organisations, the German Red Cross, the mothers' convalescent services, etc.

As a rule it is the pension insurance institutions which are competent to provide "bath cures" at watering places which have natural factors of benefit to the health, particularly mineral springs. However, if the insured person cannot claim such a benefit from a pension institution, his sickness fund can take over the cost of the baths and relevant medical care. So far as the local, rural, works and guild sickness funds are concerned, medical care in connection with bath cures, and its payment, are regulated in special contracts. The situation regarding substitute funds is similar.

Medical care in connection with bath cures is given only at officially recognised baths and watering places. On certain conditions, which are determined by the contract, any physician established in practice at a watering place and qualified to give this service (he need not be a sickness fund practitioner) may participate in provision of the care. The patient has free choice among all the physicians who are parties to the special contract. According to the data for September 1966, about 1,000 physicians provide care of the above kind.

8. Social Services Provided by or through the Body Administering the Scheme

One benefit under social sickness insurance which may certainly be classified as a "social service" is that known as home care (Hauspflege). With the insured person's consent, the sickness fund can provide attendance and assistance by sick nurses, male or female, or other such personnel, if hospitalisation of the patient is appropriate but impracticable, or if there is very good reason to leave the patient in his or her household or family. This benefit is seldom claimed. Moreover, as a rule it is not provided directly by or through the sickness insurance institution. Usually the bodies which employ the nursing or other personnel in question (local authorities, religious or welfare organisations, German Red Cross, etc.) make the arrangements and apply directly to the sickness fund for a contribution to the cost.

9. Procedure to be Followed when Care is Sought

The procedure when hospital (in-patient) care is required has already been described (see C.4(3)).

If ambulatory medical (or dental) care is required, the insured person has to obtain a sickness form for himself or - if an entitled dependant is sick - for the dependant. However, this does not apply to persons entitled to benefit under the "miners' medical officer" system: they can simply ask for care from the medical officer with whom they are registered.

The sickness forms are made out by the funds and their branch offices, or sometimes, on request, by employers or local authorities. The funds have recently been following to a larger extent the practice of issuing books of sickness forms for particular groups of insured persons such as pensioners and the voluntarily insured. The books contain several blank forms, which the insured person can fill in if necessary.

When a sickness form has to be made out the personal particulars are recorded first of all. Oral communication is usually sufficient. The particulars help in ascertaining whether a claim for benefit is justified: if the sickness fund is making out the form, this can be done by checking in the card index of members. If an employer makes out the form on request, he has only to check whether the patient is engaged in an insurable occupation: if so, the claim to benefit is usually in order.

The sickness form is the patient's documentary evidence that he has a claim to benefit against the fund which issued it. The form also serves the medical practitioner as a kind of justification for his account. The patient is expected to hand the form to the practitioner, without being so requested, at the beginning of the care. At the practitioner's request he must also show that he is the person named on the form (perhaps by producing an identity document); but as a rule this is not done, for abuse seldom occurs.

If care continues over into a fresh calendar quarter-year, the patient has to produce a new sickness form at the first opportunity, again without being requested.

If in case of urgency a sickness form cannot be produced immediately, the patient must give the practitioner evidence that he has a claim to benefit from the fund (for instance, by showing a membership card) and must make arrangements for the form to be produced soon afterwards - within ten days at the latest. If a valid sickness form is not produced the practitioner may require payment of a private fee; if he does so, and the sickness form is produced within ten days, the fee must be reimbursed. If the form is produced later than this, the practitioner can of course not make any private charge for the care given after its production. Mostly, however, no private fee is charged even if the sickness form comes late. The fund does not reimburse any private fee which may be paid, even if the patient had a valid claim for benefit at the time.

In addition to the procedure for checking described above, which both the sickness fund and the medical practitioner can apply at the outset, it is usual also, at the end of the treatment, to check the services rendered as regards their necessity and economy (see also under 13 below).

Restriction of the validity of a sickness form to a particular calendar quarter also makes it possible to check while the treatment is going on, whether there is still a claim to benefit. The insured person is also required by the rules of the fund to report if he has become a member of another fund during the treatment and the new fund has become liable for benefit. Furthermore, a sickness form becomes invalid if it is not used within a fortnight of issue. This prevents insured persons from obtaining completed forms in advance and making improper use of them. Lastly, the form is not transferable. Abuse is a criminal offence.

On the basis of a valid sickness form, when this has been produced, the practitioner may in permissible cases make out a referral form for joint care, further care, diagnosis or the rendering of a particular service by another practitioner (general or specialist). A referral form has the same documentary purposes as an original sickness form (evidence of the patient's claim and of the practitioner's right to payment). In this case the practitioner has sole responsibility for checking: the fund is not involved at first, though it may subsequently check whether a valid sickness form was produced and whether there was indeed a claim to benefit.

To obtain maternity (pre-natal) care, the sickness form is replaced by a special pre-natal care form. The employer is not involved in this procedure. Very much the same possibilities of control apply as when sickness benefit is claimed, but the pre-natal care form has a different period of validity: it holds good for the whole duration of pre-natal care by the same practitioner unless the sickness fund indicates on the form that its validity is shorter or unless the practitioner sends to the fund a special notice to that effect (for instance, the case of change of fund).

10. Medical Certification of Incapacity for Work

Under the German regulations the fact of incapacity is relevant only in the case of persons who can claim a cash allowance if incapable of working. This allowance can be claimed only if the insured person has been rendered incapable by sickness or accident.

Naturally it is the medical (or dental) practitioner who decides on incapacity. It is part of the duties of practitioners who are entitled to act on behalf of the sickness funds that in case of incapacity they shall make out a certificate to that effect, free of charge, for the fund, on a standard form provided by it and identical throughout the Federal Republic. The same applies to certification of termination of incapacity.

Strict standards are laid down regarding determination of incapacity. As regards the Insurance Code funds, clause 12 of the Federal Blanket Contract (Physicians) states that the practitioner shall act with special care in this connection. Incapacity may be certified only on the basis of a medical examination and as a rule may not be certified in respect of any period before the practitioner saw the patient; retroactive certification is permissible in exceptional cases only. Under section 369b of the Insurance Code, the sickness funds are required, where necessary, to have an insured person's incapacity checked in good time by a second ("confidential") practitioner.

11. Medical Reporting, Particularly when a Patient is Transferred from One Physician to Another, or to a Hospital

In the great majority of cases where a patient is transferred from one physician to another, or to a hospital (transfer from one hospital to another is exceptional), detailed sickness reports are not necessary. In such cases it is mostly enough for the appropriate items of the forms used - the referral form or hospitalisation order - to be carefully filled in. The forms must be standardised and their use compulsory. On the hospitalisation order an entry should be made next to the diagnosis explaining why hospitalisation is considered necessary; on referral to another physician, what medical acts are considered necessary must be indicated.

If a referral is for joint treatment or further treatment, the originating physician should inform the receiving physician what diagnoses have already been made: this will enable unnecessary repetition to be avoided.

