



THE UNIVERSITY OF  
NEW SOUTH WALES



CENTRE FOR CLINICAL GOVERNANCE RESEARCH IN HEALTH

## Selected abstracts and citations



Articles about the Australian and  
German Health Care Systems

***The Centre for Clinical Governance Research in Health  
undertakes strategic research, evaluations and research-  
based projects of national and international standing with a  
core interest to investigate health sector issues of policy,  
culture, systems, governance and leadership.***

# ***Articles about the Australian and German Health Systems***

## ***Selected abstracts and citations***

### **Duration of project**

May 2004

### **Search period**

Commencement of the databases to 11th May 2004

### **Key words searched**

Australian health system, Australian health care system, German health system, German health care system

### **Databases searched**

Medline, CINAHL, EMBASE, Science Direct, Emerald Fulltext, ABI Global (ProQuest Medical Library, Health Module, ProQuest Social Science Journals)

### **Criteria applied**

Articles about Australian and German health care systems

Articles that met the criteria were included in the project. A bibliography including citations and abstracts of these articles is presented on the next pages.

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**Anonymous (1997). "The Australian health care system: Are the incentives down under right side up? (Journal of the American Medical Association (December 25, 1996) 276 (1944-1950))." Journal of the American Medical Association 278(2).**

**Bangha, E., B. Fritze, et al. (1999). "[Quality management in the German health care system]." Hautarzt 50(5): 330-7.**

*Abstract* With the increasing demands on hospitals for improved quality and lower costs, hospitals have been forced to reevaluate their manner of operation and quality assurance programs. Hospitals have also been faced with customer dissatisfaction and intense competition. This article reviews current quality-management systems and examines their position in dermatology. [References: 53]

**Barnighausen, T. and R. Sauerborn (2002). "One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?" Social Science & Medicine 54(10): 1559.**

**Bauer, M. and A. Bach (1998). "[Managed care. Its impact on health care in the USA, especially on anesthesia and intensive care]." Anaesthetist 47(6): 442-59.**

*Abstract* Managed care, i.e., the integration of health insurance and delivery of care under the direction of one organization, is gaining importance in the USA health market. The initial effects consisted of a decrease in insurance premiums, a very attractive feature for employers. Managed care promises to contain expenditures for health care. Given the shrinking public resources in Germany, managed care seems attractive for the German health system, too. In this review the development of managed care, the principal elements, forms of organisation and practical tools are outlined. The regulation of the delivery of care by means of controlling and financial incentives threatens the autonomy of physicians: the physician must act as a "double agent", caring for the interest for the individual patient and being restricted by the contract with the managed care organisation. Cost containment by managed care was achieved by reducing the fees for physicians and hospitals (and partly by restricting care for patients). Only a fraction of this cost reduction was handed over to the enrollee or employer, and most of the money was returned with profit to the shareholders of the managed care organisations. The preeminent role of primary care physicians as gatekeepers of the health network led to a reduced demand for specialist services in general and for university hospitals and anesthesiologists in particular. The paradigm of managed care, i.e., to guide the patient and the care giver through the health care system in order to achieve cost-effective and high quality care, seems very attractive. The stress on cost minimization by any means in the daily practice of managed care makes it doubtful if managed care

should be an option for the German health system, in particular because there are a number of restrictions on it in German law.

**Beck, W. and H. U. Deppe (1990). "Oil and water? A united German health care system." *Health Pac Bulletin* 20(4): 21-3.**

**Berg, C. (1990). "East German health system: Not only drawbacks. [German]." *Pharmazeutische Zeitung* 135(25).**

**Birchard, K. (2002). "German health system tech goup pushes for system changes." *Medical Post* 38(41): 84.**

**Bonatz, E. (1994). "The German health care system.[comment]." *Southern Medical Journal* 87(7): 771.**

**Borgetto, B. (2002). "Health-related self-help groups - A contribution towards the care of the chronically ill and handicapped persons in the German health system. [German]." *Arbeitsmedizin Sozialmedizin Umweltmedizin* 37(8): 382-387.**

*Abstract* Health-related self-help groups and organisations make an important contribution to the health of the public in Germany. In particular self-help groups offer mutual aid and social support, increase knowledge about the disease and its consequences and provide ways of changing the attitudes of the group members and their social environment. They unburden the primary social networks and families of the afflicted persons and reinforce the 'intelligent' utilisation of the professional services of the health care system. As yet there has been almost no systematic investigation of the activities of self-help organisations, except for counselling services. Self-help groups and organisations are increasingly receiving financial aid from the social security system and are becoming more and more part of the health care system. Yet the co-operation between self-help initiatives and the professional health care system is characterised by an imbalance between medical laymen and experts. Research in this area is fragmented; further investigations should address the question of how larger proportions of the population can be involved in self-help activities. The promotion and co-ordination of research in this area is necessary.

**Botzel, K. (2000). "Cost refunding for treating Parkinson patients with deep stimulation electrodes. [German]." *Aktuelle Neurologie* 27(SUPPL): S70-S71.**

*Abstract* There is no uniform ruling on the reimbursement of the costs of deep brain stimulation therapy in Germany. This article illustrates the present situation and provides an outlook on the new regulations of the German health system.

**Braithwaite, J. (1993). "Strategic management and organisational structure: transformational processes at work in hospitals." *Australian Health Review* 16(4): 383-404.**

*Abstract* There is a substantial amount of organisational restructuring presently occurring in Australian public hospitals. However, there has been a lack of systematic research conducted about this phenomenon. In Australia most literature about organisational restructuring has employed a case study approach. Although there has been a great deal of support for product line management organisational arrangements in recent literature from overseas, little investigation into the adoption of product line management has taken place in Australia. In this paper, a discussion about the relationship between strategic management and organisational structure is presented. Survey results of a sample of nine teaching hospitals in New South Wales are reported. Taken together with other more descriptive literature about organisational restructuring in Australian health care, the evidence from this survey suggests that there are vigorous transformational processes at work, perhaps especially in the larger hospitals. Despite support for it in the literature, product line management is not being adopted on a widespread scale. The shift toward restructuring occurring within Australian hospitals at the moment represents a bout of experimentation with new organisational designs which seems destined to continue. A number of management theorists conclude that there need to be strong linkages between strategic planning and the choice of organisational structure. However, the empirical evidence reported here did not identify such strong linkages. This phenomenon warrants further investigation. The view is put that where these linkages are weak there is a risk that whatever structure is chosen will not be robust or flexible enough to cope with mooted or predicted policy changes to the Australian health system.