Of course, it is possible that detailed sickness reports may be necessary in connection with the above procedures. If so, the physician is bound to make such reports when acting on behalf of a sickness insurance institution. In addition it is often necessary for the physician to whom a referral is made (a radiologist or laboratory physician, for instance), or the hospital, to place the results of their examination or treatment on record in detailed reports with a view to appropriate further treatment. In order to be able to give information, to issue certificates or to write reports after treatment is concluded, physicians are required to make notes of their findings and medical acts. Section 5 of the Federal Blanket Contract (Physicians) provides for a specific obligation to make notes in case of accidents, surgery, irradiation, pre-natal care and deficiency diseases.

12. Professional Secrecy within the Scheme

The physicians and dentists concerned must as a matter of principle give the sickness funds, on request and, without special charge, the information and certificates which the latter may require in the course of their work: this includes above all - particularly in connection with orders for insurance benefits or certification of incapacity - the medical indications without which the funds would in many cases not be able to provide benefit in due form. To that extent physicians and dentists are released from their obligation of professional secrecy. Also, employees of the sickness funds are forbidden to disclose improperly any information, regarding diseases or other infirmities of insured persons and their dependants, which such employees may obtain in the course of their duties.

13. Internal Control of Benefits

(1) Persons purveying medical supplies and services - baths, massages, spectacles, trusses, abdominal bandages, orthopaedic elements for footwear, etc. - must show particular technical qualifications (the master's diploma in opticians' work, for instance), without which, indeed, they cannot receive the corresponding permit at all. The rules for such qualifications are set out in the contracts concluded with the respective groups. These arrangements are calculated to ensure satisfactory quality from the outset. It is also possible to provide for the adjustment of the quality of certain services to the most recent developments by modifying the contracts during their currency. For instance, it is customary for the spectacle frames for sickness fund members to be adapted to changes of fashion from time to time, though the funds must continue to respect the principle that benefits will only be provided if and as required.

In addition, it is possible to check the quality of supplies or services in particular cases on the basis of contractual arrangements.

Of course, in the case of services in the precise sense, such as massage, it is possible to carry out a check on quality during the actual treatment. However, such control is not usual, nor as a rule is it necessary because the quality of the service is generally defined in precise terms and failure to comply may lead to cancellation of the permit.

In general, medical supplies and services are allowed only on the basis of a physician's prescription. The sickness funds are required to have such prescriptions checked, where necessary, by another practitioner acting on their behalf - though this is not a material check on the quality of the service, but a control of the necessity of the particular prescription. However, such control is likely to be exercised only as regards the prescription of services which are unusual in insurance practice, either because of their high cost or because there is still a matter of scientific controversy.

Naturally, medical and dental treatments cannot usually be checked as regards quality. It is assumed that by reason of his training the practitioner is qualified to give satisfactory treatment; moreover, under the provisions of civil law (law of contracts) he has an obligation towards the patient to observe due care. On the other hand, it is to some extent customary for fixed dentures to be checked by a dentist in the employment of the sickness fund or its provincial federation so as to ensure that the integration of the artificial tooth or teeth is functionally correct. As already stated, however, a check is made to ascertain whether benefits prescribed - i.e. intended or actually given - are or were necessary. In medical and dental care and the prescription of pharmaceutical supplies, this subsequent control of the need for the benefit has great practical importance.

The insured person is entitled to such medical or dental care as may be appropriate and sufficient according to the rules of medicine for the care or alleviation of a morbid condition. He has no claim to benefits which are unnecessary or uneconomic, the physician has no right to give or prescribe such benefits, and the fund is not permitted to approve them afterwards. The above principles apply to all social sickness insurance institutions, and are to some extent embodied in specific detailed directives. For the Insurance Code funds, section 368p of the Code provides that the Federal Committee on the provision of care on behalf of the sickness funds shall issue any necessary directives to ensure sufficient, appropriate and economical care; and the associations of sickness fund practitioners (medical and dental) are required to include in their rules such provisions as will ensure respect for the said directives on their members' part.

As regards medical care, directives have so far been issued on the prescription of medicaments (cf. under (2) below) and regarding pre- and post-natal medical care. On the dental side, there are general directives for treatment and on the prescription of pharmaceutical supplies; directives on the provision of dentures are being prepared.

The directives are intended to enable the physician or dentist to treat his patients and to prescribe for them in accordance with the statutory provisions. Internal control by the insurance institution is aimed at ensuring compliance with those provisions. How such control shall be applied is a matter of organisation within the sickness fund. It is usual for funds of sufficient size to employ control physicians and pharmacists either full-time or - mainly in the case of physicians - on a part-time basis; but many of the funds are only in a position to carry out such controls by means of non-medical administrative personnel.

The physicians send to the respective professional associations their records and accounts of care afforded; these, with statistical data based thereon, are transmitted to the sickness funds; and the funds are able, on that foundation and with the aid of other statistics which they compiled themselves, to determine the average cost (per case treated) of the care given by all physicians of a certain speciality in any particular calendar quarter year, and also the average cost of a case treated by a particular physician. If the individual's average cost per case is found to be substantially above the general average for the speciality concerned, it may at least be considered possible that

the individual in question has not taken the principle of economy into due account. Sickness funds with their own personnel belonging to the same speciality are also able, if necessary to establish effectively in a given case that certain supplies or services were not necessary.

The fund cannot approach the particular physician directly and require him to refund the excessive cost of what it has found or suspects to be uneconomic practices in treatment or prescription. To ensure the provision of sickness fund medical care in accordance with the statutory and contractual rules, and to supervise the work of the practitioners concerned, are matters for the associations of sickness fund practitioners. They establish control and appeals committees in accordance with their own rules, to check on the economic aspect of medical care given on their behalf - unless the total remuneration is determined on the basis of the benefits effectively afforded (see under D.1(1)a). The sickness funds may send a representative to these committees, to act in an advisory capacity. If they have any matters to raise in this connection, the funds must bring them to the notice of the control committee of the practitioners' association.

The physician concerned may have recourse to the appeals committee against a finding by the control committee. The sickness funds have the same right if the matter relates to a physician's practice as regards prescriptions. Against a finding by the appeals committee, the person concerned may appeal further to the social courts.

If the total remuneration is calculated according to the benefits actually provided (see under D.1(1)a), the composition of the committees and the procedure as regards proving and checking the benefits afforded depend on the terms of an agreement between the sickness fund and the practitioners' association.

Such agreements usually provide for joint composition of the committees, or at least of the appeals committee. The sickness funds also enjoy a general right of appeal (not only regarding practice in respect of prescriptions). Control arrangements for the substitute funds, too, are regulated in this way.