**Brogie, M. G. (1990). "[What does the established physician expect from the West German health system? Fee reduction and drug control as a consequence of economic assessment. What can be done?]." *Zeitschrift fur die Gesamte Innere Medizin und Ihre Grenzgebiete* 45(18): 556-60.**

*Abstract* We have briefly tried to inform about the fact why controls of profitableness have to be carried out, how is their course and by virtue of which standards the unprofitableness is assessed. In form of a randomized summary we will once more specify what the physician by all means should do if the fee is reduced or a drug recourse takes place: 1. The date of receipt is to be written clearly visible on the control rescript, since this is of importance for the grace when legal remedies may be applied. 2. Test the rescript, whether or not the reducing or the recourse seems to be justified or whether you have the impression that the data of your activity and management of your practice have not been fully taken into consideration. In this case you at once object and announce a detailed argument. 3. Test quietly, after the first irritation has subsided, whether the points of view explained in the paragraphs 3 and 4 have

been taken into consideration, in particular: a. Is the comparative group right? b. Is the present elevation of the average values suited to justify the reducing measure performed? c. Are all peculiarities of the practice taken into consideration? d. Are the peculiarities of the practice sufficiently exactly quantified? e. Was a possible compensatory less expenditure taken into consideration? 4. Summarize the result of your own inquiries, as they are described in item 3, in a relevant argument as short as possible. If you need statistical data, which are not at your disposal, for writing this argument, so request such data from the control department of your health-insurance company. 5. In a drug recourse you control, whether or not you can acknowledge the judgment of the arguments for reducing declared. Otherwise you request from your health insurance company the examination into the adequate prescriptions, in which case you probably have to go into the business premises of your health insurance company, in order to be able to take notes there.

**Brogie, M. G. (1997). "[The physician between cost control and quality requirements]." *Zeitschrift für Arztliche Fortbildung und Qualitätssicherung* 91(7): 639-44.**

*Abstract* In times of reduced monetary resources of the current German health system, it is more and more difficult for the German physicians to comply with the high medicinal care standard and to practice economically. Nevertheless, the economical reasons cannot deny the high medical quality standards. Regarding the principle of the unity of jurisdiction, the validity of the social welfare law, that a performance has to be "just sufficient and suitable", must concur with the demand of liability law of "indication of the medical service". The economical duties reach their limit when they increase the risk for the patient. On the other hand, the economy interests have to be regarded by the "principle of the allowed risk". Therefore, it should be considered that in every single case the severity and probability of the risk has to be weighed against the cost aspect.

**Buchanan, I. and R. Sheaff (1997). "A social market in health care faces reform: The Seehofer plan for the German health system." *Health Care Analysis* 5(3): 244-251.**

**Burrows, C. (1988). "The Australian health care system: a troubled history." *Journal of Medical Practice Management* 3(3): 217-222.**

*Abstract* The operation of Australia's health care system is inherently unstable because of strong ideological differences between the alternative governing parties. There have been several major restructurings of the system over the last 30 years, and probably further substantial changes will occur in the near future. To understand the operations of the existing system, it is helpful to know something of its history. This article catalogs and explains the major developments of the national health system since its inception in the 1950s.

**Coleman, W. D. and V. Bhatia (2003). "Ideas and discourse: reform and resistance in the Canadian and German health systems." *Canadian Journal of Political Science* 36(4): 715.**

**Deimel, D., H. J. Hesselschwerdt, et al. (1997). "[Simple and valid ICD9-/10- and ICPM coding using an electronic data-assisted coding system "do it"--experiences after one years use]." *Zeitschrift fur Orthopadie und Ihre Grenzgebiete* 135(6): 528-34.**

*Abstract* Question by introducing "Fallpauschalen" and "Sonderentgelte" in German health system the coding of diagnoses and therapies gains a new momentum. Therefore, a new computer based coding-system for ICD- and ICPM- digits is presented. The physician gets enabled for simple and valid classification within his documentation routine. METHODS: Development of a hierarchic menu system, whose first part represents the anatomic region. The second part is reserved for the most common diagnosis resp. therapies within its special anatomic region. By further sub-menus all other ICD numbers in the orthopedic and traumatologic field may be coded (selection related by frequency). This coding-system has been in clinical use since jan. 1st. 1995. RESULTS: Control of the efficiency of this coding-systems by 1316 patients with 1551 operations within one year. By using ICD-10, the representation of orthopedic-traumatologic diagnosis inanced by factor 1.8 versus ICD-9. According to ICPM, 3560 therapies were coded, making it 2-3 actions per operation. "Fallpauschalen" were found in 21.9%, in 27.7% there were "Sonderentgelte". Within one year the coding error rate was reduced from 25% to 5%. CONCLUSIONS: Because of its easy handling the coding system "do it" represents a good alternative to conventional coding resp. clear text analysis.

**Diste, H. D. (2003). "Economic issues of living donor transplantation in the view of the German health care system." *Transplantation Proceedings* 35(3): 974-5.**

**Doecke, C. J. (1999). "The Australian Medication Safety Working Group: developing a strategy for reducing adverse drug events in the Australian health system.[see comment]." *Journal of Quality in Clinical Practice* 19(1): 5.**

**Duckett, S. (1999). "Policy challenges for the Australian health care system." *Australian Health Review*. 22(2): 130-47.**

*Abstract* In contrast to the regular media reports decrying the so-called crisis in the health system, a number of academic commentators have identified areas in which the Australian health care system could improve. George Palmer has been one of those, and over the years has published a body of work identifying areas for improvement. This paper reviews the performance of the Australian

health care system against the criteria of equity, efficiency and acceptability, and explicates the contemporary problem areas associated with each criterion.

**Duggan, J. M. (1997). "The Australian health care system: John Hunter's long shadow." *Medical Journal of Australia* 167(9): 481-483.**

*Abstract* In Australia, organised medicine fails to show effective leadership in health care delivery, health bureaucracies lack long-term plans, the community is concerned about the health care system and, although denied by politicians, there is de facto health care rationing - surely it is time for an in-depth review?.

**Felsch, M., J. Friedrich, et al. (1991). "[Opinions and expectations of physicians of the Halle district for restructuring health care]." *Offentliche Gesundheitswesen* 53(2): 71-6.**

*Abstract* The article reports on a sociological investigation on physicians' views and expectations regarding the restructuring of the East German health system. 1,420 physicians of a former GDR district (= some 3.5 per cent of GDR doctors) were questioned. The data were ascertained in April 1990 via questionnaire.

**Fozouni, B. and B. Guntert (2000). "[Determining priorities in German public health--triad between rationing, rationalization and rational allocation]." *Gesundheitswesen* 62(11): 559-67.**

*Abstract* Is there a crisis of the German health system? Will necessary medical services be rationed? These or similar questions have been intensely discussed in the public ever since the realization of reforming the health system by the Red-Green coalition. Opposers of the health structure reform 2000 have especially regarded the global budget, which was meanwhile stopped by the Federal Council, as an enormous threat for a functional health system. Many actors of the health system have uttered deep apprehensions regarding a reform of the health system. As various attempts of legal controlling have proved during the last ten years, it will be necessary in our society to negotiate the health services which we will be able to afford in future at which price, and which we want to realize. Even presently it is not possible to guarantee maximum medical care according to the latest technology. The future question in the German health care system will no more be whether it will be necessary to set priorities, but only how they will have to be established.

**Fritze, B. and U. Amon (1999). "[The "Hersbruck Model". Application and integration of the DIN EN ISO 9001 quality norms with criteria of the European Foundation for Quality Management in a clinic]." *Zeitschrift für Ärztliche Fortbildung und Qualitätssicherung* 93(9): 701-7.**

*Abstract* The German health system has dramatically changed and still continues to do so. Modified aspects concerning economy, customer orientation, competition, quality assurance and quality management seem to be increasingly important. Appropriate response to this challenge demands a relevant adjustment of a quality "philosophy" within a hospital. The "Hersbruck Model" has proven to be a suitable approach: on the basis of a quality management system--established and certified according to DIN EN ISO 9001--it implements all components of the model of the European Foundation for Quality Management. The modern quality tools as Total Quality Management and continuous quality improvement allow a permanent increase of customer/patient satisfaction.

**Gillroy, J. (1982). "Hospital associations & the political process." *Australian Health Review* 5(5): 25-7.**

*Abstract* Development of the concept of an association and its responsibilities to its members; examination of the diversity of influences (political and otherwise) within the Australian health system; the problem of dealing with short-term Ministers and untrained Oppositions; handling the nonissues and sorting out the real issues from a hospital association's point of view; defining then finding the persons to influence who will be staying around!

**Gotthardt, M. (1994). "Revolution in the German health care system." *Journal of Clinical Anesthesia* 6(3): 250-251.**

**Haar, H. O. (1991). "The German health system: inside and outside." *Internist* 32(5): 28-9.**

**Hall, J. (1999). "Incremental change in the Australian health care system: tensions exist in a system that features universal coverage and a strong private insurance tradition." *Health Affairs*. 18(3): 95-110.**

*Abstract* Australia is similar to the United States in that it is a federation of states, its medical profession is well organized and politically powerful, and it has a substantial private sector. Unlike the United States, Australia provides universal access to health care and has controlled its total health care spending to around 8.5 percent of gross domestic product (GDP). This paper reviews the role of private health insurance and recent initiatives to support this; the strategies used to control costs in the fee-for-service sector; and the capacity for experimentation in health care financing within a national system that guarantees universal access.

**Harris, M. G. and R. D. Harris (1998). "The Australian health system: continuity and change." *Journal of Health & Human Services Administration* 20(4): 442-67.**

*Abstract* The health of Australians, with the exception of Aboriginals and Torres Strait Islanders, compares favourably with other industrialised nations. Since 1984, universal access for citizens to medical and public hospital services has been achieved under a national Health Insurance Scheme called Medicare, partially funded by a 1.4 percent levy on all taxpayers. Medicare found early widespread support from the electorate but continues to be buffeted by a minority coalition of some medical associations, private health insurers, and conservative "libertarian" politicians. Over the decade since its inception, Medicare has provided stability in maintaining total health costs around 8 percent of GDP. This has been largely due to capping hospital costs via Commonwealth-State agreements. Medicare has failed in the past five years to contain medical costs which have increased proportionally with increases in the medical workforce. This article examines the structure and performance of Medicare and its role within Australia's overall health system. Benefits of a universal access insurance program are outlined together with challenges associated with inequities in health status, geography, aging of the population, burgeoning technology, ideological diversity, and an economic climate requiring cost containment and favouring privatisation and the role of the market. It can be concluded that, despite these challenges, universal access to health care is here to stay. Australia's Medicare program has become popular with the electorate.

**Henke, K. D., C. Ade, et al. (1994). "The German health care system: Structure and changes." *Journal of Clinical Anesthesia* 6(3): 252-262.**

*Abstract* The German health care system has often been viewed by American policy makers as a model for a system that controls costs and provides coverage to virtually all of its citizens, while maintaining a private market for the delivery of most services. Nevertheless, German policy makers are as concerned as their American counterparts about the increasing share of national income devoted to health care. To control rising health care costs, the German government, after two decades of cost control interventions, has enacted a major health care reform aimed at reducing structural deficits of the current system and enhancing competition within the system. We review the general structure of the German health care system and analyze its specific problems. We also discuss its accomplishments and present the recently enacted health care reform.

**Henry, D. and R. Lopert (1999). "Pharmacoeconomics and policy decisions: The Australian Health Care System." *Clinical Therapeutics* 21(5): 909-915.**

*Abstract* This paper provides an overview of the use of pharmacoeconomic analysis in the process that governs drug reimbursement decisions in Australia. It discusses the methods by which drugs are evaluated, both clinically and economically, and the means by which these 2 facets are amalgamated; the types of pharmacoeconomic data submitted in support of requests for reimbursement; the methods and standards used to assess these data; some of

the more commonly encountered flaws in the data submitted; and how the different types of data influence reimbursement decisions.