The associations of sickness fund practitioners also have to perform supervisory functions. As regards the Insurance Code funds, section 23 of the Federal Blanket Contract (Physicians) specifically provides that in the discharge of these functions the associations have to advise the physician, to examine his claim for fees and to make reductions where appropriate. In order to enable the association to check on the economic aspect of benefits, the sickness funds are to prepare the necessary material and make it available. The practitioner has to provide the control organ with all the necessary documentation at its request. Regarding dental care, for which the total remuneration is always calculated on the basis of effective benefits, a detailed procedure has been agreed on at the federal level.

The control organs must also ascertain what other damage a physician may have caused to a sickness fund by reprehensible disregard of his duties as a fund practitioner. The sums finally determined as due for reimbursement are usually credited to the fund concerned and deducted from the claims for fees.

(2) The control of the volume and cost of pharmaceutical supplies is a special problem within the general question of control. As a rule, the principles set out under (1) apply here also. In particular, the above-mentioned directives concerning the prescription of medicaments state clearly what principles are to be respected. Some supplies cannot be prescribed by physicians - wine, luxuries, mineral water with no therapeutic effect, drugs serving only to prevent conception, remedies against excessive smoking or drinking in so far as they are not to be used in the treatment of a morbid condition, etc. The physician is permitted to prescribe only medicaments the effect of which is sufficiently reliable. Whether that is the case will be determined where appropriate by the Federal Association of Sickness Fund Practitioners, after obtaining an expert opinion from the Pharmaceutical Products Commission of the German Medical Corps. The directives also state that the therapeutic value of a medicament prescribed shall be a more important factor than the price in determining whether it is economical; however, the physician should always consider whether the desired result could be achieved by a less expensive means. Putting this rule into effect is rendered difficult by the many different pharmaceutical preparations on the market. Some of the sickness funds have therefore begun to assist the physicians by circulating comparisons of the prices of medicaments with similar effects.

The prescriptions for pharmaceutical products, as issued by the physicians, reach the sickness fund together with the pharmacists' monthly accounts; they are sorted out according to their authors, and the fund calculates the average cost, in pharmaceutical products, per case handled by each practitioner. The resulting figures are compared with the general average cost per case of the products prescribed by all practitioners of the specialty in question. If an individual's average cost exceeds the general average, the fund can ask for an examination. The same applies, of course, if uneconomic practices are discovered in individual cases although the general average is not exceeded. In other respects, please see (1) above.

(3) In order to prevent the abuse of services by persons claiming benefit, the sickness funds use, in general, the measures set out below:

As already stated elsewhere, the fund is obliged under section 369b of the Insurance Code to have insured persons' incapacity and the prescription of insurance benefits checked in good time by a physician which it appoints for the purpose. The "confidential physician" is however not allowed to interfere in the treatment afforded by the practitioner. The funds use this power particularly in order to check on alleged incapacity. Another means of counteracting abuse is to have a "sick visitor" - an employee of the fund - check on the spot, at a patient's home, whether he is behaving in accordance with his supposed condition and with the instructions of the physician handling the case - for instance, whether he is staying in bed if so ordered. A fund is empowered to fine an insured person up to three times the daily cash allowance every time he disregards the physician's instructions or the fund's own rules.

(4) The system of "confidential physicians" functions in the manner described below. There are schedules of posts in this service in different localities. These include the number of "confidential physicians" in the various salary categories. In the event of vacancies in certain posts competitions are announced in the professional journals. The most capable candidates are chosen on the basis of their studies, their previous professional activities their age and their general personal situation. However, it must be said that in view of the very high incomes of physicians in private practice it is extremely difficult to recruit an adequate number of "confidential physicians". Newly recruited "confidential physicians" learn their tasks under the direction of experienced colleagues. They have an opportunity to pursue more advanced training in special courses.

The principal duty of a "confidential physician" is to check incapacity for work, which is done only in selected cases. Different methods are applied. Usually the sickness funds choose from among the certificates of incapacity those which seem to require checking, taking into account the diagnosis, or possibly, if the attending physician has not yet been able to indicate a diagnosis, the frequency of the previous illnesses of the insured person or the fact that the attending physician is known to be obliging in the certification of incapacity. According to another method copies of all certificates of incapacity established by the attending physician, with the most detailed indications are presented to the "confidential physician". The latter chooses from among them those that indicate the necessity of control in view of the character or uncertainty of the diagnosis.

At the request of the sickness funds the "confidential physicians" also give their opinion on the sending of patients to hospitals or spas, and on the provision of major therapeutic and orthopaedic appliances.

If there is a difference of opinion concerning incapacity for work between the "confidential physician" and the attending physician, the latter may have recourse to the decision of the sickness fund. If the sickness fund, supported by the view of the "confidential physician", does not recognise incapacity for work and refuses cash benefits, the insured person may appeal against its decision.

14. Records (Documentation, Card Index)

(1) List of persons assigned to a clinic or practitioner, compilation and keeping up to date.

(2) Records of benefits provided to individual beneficiaries.

(a) Register of Members

The names of all persons reported as entering a sickness fund and of all members reported as leaving the fund are recorded in a register of members, which has to be kept in the form of a card index. According to the present administrative regulations, at least the following data must be registered in respect of every compulsorily insured member:

(a) full name date of birth, marital status and address;

(b) date of beginning of membership;

(c) date at which entry was reported;

(d) the member's occupation or employment;

(e) the name and the position or trade of the employer (if the member is an employed person);

(f) the data required under the rules for grant of insurance benefit;

(g) date of termination of membership;

(h) date at which termination was reported.

In the case of home workers and persons employed by them, the register must also indicate the name and business address of the person for whom the member works as a contractor.

In the case of compulsorily insurable pensioners, the register must show the title of the competent pension institution, the pensioner's number, the dates of the beginning and end of the pension institution's liability to contribute to sickness insurance and the date of termination of membership (in addition to items (a), (b) and (f) in the above list).

In the case of voluntarily insured persons the record must show items (a), (c), (d), (f), (g) and (h) in the list and also (for members in "continued insurance") the date at which membership was voluntarily continued or (for "voluntary entrants") the date of entry into membership.

(b) Register of Benefits

The sickness fund is required to record on "benefit cards" the insurance benefits provided to the particular members and their dependants. Accordingly, a card is started for each member and kept up to date; or the benefit card may be combined with the membership card.

According to the current rules, the following minimum entries have to be made:

In case of a morbid condition involving a member's incapacity for work (an "incapacity case"),

(a) the beginning and end of incapacity;

(b) indication of the disease;

(c) beginning, end and amount of the cash benefits paid by the fund (distinguishing between the cash sickness benefit and the "home allowance" payable during hospitalisation) with indication of how calculated;

(d) beginning, end and cost of care given in a hospital or similar institution (whoever ordered the hospitalisation).

In case of grant of preventive or convalescent benefits to members (excluding pensioners), items (c) and (d) above, and if possible item (b), are entered on the card.

If institutional care, including preventive and convalescent benefit, is granted to pensioners, items (b) and (d) are entered. The same applies in case of grant of benefits to members' dependants (members of any kind) with the additional indication whether the beneficiary is male or female.