**Hensen, P., S. Wollert, et al. (2003). "Analysing strengths and weaknesses: Opportunities and threats for service providers in the German health care system. [German]." *Journal der Deutschen Dermatologischen Gesellschaft* 1(5): 346-351.**

*Abstract* Hospitals in the German health care system are confronted with increasing economic competition due to paradigm shifts in funding inpatient treatment. Major hospitals, such as university hospitals, will be under significantly greater pressure to keep up the ability to compete by uniform per case payment. The new hospital funding system based on a Diagnosis Related Group (DRG) system and the economic competition involved require analyses of organisational and locational factors. Cooperativeness and efficient utilisation of resources, properties and staff will be determining factors to secure existence. Adequate responses and strategies are essential to cope with the growing operating requirements. Carrying out an analysis identifying one's own strengths and weaknesses, opportunities and threats will help to focus activities and sustainable strategies into areas where the strengths and the greatest opportunities lie. An example of the process of strategic planning and positioning is shown for a university department of dermatology.

**Herrmann, M. (1999). "[Perspectives in public health care for refugees in Germany]." *Gesundheitswesen* 61(6): 312-8.**

*Abstract* Germany in fact became an immigration country during the last 25 years. The German public health service for refugees aims at avoiding epidemic diseases and protecting the local population. In spite of the internationally recognised high capability of the German health system it is open to question whether sufficient health care for refugees who are regarded as highly vulnerable is guaranteed. Relevant investigations are missing. The present article illustrates perspectives of the health situation, health perception, health behaviour and finally also the health resources of refugees. Health as well as the health care of refugees appears to be fragmented. Three possible scenarios of the health care of refugees are discussed: Compartmentalisation of general health care, incorporation of health care through the communities of migrants as well as stronger integration in the German health care system. The article bases on a research of present scientific work about health and illness of refugees as well as on empirical data of a feasibility study in an area in south-west Germany on the health and primary health care for refugees. [References: 39]

**Hindle, D. and M. Lenz (2001). "Using Australian DRGs in Germany: a commentary." *Australian Health Review* 24(1): 136-147.**

**Hua, M., C. Rissel, et al. (2002). "Effectiveness of a resource on the Australian health care system among the Sydney Chinese-speaking community." *Promotion et Education*. 9(3): 98-100.**

**Hughes, R. (2003). "Competency development needs of the Australian public health nutrition workforce." *Public Health Nutrition* 6(8): 839-47.**

*Abstract*      **OBJECTIVES:** To assess factors affecting competency development of the Australian public health nutrition workforce and investigate competency development intentions, barriers and self-reported training needs. **DESIGN:** Cross-sectional study using self-administered mail- or email-delivered questionnaire. **SETTING AND SUBJECTS:** Two hundred and forty practitioners working in designated community and public health nutrition positions in the Australian health system. **RESULTS:** An 87% questionnaire response rate was achieved. The profile of the sample included female practitioners (95%) within the age range of 26-45 years (67%), from dietetic backgrounds (75%) and employed in state health departments as community dietitians/nutritionists (52%) or public health nutritionists (32%). Only 14% had completed higher degree qualifications but most (80%) reported an intention to do so in the future. Entry-level dietetic education was considered by most respondents (57%) to be inadequate preparation for public health nutrition practice but considered it had utility as a precursor for public health nutrition competency development because of its strong grounding in nutrition knowledge, basic research skills and problem-solving. On-the-job learning was the most prominent competency development influence reported by this workforce. Flexibility in teaching and learning approaches is needed to facilitate workforce participation in further competency development. The main competency development needs focused on analytical and policy process competencies; however, there was a general need expressed for competency development across many competency areas. **CONCLUSIONS:** These data provide intelligence to inform public health nutrition workforce development, particularly that relating to continued professional development amongst the existing workforce.

**Jackson, J. L. (1997). "The german health system: Lessons for reform in the United States." *Archives of Internal Medicine* 157(2): 155-160.**

**Jones, M. and B. P. Jones (1975). "The Australian health system. Allocation of resources in production and distribution of medical services in Australia." *Medical Journal of Australia* 1(16): 508-10.**

*Abstract*      The writers suggest that before July, 1971, the resultant effect of the interaction of all market forces was efficient production and distribution of medical care. Efficiency of health-service production and distribution is defined as availability of short-term life-saving services to all members of the community.

**Kamke, K. (1998). "The German health care system and health care reform." *Health Policy* 43(2): 171-94.**

*Abstract* This article presents a structured survey of the German health care and health insurance system, and analyzes major developments of current German health policy. The German statutory health insurance system has been known as a system that provides all citizens with ready access to comprehensive high quality medical care at a cost the country considered socially acceptable. However, an increasing concern for rapidly rising health care expenditure led to a number of cost-containment measures since 1977. The aim was to bring the growth of health care expenditure in line with the growth of wages and salaries of the sickness fund members. The recent health care reforms of 1989 and 1993 yielded only short-term reductions of health care expenditure, with increases in the subsequent years. 'Stability of the contribution rate' is the uppermost political objective of current health care reform initiatives. Options under discussion include reductions in the benefit package and increases of patients' co-payments. The article concludes with the possible consequences of the 1997 health care reform of which the major part became effective 1 July 1997.

**Karcher, H. (1996). "German health insurance system faces new deficits." *British Medical Journal* 312(7023): 74-75.**

**Kirkman-Liff, B. and G. Neubauer (1992). "The development of quality assurance in the German health care system." *Qrb Quality Review Bulletin* 18(8): 266-74.**

*Abstract* Quality assurance efforts in the German health care system have primarily been a responsibility of the medical profession. The Federal and State Physician Chambers coordinated early quality assurance studies, which conformed to the guidelines of voluntary participation by physicians, confidentiality of data, and no imposition of sanctions for poor performance. These guidelines were challenged by the Health Reform Act of 1989, which made the legal regulations for quality assurance the same for hospitals as for out-patient care. Some current draft implementation plans conform to the principle of anonymity, requiring no disclosure of patient-specific, physician-specific, or hospital-specific data to third parties; others allow release of data to individual insurers or their associations. Although no consensus has been reached as to how quality assurance will be performed in the future in Germany, it will clearly become an integral part of the system.