Provision of medical supplies, appliances and services (including dentures) is entered separately for members and their dependants (kind of benefit, cost, date of provision and - if beneficiary is a dependant - whether male or female).

If a death benefit is paid, the entry differentiates between members and dependants and indicates the day of death and the amount of benefit paid by the fund.

In case of confinement benefits also, a distinction is made between members and dependants. The entry mentions: (a) the date of confinement, (b) the beginning, end and amount of the cash benefits paid (differentiating between the various kinds - confinement grant, nursing allowance) and how calculated.

The data appearing on the membership and benefit cards are summarised annually and - together with the annual accounts - laid before the supervisory authority to constitute a statement of results for the year. On the basis of the statements of results and annual accounts of all statutory sickness funds, the over-all records of sickness insurance in the Federal Republic of Germany are prepared and annually published by the Ministry of Labour and Social Organisation, Bonn.

Lastly, the sickness funds are required to prepare monthly statistics (as on the first day of each month) regarding membership and incapacity. These statistics show:

(a) the number of members;

(b) the number of members sick (incapable of working) not including pensioners;

(c) the number of members sick in hospital;

(d) the "sickness rate", i.e. the number of members incapable of working as percentage of the total number of members;

(e) the "hospital rate", i.e. the number of members in hospital as percentage of the total number of members.

All the data are shown separately for males and females and for the different kinds of members. Once in every calendar year, usually on 1 October, a count is made of the membership, differentiating by kinds of members, sex and age. Current adjustments of these figures are used at other times.

D. Methods of Remunerating Members of Medical and Allied Professions and of Paying for Hospital Facilities and Pharmaceutical Products and Other Medical and Surgical Supplies

1. Remuneration of Members of Medical and Allied Professions

(1) As regards the methods by which ambulatory medical care is remunerated, a distinction must be made between the various kinds of sickness funds. It should be noted first of all that as a rule the same methods are employed for the remuneration of general practitioners and specialists (and of chiefs of hospitals or departments where these participate).

(a) Local, Rural, Works and Guild Funds (Insurance Code Funds)

These funds pay a lump sum every quarter to the insurance practitioners' association concerned, to cover all the medical care given in that quarter. The amount is negotiated and contracted between the association and the fund - or determined by arbitration if necessary.

The statutory method of calculating the lump-sum remuneration is the "rate per head" system mentioned in section 368f subsection 2, of the Insurance Code. The rate is fixed according to an insured person's annual average need for sickness benefits, and the total - the lump sum - is obtained by multiplying the agreed rate per head and the average number of insured in the quarter-year. This amount is calculated and paid every quarter; it is subject to adjustment having regard to any change in insurable remuneration (i.e. the wages or salaries on which contributions to the insurance are payable) and to any alteration in recourse to benefit (i.e. in the total cost of the benefits accounted by practitioners).

It is the insurance practitioners' association which pays each practitioner out of the lump sum. In doing so, it must have regard to the character and extent of the services provided by the particular practitioner, which are priced on a scale approved in advance by the association - i.e. the official schedule of charges to be made by physicians. It is not permissible to pay practitioners on a flat-rate system, according to the number of "cases" which they have handled, as evidenced by the number of quarterly sickness forms. This is a general rule applying to all systems of remuneration.

If the total due to the practitioners for all services rendered, at the rates indicated in the schedule of charges, is not identical with the lump sum, the percentage difference is applied by way of increment or deduction to each item of the schedule and the services are paid at the resulting rates.

Another method may be used instead of the rate-per-head system. According to section 368f, subsection 3, of the Insurance Code, it may be stipulated in the contract that the lump sum shall be computed according to a rate per case treated, or according to the benefits provided, or by a combination of several of the methods already mentioned.

Whereas the rate-per-head system dominated at one time, many Insurance Code funds have recently started calculation according to the benefits provided (the other possible systems are not used to a significant extent). Under this arrangement the lump sum to be paid by the fund to the practitioners' association corresponds to the total charged by practitioners for the services rendered; no provision is made for adjustment to changes in the general level of remuneration. About half the Insurance Code funds calculate the lump sum according to the rate-per-head system, and the other half according to the benefits given. In April 1966, 136 local general sickness funds (34 per cent. of the total number) with 6,714,180 members altogether (43 per cent. of the aggregate membership of these funds) calculated the lump sum according to benefits.

(b) The Substitute Funds

All the substitute funds calculate the remuneration according to benefits provided. Each benefit (medical service) is paid on the basis of a special schedule of charges agreed on by the Federal Association of Sickness Fund Practitioners and the top organisations of substitute funds: it differs from the official schedule.

(c) The Miners' Funds

In so far as medical care for persons insured with the miners' funds is provided by the associations of sickness fund practitioners, the same principles apply as those described in relation to the Insurance Code funds. Mostly the lump sum is based on a rate per head.

Where medical care is given by means of the "miners' fund medical officer" system (which is used for 80 per cent. of the persons protected by the miners' funds), the following applies.

The general practitioners ("district doctors") receive an over-all fee for basic services (consultations and visits) calculated according to the number of persons on the particular practitioner's list and his period of activity as a miners' fund medical officer. So the basic services are remunerated on a lump-sum system, the rate per head being determined in the light of the average need for medical services which is projected by experience. The morbidity rate has no bearing on the fee. Special medical services, such as obstetrical assistance, medico-technical treatments, expert opinions, etc. are remunerated separately.

Those miners' fund medical officers who are specialists receive a flat rate for every "case" referred to them - i.e. for

every referral form. In exchange, they are obliged to take care, for six months, of each patient affected by sickness within the particular speciality.

The rates payable to the miners' fund medical officers, both general practitioners and specialists, are negotiated by the miners' funds and the associations of miners' fund medical officers and are embodied in a general contract. The rates thus negotiated become part of the individual contracts of employment between the miners' funds and the particular practitioners. The fees are calculated by the funds and paid directly by them to the medical officers concerned.

(2) The remuneration of dental care (conservation of teeth and surgery) is governed, on the whole, in the same way as that of ambulatory medical treatment.

However, all Insurance Code and substitute funds calculate the lump sum according to benefits actually provided. Under the "miners' fund dental officer" system, a flat rate is paid for each "form" - i.e. for each case per quarter-year.

Special practices apply to remuneration for the provision of dentures. By reason of the particular situation prevailing in this field, the only contracts relate to the remuneration for certain basic services in connection with dentures; in some areas there are not even contracts for these basic services. Where contracts exist, the dentists perform the specified "denture services" at the rates stipulated therein. As regards services not specified, or as regards all denture services if there is no contract at all, the insured person or dependant counts as a private patient; to that extent the dentist is not restricted as regards the fees he may charge. The sickness fund may grant a contribution to the cost of dentures or it may take over payment of the whole cost. Usually a contribution is paid; in some cases there is also a contribution by the pension insurance institution, which the sickness fund pays over on its behalf.

The amounts not covered by such contributions must be paid by the insured person directly to the dentist. Generally the sickness fund pays its contribution globally to the association of insurance dentists, which passes on the appropriate amount to the practitioner concerned; but in some cases the fund pays its contribution directly to the dentist or insured person.

Under the "miners' fund dental officer" system, on the other hand, payment for services relating to dentures is regulated with the other conditions of employment.

(3) Medico-technical benefits given as part of in-patient treatment in hospitals (cf. C.2(2)b) are remunerated out of the lump sums paid quarterly by the funds, the rates being negotiated between the various associations of insurance practitioners and the hospitals or their organisations.

Most of the physicians performing these services are employees of the hospitals and are paid on a salary basis for their work as a whole: so the remuneration paid by the practitioners' associations goes to the hospitals.

Regarding remuneration for the care of insured persons at university polyclinics (cf. C.2(2)c) the practitioners' associations conclude contracts with the universities; the remuneration comes out of the "lump sums" received by the said associations from the sickness funds (see D.1(1)a).

As for the costs of care by baths physicians in connection with cures at bathing places (C.7), the sickness funds pay a flat rate for each person undergoing such a cure. The money goes to a "baths physicians department" (of the insurance practitioners' associations) for the whole federal area, and is used to remunerate the services of the physicians who direct and supervise the cures.

The physician is remunerated separately for any special services which may be necessary in connection with a bathing cure, such as injections. The sickness fund pays an additional flat rate, for each cure, to meet such costs as this.

Medical and dental services rendered at sickness funds' own establishments are performed by physicians or dentists in the employment of the funds and are remunerated by way of the salaries they receive.

(4) The services rendered at the expense of a sickness fund by members of the professions (or by the establishments) listed under C.6 - masseurs, bandage makers, orthopaedic mechanics, opticians, remedial gymnasts, bathing establishments - are remunerated by the funds at rates negotiated at the local or provincial level for the particular service. The conditions so agreed are usually applied also to members of funds established outside the area, with which the persons providing the services have no direct contractual reations. The sickness funds remunerate midwives at rates fixed by the Federal Minister of Health in the "Order respecting the fees to be paid by sickness funds to midwives in independent practice for obstetrical aid". As this is a statutory instrument, no contractual procedure is required.

2. Payment for Hospital (In-Patient) Facilities

The sickness fund pays a flat rate per patient per day to cover all costs of in-patient care (C.4) - i.e. not only medical care but also pharmaceutical supplies, board and lodging. This is called the "hospital rate". It is negotiated between the fund and the hospital or the respective organisations at some convenient level. If no agreement is reached regarding the amount of the hospital rate, an official arbitration authority, the provincial Price-Fixing Office, will determine it.

The principles to be followed in fixing this rate are laid down in a Federal Hospital Rates Order dated 1954, which is supplemented by provincial orders with similar titles. Several of these provide for a range of various rates or for the classification of hospitals in this respect. Most of the provinces have

such classifications, since the Federal Order permits a uniform rate to be laid down for a group of similar hospitals (i.e. with the same standards for medical staff and medico-technical equipment). Accordingly, most of the provinces have arranged their hospitals in anything from 6 to 20 groups, each with a standard "hospital rate". Nowadays the rate ranges approximately from 20 to 40 marks a day.

In the negotiation or arbitration of hospital rates, according to the Federal Order, "bare cost" is to be taken as the basis. "Bare cost" in this connection is to mean the cost caused by in-patient care with economical administration, after deduction of the customary public subsidy. The Federal Order also prescribes that regard must be had to the economic strength of the social insurance institutions. The kinds of costs which have to be borne in mind in determining the hospital rates, according to the Federal Order, do not guarantee full cover for costs in the sense known to managerial science; still, not only direct expenditure but also overheads (depreciation, interest, payments to reserve) must be taken into account. The sickness funds have for years been pressing for a change in the method of determining hospital rates, so that the overheads may be borne by the public authorities (federation, province, municipality); the funds would be prepared to pay the direct costs. The current hospital deficits can be evaluated only approximately. The estimates oscillate around 500 million D.M. per year. The cost is borne by the public authorities to which the hospital belongs or, when it belongs to a chartitable organisation, a church etc., by the proprietor.

The Federal Ministry of Health has for some time been planning an amendment to the Federal Hospital Rates Order with a view to making the hospitals more profitable. It is not yet clear whether the wishes of the sickness funds regarding separation of direct and overhead costs will be taken into account, but in any case the proposal has found much support among the public. In the social survey commissioned by the Federal Government, carried out by five professors and presented in 1966, it is stated regarding this problem that maintenance of a certain hospital capacity is a public responsibility but that its use is the satisfaction of a private need. Accordingly, it is argued, the total cost should be shared by the public authorities on the one hand and the users (or their insurance institutions) on the other.

If medical care in a "bespoke" bed or hospital is provided by a physician ordinarily engaged in independent practice - cf. C.4(1) - no cost of medical care on his part is included in the hospital rate. Such a physician is paid for his in-patient care by the practitioners' association out of the lump sum it receives from the sickness fund.

3. Payment for Pharmaceutical Products and Medical Supplies from Pharmacies

The manufacturers of pharmaceutical products are free to fix their prices as they think fit. On the other hand, how much the pharmacist may add to the wholesale price of any preparation is laid down by law: the particulars are specified in the German Medicaments Schedule, a statutory instrument issued by the Federal Minister of Economic Affairs.

The following are the proportions which, under the Schedule, the pharmacist may add to the wholesale price of a preparation, as determined under ordinary market conditions:

Wholesale Price DM	Pharmacist's Charge Per Cent.	Gross Profit Per Cent.
Up to 2.50	70	41.2
2.73 - 8.00	64	39
8.53 - 15.00	60	37.5
18.00 - 25.00	50	33.3
27.78 - 40.00	45	31
45.00 - 60.00	40	28.6
Over 72.00	33 1/3	25

If the wholesale price lies outside the ranges mentioned above, the pharmacist makes a fixed charge, as follows:

Wholesale Price DM	Pharmacist's Charge DM
2.51 - 2.72	1.75
8.01 - 8.52	5.12
15.01 - 17.99	9.00
25.01 - 27.77	12.50
40.01 - 44.99	18.00
60.01 - 72.00	24.00

Lower charges are agreed for many specific products - for instance, medicaments to be used at the physician's consultation office.

The pharmacists allow the sickness funds a reduction (rebate) on the retail prices calculated according to the Schedule. This is laid down as regards the Insurance Code funds in section 376 of the Insurance Code. The amount of the reduction, fixed by the highest administrative authorities, is a uniform 7 per cent., but less in the case of pharmacies with a small turnover ("marginal pharmacies"). In order to increase the yield of a pharmacist's business, the pharmacists seek to obtain the elimination or at least a decrease of the statutory rebate. In some areas additional "special rebates" have been negotiated.