**Kirkman-Liff, B. (1994). "German health care - Germany's health system: one nation, united with health care for all by Richard Knox." *JAMA* 271(19): 1546-1547.**

**Kletter, M. (1996). "The necessity for integrating different methods in psychotherapy. [German]." *Psychotherapeut* 41(6): 361-367.**

*Abstract* With the recent changes in the German health service, psychoanalysis as a therapeutic method gets into increasing difficulties. The self-satisfaction of having the therapeutic monopoly in the health service for 20 years has led to ignoring the development of other probably even superior methods. The favouring of long-term therapy and the puristic fencing off of other approaches have led to an impasse. If psychoanalysis wants to continue to have a place in the German health service, the so far neglected brief and medium-term therapeutic approaches need to be supported. Their efficiency needs to be improved through the integration of elements from other therapeutic methods and through research. Furstenau's integrative model of psychoanalytic-systemic psychotherapy as a method proved to be worthwhile is presented. Its application within the medium-term psychodynamic psychotherapy (which is part of the funded psychotherapy in the German health system) is outlined. The author describes the difficulties that a psychoanalytically trained psychotherapist encounters in freeing himself from the restrictions of the method, as well as the rewards he has through gaining therapeutic competence and efficiency.

**Knueppel, D. A. (2001). "Introduction to the German health care system." P & T 26(7): 355-370.**

**Knuth, P., D. L. Wahner-Roedler, et al. (1997). "The German health system: lessons for reform in the United States.[comment]." Archives of Internal Medicine 157(15): 1773-4.**

**Koch, U. (2003). "[The German health care system needs a new commission of enquiry! The Hamburg Health Care Congress's proposals]." Psychotherapie, Psychosomatik, Medizinische Psychologie 53(11): 431.**

**Kovac, M. (1998). "Rationing of hospital services in the Australian health system." Croatian Medical Journal 39(3): 339-45.**

*Abstract* This article reports on the rationing in the Australian hospital sector and explains why it has been undertaken. It also briefly overviews the Australian health system in order to provide a necessary background for the issue of rationing itself. Rationing of hospital services has occurred because governments in Australia have limited hospital sector resources trying to ensure the containment of their health budgets. The resources available to hospitals have been insufficient to ensure that the supply of services meets the demand for such services. Therefore, in order to contain hospital budgets rationing has been required. Medicare, the universal health insurance system, assures that access to public hospital services is on the basis of clinical needs. However, due to the federal nature of government in Australia, the available services are determined by health system structural interrelationships and direct government regulation. For example, services provided in the community sector, and funded by the Commonwealth government, are prime candidates for being removed from the

hospital sector by State/Territory governments. Similarly, expensive services with a wide range of usage are candidates for regulation to contain costs.

**Kraft, K. (2001). "History of herbal medicinal use in Germany with a treatise on present day practice." *Journal of Herbal Pharmacotherapy* 1(2): 43-49.**

*Abstract* In this article a brief synopsis on the history of the use of herbal medicinal drugs from old ages until present time is given, with special impact on the important role of the German herbalists, physicians and pharmacists. Thereafter the present difficult situation of herbal medicinal drugs in Germany is illustrated. Increasing standards for quality and efficacy for drugs, economical and health problems due to the demographic development and preferences of the population are some of the many facets of the present difficulties in the German health system.

**Lederer, P. (2000). "The public health service, the third column of the German health care system - Or an out-dated institution?. [German]." *Arbeitsmedizin Sozialmedizin Umweltmedizin* 35(6): 260-264.**

*Abstract* The public health service in Germany has seen much functional and organisational restructuring in its long tradition. According to the German constitution, the public health services are the responsibility of the federal states. Nevertheless, all German municipalities and local governments have their public health departments with the following tasks: hygiene and infection surveillance, environmental hygiene and medicine, school medical services, medical assessments for public administration, health reports, disease prevention and health promotion, supervision of medical professions. The public health service, often called the third column of the German health care system, spends only 0.5% of the total budget of the German health care system. At present there is much discussion on how to update the public health service in each of the federal states and make it more efficient. The main topic of discussion is which tasks will in future continue to be performed by the public health service (i.e. those particularly relevant to population medicine and health protection), and which of them (of more individual concern, such as medical assessments and school medical services) could be performed by other institutions or privatised.

**Leeder, S. (2000). "The Australian health system." *Telemedicine Journal* 6(2): 201-4.**

**Loffler, S. (1990). "Starting problems in the German-German health care system. [German]." *Pharmazeutische Zeitung* 135(40).**

**Lungen, M. and I. Lapsley (2003). "The reform of hospital financing in Germany: an international solution?" *Journal of Health Organization and Management* 17(5): 360-372.**

*Abstract* From 2003, each inpatient's stay at a German hospital will be reimbursed according to diagnosis related groups. The former German hospital financing system, which consisted partly of per diem rates and partly of per-case rates, was abolished in an attempt to increase efficiency in hospitals. This can be seen as the government's attempt to act on the principles of evidence-based policy. Since there is no strict global budget for inpatient treatment, it is not certain that those diagnosis related groups will actually decrease overall expenditures on hospitals. Also, it is argued that the introduction of diagnosis related groups in Germany may not be the last step in rebuilding the German health care system. The manner, scope and timing of this reform suggests that it will not succeed. Reforms lead to yet more reforms.

**Lueschen, G., S. Niemann, et al. (1997). "The integration of two health systems: social stratification, work and health in East and West Germany." *Social Science & Medicine* 44(6): 883-99.**

*Abstract* This is an analysis of system integration, social stratification and work for health status and health care in East and West Germany. It is based on aggregate data and representative survey data of random samples of 2554 adults in both subsystems. Findings show that there were marked differences in life-expectancy prior to unification. The integration of the two systems, which occurred almost totally with regard to terms of West German health care organization, shows adjustment problems in the East for the public Health-Care-Funds and few if any for ambulatory care. The work situation has an impact on health, but there are no significant differences for East versus West. Social stratification variables show an influence on subjective health status for education (East) and for income, social status (West), while physician utilization (despite a preference of specialists by those with higher status) is not significantly determined by stratification variables in either East or West Germany. Beyond the central focus on work and stratification determinants a major finding pertains to a comparatively worse health situation for the aged and for women in what was the former East Germany. System models of Capitalism versus Socialism fit the results and recent history of the two systems to only a limited degree, as the West German corporate health system shows clear limits in following free market principles. The East German system, regardless of its centralized organization and move towards a socialist system, never fully abandoned the traditional model of German health care. Unlike the East German health system, that of West Germany, with its general expansion to 92% of the population, shows an increasing effect for social redistribution. The latter may be a reason why standard indicators of social stratification show less of an impact on health and health care than expected, while conditions at work clearly determine the health of people-the latter being the case in both the former East and West Germany.

**Moeller, J. and A. K. Sonntag (2001). "Evaluation of health services organisations - German experiences with the EFQM excellence approach in healthcare." 13 5(361-366).**

*Abstract* Expands on previous reports by illustrating experiences of German health services organisations made in their assessment against the European Foundation for Quality Management (EFQM) excellence model. Indicates the EFQM method and scoring system. Refers to the experiences German health care pioneers made during their early assessments. Also, success factors and best practices of self-assessments are shared, as well as limitations, barriers, and lessons learned during the implementation phase. The excellence model is a systematic quality management approach to gain competitive advantage. It is non-governmental, non-financier driven, and generic enough to address health care issues. Having its foundation in industry, however, it is not specific enough to cover all areas relevant to health care.

**Mooney, G. (2002). "Health information management in the Australian health care system as a whole." Health Information Management Journal. 31(2): 4p.**

**More, E. and M. McGrath (2002). "An Australian case in e-health communication and change." Journal of Management Development 21(8): 621-632.**

*Abstract* Australia's health industry is grasping the need to use IT and telecommunications with e-commerce strategies for improved cost-effective services to its key stakeholders. Addresses the changes occurring in Australia's healthcare industry influenced by experiments in e-commerce and focussed on the Project Electronic Commerce and Communication for Healthcare (PeCC). Initiated in 1997, as a joint activity of both government and industry, PeCC was developed to introduce e-commerce practices into the health sector with almost 700 suppliers, automating pharmaceutical and other supplies to hospitals. Supply chain communication will be facilitated by an Internet-based platform, allowing more efficient interaction between the pharmaceutical industry's outlets (retail and hospital pharmacies), wholesalers, suppliers and manufacturers. Promoting and demonstrating e-commerce for the pharmaceutical industry supply chain, the project connects manufacturers, wholesalers, suppliers and hospitals. Examines lessons in change management and communication that emanate from this health sector case, emphasising the issue of improving communication with key stakeholders about e-commerce and changes to the health system, and ensuring appropriate communication practices (including media selection) through the different phases of the project over time.

**Nadolski, H. (2002). "Budgeting and rationing in the German health care system." Journal of Contemporary Health Law & Policy 18(3): 697-702.**

**Najman, J. M. and J. S. Western (1984). "A comparative analysis of Australian health policy in the 1970s." *Social Science & Medicine* 18(11): 949-58.**

*Abstract* In the decade of the 1970s there were some significant changes to the Australian health system while the health systems of most other countries remained stable. By comparing the Australian health system with that of a number of other countries in the 1970s, the paper examines both the causes and consequences of these changes. The substance of the various Australian health system initiatives was a change from a voluntary to a mandatory health insurance system and then, after a short period of 'catastrophic' health insurance, a return to a voluntary system. Most of these changes appeared to be motivated by political and ideological preferences rather than by a rational assessment of their likely efficiency or effectiveness. In any event, and despite claims to the contrary, these changes were minor when viewed in the broad context of international systems of health care. The conclusions of the analysis, while tentative, suggest that the health system changes had little, if any, direct impact on health costs, service use and indicators of health outcomes.

**Nass, G. E. and R. A. C. Kretschmer (2002). "Trauma nursing in the German health care system." *International Journal of Trauma Nursing*. 8(1): 9-14.**

*Abstract* This article provides an overview of the history and current practice of trauma nursing in the German health care system. A description of nursing education, skills, duties, and responsibilities of the nursing workforce is complemented by a brief description of the trauma system. As current demographic developments, structural changes, and medical progress result in a rapidly changing health care environment, tasks for nurses are becoming increasingly complex. The development of academic programs and extended nursing tasks are expected to help manage the upcoming changes and challenges in the manifold processes of patient-centered-nursing-care delivery.

**Navarro, V. (1991). "The West German health care system: a critique." *International Journal of Health Services* 21(3): 565-71.**

*Abstract* Several leading health policy staff of the AFL-CIO and major unions met with the Board of Physicians for a National Health Program (PNHP) in May 1990. They described the active discussions currently ongoing within the AFL-CIO Health Care Committee, which is composed of 14 international union presidents and sets AFL-CIO policy on health care issues. Some union presidents reportedly favored a single-payer, Canadian-style approach, while others apparently preferred a proposal modeled after the West German system, which preserves a major role for insurance companies. The PNHP Board was emphatic in its preference for the single-payer approach. Board member Dr. Vicente Navarro wrote the following letter to the union presidents on the AFL-CIO Health Care Committee detailing his critique of the West German approach.

**Ng, J., J. Li, et al. (2002). "Experience with coding accuracy for endophthalmitis." *Health Information Management Journal*. 31(2): 4p.**

*Abstract* The Endophthalmitis Population Study of Western Australia aims to investigate the epidemiology of endophthalmitis, a potentially sight-threatening infection of the internal eye, in Western Australia in 1980-1998. Cases of endophthalmitis were identified from coded hospital discharge data, surgeon logbooks, and hospital microbiology and anaesthetic databases. This process uncovered not only widespread miscoding for endophthalmitis, but also systematic misuse of the endophthalmitis codes for external eye infections. The level of miscoding and code misuse has improved since the mid-1990s, and probably reflects the introduction of coding standards and trained coders into the Western Australian health system.

**Ollenschlager, G., C. Thomeczek, et al. (1999). "[The guideline clearing programme of the self-governmental bodies in the German health care system--a project to promote quality assurance in medicine]." *Gesundheitswesen* 61(3): 105-11.**

*Abstract* Within the German health system guidelines are increasingly considered as a meaningful and necessary aid to decision making. In this context the effectiveness of guidelines essentially depends on their methodical quality. Because of the fact that most of the German-language guidelines introduced within the past years show obvious methodological defects, the Agency for Quality in Medicine developed within the last two years the following programme for quality-assurance and promotion of guidelines: 1. Definition of quality policies for clinical practice guidelines in Germany 2. Establishment of quality demands for guidelines 3. Methods and instruments for quality promotion of guideline programmes 4. Measures to promote and check the quality of guidelines ("German Guidelines Clearinghouse") The following article reports on background, aims, instruments, method development and acceptance of the programme.