So the prices for the sickness funds are then calculated as follows:

> To the wholesale price, add the pharmacist's charge as laid down in the Schedule or agreed on; add to the result a further 4 per cent. turnover tax, obtaining the pharmacist's retail price for private customers; deduct the turnover tax, which is not charged on goods supplied for account of the sickness funds, deduct the sickness funds' rebate, statutory or agreed on; the result is the price to the sickness fund.

The pharmacist must also deduct from each item the fee payable in most cases by the insured person, namely 50 pfennig per prescription filled.

If bandages, dressings, etc. are excluded, in most cases the pharmacies furnish proprietary preparations. These represent about 90 per cent. of the preparations supplied.

E. Special Rural Medical Services

There is no provision for "special medical services" to meet claims for benefit in rural areas only: in principle, no distinction is made, as regards medical services, between town and countryside. The question whether services are effectively available for the rural population to the same extent as for townspeople is another problem (see under H below).

F. Relations Between the Statutory Social Insurance Scheme and the Public Health Authorities (Including Planning and Co-ordination of Services)

As regards the Insurance Code funds, section 414(g) of the Insurance Code states that the associations of sickness funds at the provincial and federal levels shall assist the competent provincial and federal authorities in matters of legislation and administration. The associations are thus able, particularly as regards legislation, to call attention to the points which their views and experience suggest ought to be taken into account in the interest of the insured population. The sickness funds' associations - including, of course, those of miners' and substitute funds - make frequent use of this possibility.

In 1964 and early 1965, for instance, they took an active part in the discussion of the new schedule of medical and dental charges, which came into force on 1 April 1965. The same applies to the still continuing efforts of the Federal Ministry of Health to modify the terms of the Hospital Rates Order. Furthermore, there is statutory provision for collaboration by the associations of sickness funds on specific questions: the Federal Insurance Code states, for instance, in section 376(a) that the Midwives' Fees Order shall be issued with their collaboration; and the statutory orders which regulate in detail the approval of physicians, etc. for sickness fund practice are issued after consultation with "federal committees" on which sickness funds and their associations are represented (sections 368(c) and 368(o) of the Insurance Code).

The above review of the situation at the federal level applies also at the provincial level, although there the co-operation of the sickness funds' associations in legislative processes is not so great.

Whereas the function performed by the federal and provincial authorities is mainly legislative (the creation of law in a particular field to regulate future conduct), at the local level the chief public authorities concerned - the health offices - are mainly administrative institutions which give effect to existing law. The duties conferred by legislation on the health offices do not involve any regular relations with the social insurance institutions. The offices are required to give certain inoculations -

against smallpox and poliomyelitis, for instance; they have some supervisory functions (they supervise the midwives and are required to ensure that hospitals and pharmacies comply with certain regulations); and they may take action in such special circumstances as the threat of epidemic of an infectious disease.

Relations between the health offices and the sickness funds may arise out of the above functions in particular cases. In most areas there are agreed arrangements (though mainly above the local level), under which the sickness funds share in the cost of measures against venereal disease.

As part of their responsibility for social welfare, the local government authorities give "social assistance" benefits to the needy. In case of sickness, if they have no claim to benefit from a sickness fund, such persons are provided by the local authority - mostly via its "social welfare office" - with medical care by practitioners in independent practice, hospitalisation (in-patient care), pharmaceutical requirements, etc. If it transpires that a sickness fund has wrongly refused benefit to such a person, relations with the local social welfare authority may arise in the sense of a request for reimbursement of its expenses. Sometimes a social welfare office requires a sickness fund to provide necessitous persons with medical care at the former's expense.

The number of persons who received medical benefits under social assistance in 1965 was as follows:

Preventive care	89,500	Care for persons with tuberculosis	119,300
Curative care	304,200		
Care before and after confinement	4,400	Care for the blind	36,200[1]

G. Attitudes of Persons Concerned with the Scheme

Valuable insight into the attitudes of persons protected is given by the changing extent to which they have recourse to medical care. The yardstick employed is the number of sickness forms made out, and paid for, per 100 members. The forms for medical and dental care are counted separately; those for members and dependants are taken together. As an example, quotation of the figure 397 as the index of recourse to medical care in 1951 means that there were, in that year, 397 sickness forms issued (to members and dependants) for every 100 members. This figure merely gives one piece of information about recourse to medical care, namely its frequency; that is not the same as the morbidity rate; one cannot deduce from a rise in the index any increase in the incidence of disease.

For every 100 members:

75 sickness forms were issued in 1888;
125 in 1913;
150 in 1924;
175 in 1931;
397 in 1951; and
527 in 1963.

The reasons for this massive increase in recourse to medical care are manifold. For one, the duration of entitlement to medical care has been extended (since 1941 there has been no limit on its duration).

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[1] Wirtschaft und Statistik, 1967, S. 207 ff.

Next, the membership has become very different, owing mainly to full employment and a modified age structure caused in its turn by greater average longevity; for instance, in the local sickness funds about 25 per cent. of the members are pensioners, very many of them receiving permanent medical attention. A third very important factor is the development of medical science, which not infrequently causes remarkable alterations in statutory sickness insurance; owing to the character of the scheme, the results of scientific progress in medicine are made available to insured persons on a very broad basis in a relatively short time.

The great spread of hygiene, together with explanations of matters of health, has also led to a change of attitude regarding recourse to medical care. This is no longer felt as something exceptional, to be undertaken only in case of acute threat to the health; on the contrary, it is increasingly seen as a means of maintaining good health, as a normal preventive measure. Accordingly, the increased recourse to medical care is no doubt due to a considerable extent to a change in behaviour: the insured person tends to seek care not only in case of serious, fairly serious or even slight disease, but sometimes also when he merely feels unwell. It should be added that the number of accidents, particularly traffic accidents has greatly increased.

A very interesting inquiry into the attitude of the population towards social sickness insurance was undertaken by an institute for research into popular behaviour[1], at the request of the Federal Ministry of Health. The results were made available in 1958. Gainfully occupied compulsory members had been asked inter alia whether they would voluntarily remain with their sickness funds if the obligation to insure should cease tomorrow. Over 90 per cent. replied in the affirmative, and only 4 per cent. said that they would leave. This "vote" expresses the favourable view which insured persons take of their sickness funds. Social sickness insurance, which takes care of over 87 per cent. of the total population, has become a matter of course, a part of civilisation, during the more than 80 years of its development.

The above situation was confirmed in a social survey undertaken by a committee of four independent scientists as decided by the Federal Government on 29 April 1964; the report of this "social survey committee" was published in July 1966. The scientists say that the whole system is a structure of imposing completeness and self-consistency; that the threat to family budgets caused by the risk of additional expenditure and loss of income which may result from sickness is regarded as intolerable; that there is on all sides a strong sense of the need to quantify such a grave risk of expense or loss so that plans may be made to face it; and that this - it is felt - should be done by insurance. The broad scope of protection against the risks of sickness by application of the insurance principle, the committee found, meets an elementary requirement of the "good housekeeper".