**Oppl, H. and E. von Kardorff (1990). "The national health care system in the welfare state." *Social Science & Medicine* 31(1): 43-50.**

**Peabody, J. W., S. R. Bickel, et al. (1944). "The Australian health care system: Are the incentives down under right side up? [1]." *Journal of the American Medical Association* 276(24): 1944-1950.**

**Peacock, S. and L. Segal (2000). "Capitation funding in Australia: imperatives and impediments." *Health Care Management Science* 3(2): 77-88.**

*Abstract* Health service funding mechanisms are pivotal in the pursuit of health system objectives, as they provide strong financial incentives for actors in

the system to achieve policy goals. Underpinning funding mechanisms is a set of key economic principles, or objectives, that should guide their design and use: efficiency, equity, and accountability. The Australian health system has historically performed relatively poorly in relation to these objectives, with evidence of inefficiencies, inequities, and poor accountability in many areas of health services. The primary cause of these shortcomings may lie in the complex set of funding and delivery arrangements at the State and Federal levels of government. Potentially significant improvements in the performance of the health system would be available from the integration of the funding and delivery of services within a single tier of government, coupled with the development of a national weighted capitation approach to funding. To develop a national capitation funding model a number of unique factors require consideration, including the current fragmentation of services, the role of the private sector, the needs of indigenous populations, and the effects of rurality. The data available to develop a capitation model is of a level of detail and quality not readily found elsewhere. If policy statements promoting efficiency, accountability, and particularly equity are to be actively pursued, a national capitation model based on robust methods should become a cornerstone of Australian health system reform.

**Phillips, C. and M. Carter (1988). "Quantifying discontent in the nursing profession: a study of staff mobility in Victorian nursing homes." *Australian Health Review* 11(4): 256-65.**

*Abstract* Two problems facing the Australian health system are discontent within the nursing profession and matching limited resources to a growing aged population. It is argued in this paper that the solutions to these two problems can only be evaluated by quantifying the scale of the problem. Three measures are used to demonstrate how to measure the size of the problem: participation rates, staff turnover rates and proportion of permanent/casual staff. These three measures are useful to monitor both at a systems level and at the level of individual health services. The discussion refers in particular to staffing in Victorian geriatric nursing homes.

**Podger, A. (1999). "Reforming the Australian health care system: a government perspective." *Health Affairs* 18(3): 111-113.**

**Poensgen, A. (2004). "Reform of the German health system - Fundamental new approach instead of temporary repair: Results of a working paper of the Boston Consulting Group. [German]." *Pharmazeutische Industrie* 66(1): 37-42.**

**Reinecke, H., H. Bunzemeier, et al. (2003). "[Evaluating the first German diagnosis-related groups (G-DRG) in cardiological patients: problems in the correct medical and economic grouping]." *Zeitschrift fur Kardiologie* 92(7): 581-94.**

*Abstract* About three years ago, the German Government initiated a complete change in the reimbursement system for costs of the in-hospital treatment of patients. A commission of representatives from every component of the German health system decided to adapt the Australian refined Diagnosis Related Groups (AR-DRG system). The AR-DRG system was selected as it would fit best to the German system and because of its high flexibility and preciseness reflecting severity of diseases and treatments. In October 2002, the first German Diagnosis Related Groups (G-DRGs) were calculated from the data of about 116 hospitals. These data now allow first analyses in how far a correct and precise grouping of patients in specific hospital settings is indeed performed and corresponds to the actual costs. Thus, we thoroughly calculated all costs for material and personnel during the in-hospital stay for each patient discharged during the first 4 months of 2002 from our cardiological department. After performing the grouping procedure for each patient, we analyzed in how far inhomogeneous patient distribution in the DRGs occurred and which impact this had on costs and potential reimbursements. Several different problems were identified which should be outlined in this work regarding three G-DRGs: costs of patients who received an implantable cardioverter defibrillator (F01Z) were markedly influenced by multimorbidity and additional expensive interventions which were not reflected by this G-DRG. Use of numerous catheters and expensive drugs represented a major factor for costs in patients with coronary angioplasty in acute myocardial infarction (F10Z) but seemed to be not sufficiently included in the cost weight. A specific area of patient management in our department is high frequency ablation of tachyarrhythmias which is included in other percutaneous interventions (F19Z). Complex procedures such as ablation of ventricular tachycardia or new innovative procedures as ablation of atrial fibrillation were associated with high costs leading to inadequate reimbursement. Furthermore, problems in the associated codes for diseases and procedures became apparent. Opportunities for future optimization such as specific new DRGs, splitting of DRGs, or the impact of changes in reimbursement for high-outliers were discussed.

**Reid, B., G. Palmer, et al. (2000). "The performance of Australian DRGs." Australian Health Review 23(2): 20-31.**

**Roeder, N. (2001). "Building a Star Alliance: Australian and German DRGs." Australian Health Review 24(3): 29-32.**

**Rommel, A. (2000). "Allocation ethics within the German health system: The discrepancy between the rationing debate and rationing practice in Germany. [German]." Zeitschrift fur Gesundheitswissenschaften 8(1): 38-57.**

*Abstract* This paper takes a close look at the distributive principles of the German health system and analyses to what extent the highest standard of

health care can still be ensured for all patients in Germany. The way in which the public rationing debate is being conducted and ethical issues are being addressed, highlights the necessity to distinguish between egalitarian and utilitarian approaches to the distribution of health care services. The terminology derived by making this distinction can then be used to analytically classify the rationing of health care services as well as the debate surrounding the issue within the context of German neocorporatism. Whilst there is already clear evidence of rationing in Germany, in the debate the exclusion of health care services is generally treated as something that will become relevant in the future. This apparent discrepancy between debate and reality is also mirrored by a rationing praxis, which at times contravenes the principles upon which a pluralistic society is based. This paper concludes with an attempt to define the democratic bounds within which justifiable restrictions to current health care services can conceivably be carried out.