A further indication of the favourable popular attitude towards statutory sickness insurance can be drawn from the results of a legislative amendment which came into force on 1 September 1965.

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[1] The Institut für Demoskopie.

On that day the upper limit of liability to insurance for salaried employees was raised from 660 to 900 marks a month. About a million employees were thus once more compulsorily insured, with the following proviso: any such person could obtain exemption from statutory insurance, at his request, by showing that he was a member of a private sickness insurance on 1 September 1965 and intended to maintain his membership. However, only about 15,000 salaried employees - some 1.5 per cent. of the total concerned - have used that right of exemption.

The strong general confidence in the sickness funds and the sense of need for the protection which they afford do not of course preclude a critical approach on the part of insured persons. The 1958 report mentioned above speaks of the following four unfavourable criticisms:

(a) "Not all medicaments are prescribed - although they ought to be."

Objectively speaking, this criticism was only partly justified. Formerly, in some parts of Germany, it was the practice for the physician, when prescribing medicaments, to keep (on average) to a "usual amount" based on experience. However, averaging proved too complicated for the patients, and evidently for some of the practitioners too; so it was often understood that no individual patient's prescription could exceed the "usual amount". This difficulty has since been overcome by abolishing the "usual amount" altogether.

(b) "We don't get modern remedies at once."

This complaint is essentially due to the rule of economy, which cannot be dispensed with. When, for instance, antibiotics came in, they were first of all generally considered to be miraculous and patients asked for them even where medically speaking they were not appropriate. Such an attitude is prompted by sensational reports in the newspapers and illustrated magazines. Here too more understanding has been brought to wider circles in recent years - not least because communication of new medical discoveries to the public has become more accurate. Also the Contergan case has shown how important it may be in some circumstances to test a preparation for years, and that the newest medicament need not always be the best. Public understanding on these questions, which are so significant for sickness insurance, has improved very much since 1958, so that this particular complaint is no longer common.

(c) "No free choice: we ought to have it."

This grievance was met by the judgment of the Constitutional Court in 1960, which has already been mentioned more than once. Since then, practically every qualified physician has the right to engage in sickness fund practice if he so requests. As almost every physician does make such a request, the "density" of practitioners has considerably increased in most areas - a fact which is generally welcomed - cf. C.1(3).

(d) "Insurance patients are not so well cared for as private patients."

This belief too has become less common since 1958. The grievance was indeed caused largely by appearances. Nowadays it has become the exception for a practitioner to have a separate waiting room for insurance patients. On the physicians' side, too, it has more than once been publicly - and convincingly - declared that there is no difference in medical treatment between sickness fund and private patients.

The complaints of compulsorily insured persons which found an echo in the report of 1958, and the relative dissatisfaction with benefits received under social sickness insurance, were not the least of the reasons why a big improvement has since been introduced by legislation. For instance, the possible duration of hospital care and of cash benefits (the sickness and home allowances) is in practice no longer restricted, and if appropriate a patient can now go on without interruption from sickness benefit to a pension. Insured persons are thus fully and continuously protected against the economic effects of sickness. Furthermore, the allowance paid to a wage earner during the first six weeks of incapacity due to sickness has been raised to his full net wage, so that wage earners and salaried employees are now in the same economic situation.

To sum up, it may be said that the persons protected are fully aware of the value of their sickness funds, have frequent recourse to them, and when necessary contribute by criticism towards regular adjustment to changing conditions.

H. Special Problems

1. Maldistribution of members of the medical and allied professions, and of medical facilities, between urban and rural areas; methods used to rectify such situations, and experience.

The required new intake of physicians (including specialists) in 1966 is estimated at some 2,000; about 4,500 persons are expected to take the final examination. Similar ratios have occurred in the past. This situation, which has in practice existed for years, has led to an excessive supply of physicians (there are some shortages in respect of junior hospital staff, but according to the latest reports from hospitals an improvement is occurring there). In 1938 there were 1,379 inhabitants per physician engaged in his profession; in 1965 the figure was 691 so the number of active physicians has increased more rapidly than the population. However, a certain increase in medical "density" does not necessarily mean a corresponding general improvement in the medical care of the population.

The above conditions are reflected in the availability of medical care for persons protected by the sickness funds. The restriction on approval of practitioners for sickness fund work which had been prescribed in section 368(a) of the Insurance Code (for local, rural, works and guild funds) was declared invalid by judgments of the Federal Constitutional Court, dated 23 March 1960

(physicians) and 8 February 1961 (dentists) - cf. C.1(1)a and C.5(3)a. Now the approval committees must in effect enable every physician to engage in sickness fund practice in whatever place he chooses, provided he meets the personal standards set in the Insurance Code and the Approvals Order. In 1959 the number of physicians approved for sickness fund practice was 36,864, in 1965 it was 43,765 - an increase of 18.7 per cent.

Elimination of the possibility of any numerical restriction by the approval committees has had three principal unfavourable results:

(a) It is no longer permissible to direct a candidate to a particular local practice or "post". This prohibition has led to mounting difficulty in inducing physicians to act as sickness fund practitioners in areas to which, because of lack of cultural facilities or secondary (or higher) schools, or for other reasons, physicians are unwilling to go. The insurance practitioners' associations do attempt, chiefly by offering financial advantages, to ensure medical care for sickness fund members in such areas: but despite an increase in the over-all ratio of physicians to the population, there are shortages of medical personnel, particularly in certain rural districts. So the urban population has more physicians available than do some sectors of the rural population.

(b) Because previously the approval committees could designate not only the place but also the speciality in which a particular physician would be permitted to practise, many physicians with specialist qualifications set themselves up as general practitioners: consequently there was an appropriate ratio between the numbers of general practitioners and specialists. Since the "liberalisation" of approval for sickness fund practice, however, thanks to the higher social prestige of the specialists, the (in some cases) higher fees they can command and the lower pressure on most specialists as regards calls to visit patients, there has been a shift away from general and towards specialist practice, as the following table shows. This development will probably continue; at present there is no possibility of intervening to correct it.

	1959	1965	Increase Per Cent.
Number of sickness fund physicians	36,864	43,765	18.7
including:			
general practitioners	24,279	25,944	6.9
specialists	12,585	17,821	41.6
Specialists as per cent. of physicians	34.1	40.1	

(c) Free access to sickness fund practice brings with it the danger that certain branches of medicine may be overfilled and that the practitioners concerned may be attempting to make up for a decline in the number of patients by an excessive increase in the number of services rendered per case. The following figures seem to indicate that this surmise may be correct.

Relationship between Number of Services Rendered per Case and Number of Cases Treated (Data regarding 95 General Practitioners in a Large City[1])

Number of Cases Handled By Physician	Av. No. of Cases per Physician in Each Group	Av. No of Services Per Case
600 - 999	817	8.90
1,000 - 1,499	1,288	6.24
1,500 - 1,999	1,756	5.64
2,000 - 2,499	2,211	5.51
2,500 - 2,999	2,726	5.06

The above facts indicate that the present regulations are not sufficient to ensure adequate distribution of physicians between town and country and between general and specialist practice. The situation could only be improved by a change in the law. The bodies responsible for approval of practitioners should be enabled by legislation, to direct admittance to sickness fund practice in a reasonable way, as was done before (but without infringing the judgments of the Constitutional Court).

As regards dentists, the situation may be summarised as follows. Density is decreasing: on 1 January 1960 there were 1,716 inhabitants for each dentist; in 1965 there were 1,873. The necessary intake is estimated at 1,350 a year; effective entries in, for instance, 1964 were only 471. This unsatisfactory situation is due above all to the insufficient number which can be accommodated at the universities. According to the German Dentists' Federation, 50 per cent. of the 1,700 applicants for study had to be rejected in 1964 because there was not room for them all at the university dental clinics.

Though an actual shortage of dentists cannot be said to exist at present, it can be expected unless the authorities come to the rescue.

As regards admittance to sickness fund practice, the same problems arise as on the medical side (except that there is of course no question of an increase in specialists).

Provision of the necessary benefits by personnel of other professions or by health service undertakings may be regarded on the whole as ensured, though here too the same problems may arise locally as in the case of medical and dental care.

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[1] Liebold in "Gesundheitspolitik", 1966, No. 3.

As regards the hospitals, instances may be quoted in which patients could not be admitted for lack of space. There are other hospitals where the accommodation is not fully used. Several provinces have started rational planning so as to produce a balanced situation in this regard. However, some of the hospitals are very short of personnel: there is, above all, a lack of female nurses.

The number of midwives in independent practice is decreasing sharply, but - again with local exceptions - it cannot be said that there is actually under-provision of care by this group of persons, since the number of confinements at home has fallen off very much (the number in institutions has increased).

2. Lack of Medical Personnel and Facilities

See under 1 above.

3. Lack of Means of Communication

Means of communication are sufficient as regards both quantity and quality.

I. Statistical Data

Table I. Volume of Benefits in Kind Provided by Statutory Sickness Insurance

Year	Ambulatory and Domiciliary Medical Care				Dental Care	Hospital Care	
	No. of cases accounted per member	No. of Prescriptions[1] per Case[2]			No. of cases accounted per member[3]	No. of hospital cases per member	No. of days hospital care per member
		members	dependants	pensioners and dependants			
1961	4.85	1.938	1.818	3.461	-	0.15	3.30
1962	4.99	1.980	1.811	3.480	1.084	0.15	3.45
1963	5.13	-	-	-	1.110	0.15	3.51
1964	5.24	-	-	-	1.145	0.15	3.52

[1] Irrespective of number of items on each prescription form.

[2] Data from local sickness funds of one province.

[3] Data from local sickness funds only.

General Observations

(a) As the number of protected dependants is not known (membership figures cover only insured persons paying contributions), per capita calculation of benefits and costs is possible in respect of members but not of dependants.

(b) Data regarding the number and cost of cases can only be given in respect of cases accounted, not cases treated. A case "accounted" includes all the services rendered by a given practitioner in a given quarter-year. The number and cost of cases treated, in the medical sense, cannot be given.

Table 2. Cost of Benefits in Kind Provided by Statutory Sickness Insurance
(figures in German marks)

Year	Ambulatory and Domiciliary Medical Care										Dental Care		Hospital Care	
	Remuneration		Cost per		Pharmaceutical Costs per Case[2]			Pharmaceutical Costs per Prescription[3]			Remuneration[4]			
	per member	per case accounted	consul-tation	visit[1]	members	dependants	pensioners and dependants	members	depend-ants	pensioners and dependants	per member	per case accounted	cost per member	cost per case
1961	70.07	14.43	-	-	10.39	9.74	20.92	5.36	5.36	6.04	-	-	64.34	439.56
1962	76.35	15.30	-	-	-	-	-	5.79	5.72	6.59	17.72	19.23	73.08	491.17
1963	82.05	16.01	-	-	-	-	-	-	-	-	18.79	20.86	81.75	545.22
1964	92.47	17.65	-	-	-	-	-	-	-	-	19.70	22.56	90.67	594.03
1965	-	-	7.12	3.08	-	-	-	-	-	-	23.61	27.29	-	-

[1] Data from local sickness funds only.

[2] Not including "other", "special" or physical-medical benefits.

[3] Data from local sickness funds of one province; irrespective of numbers of items on each prescription form.

[4] Data from local sickness funds only.

See also General Observations to table 1.

Table 3. Breakdown of Annual Costs by Kinds of Benefit

Expenditure of Statutory Sickness Insurance, 1964

Heads of Expenditure	Expenditure in thousands of marks	Expenditure per member (marks)
Medical care	2,748,382	96.88
Dental care	782,643	27.59
Pharmaceutical, medical and surgical supplies	2,068,714	72.92
Dentures	340,912	12.01
Hospital care	2,571,893	90.66
Cash benefits (sickness allowance, home allowance)	3,344,322	117.89
Confidential physicians and dentists	97,889	3.45
Convalescent care	20,550	0.72
Prevention	128,707	4.53
Confinement care	626,782	22.09
Death benefit	240,231	8.46
Other benefits	95,612	3.37
Administrative costs	740,016	26.08
Expenditure on property and sundry	31,953	1.12
Total net expenditure	13,838,606	487.77

Table 4. Number of Physicians in the Federal Republic

	1960	1964
All physicians	83,247	89,112
Physicians professionally active	79,350	84,203
in independent practice	49,225	50,060
on staff of hospitals	22,646	25,324
in administration[1]	7,479	8,819
Officially approved insurance physicians	42,144	43,647
including: general practitioners	26,360	26,132
specialists	15,784	17,515

[1] Employed by public authorities, institutions and private industry.

Table 5. Professionally Active Physicians, According to Branch of Medicine

	1960	1964
General practitioners	26,360	26,132
Specialists	15,784	17,515
including[1]:		
anaesthetists	73	275
ophthalmologists	2,058	2,193
surgeons	4,619	4,728
gynaecologists	3,371	3,717
ear, nose and throat specialists	2,299	2,350
dermatologists	1,787	1,745
internal medicine	7,550	9,073
paediatricians	2,621	2,974
laboratory physicians	173	324
chest specialists	1,740	1,820
mouth and jaw specialists	393	371
neurologists	2,214	2,536
nerve surgery	51	95
orthopaedists	1,151	1,364
radiologists	1,259	1,447
urologists	508	655
other specialists	515	-[2]

[1] The German alphabetical order has been retained.

[2] Included under general practitioners.

Table 6. Dentists in the Federal Republic
(includes both dental surgeons and dentists not entitled to that designation)

	1960	1964
All dentists	33,329	33,316
Dentists professionally active	32,509	32,047
in independent practice	31,689	30,980
on staff of hospitals	357	455
in administration[1]	463	612

[1] Employed by public authorities, institutions or private industry.