**Roy, M. J. (1993). "The German health care system: model or mirage?[see comment]." *Southern Medical Journal* 86(12): 1389-94.**

*Abstract* Rising costs have spurred America's leaders to look abroad for a model upon which to pattern reform of our health care system. On the surface, at least, Germany would appear to have an ideal system combining universal access, high quality, free choice of physicians, and cost control. Germany has been particularly effective in curbing pharmaceutical and administrative expenses, and has avoided the progressive imbalance between primary care providers and medical specialists seen in America. However, Germany lags behind the US in emphasizing preventive services and in shifting services to the ambulatory setting. Also, an oversupply of physicians, lack of incentives to limit the volume of services, and a global budget cap have combined to induce physicians to do more while their incomes were falling sharply relative to those of other workers. Although selected elements of the German health care system could be beneficial to America, full-scale adoption of the German system is neither realistic nor desirable.

**Rublee, D. (1998). "Uneasy marks... German health system management." *Hospitals & Health Networks*. 72(9): 34-6.**

**Rublee, D. A. (1998). "Update on the German health care system." *Journal of Medical Practice Management* 13(6): 286-290.**

*Abstract* For all its problems, the German health care system has exercised enormous influence over other nations. Today, the reach of Germany's venerable health insurance system extends to eastern European countries. Domestically, the system is very popular. Current policy is marked by a preoccupation with economic constraints. German health spending is growing faster than wages, testing Germany's long commitment to income-proportional financing of the health care system. The pay-as-you-go system of financing is unstable. To shrink

the budget deficit, Germany is cutting the growth in health care spending. The sickness funds are running short of money and the number of funds has declined. The unabated growth in the physician workforce is having major impact on the economic dimensions of medical practice.

**Runciman, W. B., E. E. Roughead, et al. (2003). "Adverse drug events and medication errors in Australia." *International Journal for Quality in Health Care* 15(Suppl 1): i49-59.**

*Abstract*      **PURPOSE:** To review information about adverse drug events (ADEs) and medication errors in Australia. **DATA SOURCES:** Systematic literature reviews and reports from data collections of the Australian Bureau of Statistics, Institute of Health and Welfare, Council for Health Care Standards and Patient Safety Foundation. **RESULTS:** (medical record reviews): We have shown that 2-4% of all hospital admissions, and up to 30% for patients > 75 years of age, are medication-related; up to three-quarters are potentially preventable. **RESULTS** (routine data collections): Routine death certificate and hospital discharge data coded using the International Classification of Diseases capture less than half as many ADEs as medical record reviews. Of coded adverse events that contributed to death, 27% involved an ADE, as did 20% of adverse events identified at discharge and 43% at general practice encounters. There is a strong correlation between increases in medication use and rates of adverse drug reactions (ADRs) associated with hospitalization. **RESULTS** (drugs implicated): These were similar in all the above studies: anticoagulants, anti-inflammatory drugs, opioids, anti-neoplastics, antihypertensives, antibiotics, cardiac glycosides, diuretics, hypoglycaemic agents, steroids, hypnotics, anticonvulsants, and antipsychotics. **RESULTS** (clinical indicators): An ADE is reported in 1% of hospital admissions, while some hospitals do not report ADRs to the national collection. Only three-quarters of patients with acute myocardial infarction receive thrombolytics within 1 hour of presentation. Five per cent of patients on warfarin record an international normalized ratio > 5, and 1%, 0.05%, and 0.2% -suffer abnormal bleeding, cerebral haemorrhage, or death, respectively. **RESULTS** (the Australian Incident Monitoring System): Twenty-six per cent of 27 000 hospital-related incidents were medication-related, as were 36% of 2000 anaesthesia-related incidents, and 50% of 2500 general practice incidents. **RESULTS** (errors): Errors occur in 15-20% of drug administrations when ward stock systems are used and 5-8% when individual patient systems are used. Previous allergic reactions to drugs may not be recorded more than 75% of the time. **CONCLUSION:** ADEs are common in the Australian health system. Anticoagulant, anti-inflammatory, and cardiovascular drugs feature prominently as preventable, high impact problems, and collectively make up over one-half of all ADEs. Methods for monitoring and preventing ADEs should be progressively improved. [References: 60]

**Rychlik, R. (2000). "Unity, right and liberty - Also for the German health system?. [German]." *Gesundheitsökonomie und Qualitätsmanagement* 5(2).**

**Scholte, M. and J. Doherty (1998). "German health system slow to change.[see comment]." *Managed Care Quarterly* 6(2): 68-70.**

**Schramm, A. (1997). "Rehabilitation from an economic point of view - What is the position of geriatric rehabilitation in the German health system?. [German]." *Zeitschrift für Gerontologie und Geriatrie* 30(6): 405-409.**

*Abstract* The paper summarizes the answers to given questions and the lecture held on the occasion of a hearing of the Enquete-Kommission 'Demographic change' of the German Parliament. The subject was the problem of cost-effectiveness of rehabilitation measures. The position of geriatric rehabilitation in Germany as an established and efficient method 1st described. The indication for rehabilitation must be correctly and individually determined, and the treatment should be available to patients in all communities.

**Schwantes, U. (1999). "Pros and cons of family doctor models. [German]." *Gesundheitsökonomie und Qualitätsmanagement* 4(2): 62-66.**

*Abstract* The German health system grows more and more expensive. In the same time the physicians in own practices are suffering from increasing economic pressure. To save costs and to ensure the income of physicians within the last years networks are built either between persons only of same supply's level or including those with different specialities. Recent statutes in social law (SGB V) are supporting those networks, which are enforcing the basic care clone by general practitioners. That's the reason they are called 'Hausarztmodelle' (family doctors model). This essay is reflecting, if the economic expectations of the established 'Hausarztmodelle' could be attained. Some claims for coming 'network models' are specified.

**Schweins, M. and M. Edelmann (1997). "[Ambulatory laparoscopic cholecystectomy].[see comment]." *Chirurg* 68(6): 613-7.**

*Abstract* A total of 140 patients underwent outpatient laparoscopic cholecystectomy in an outpatient clinic. Evaluation and follow-up of the patients were done prospectively. Population and preoperative data were comparable to published studies of patients operated on in hospitals. There were no serious intra- or postoperative complications. Postoperatively, patients needed less pain medication, were less tired and returned to work earlier than patients after clinical laparoscopic cholecystectomies. Outpatient laparoscopic cholecystectomy offers a good alternative to patients with moderate operative risks (ASA 1-3). It could reduce costs in the German health system and would be therefore highly cost effective.

**Sheaff, R. (1997). "A social market in health care faces reform: the Seehofer Plan for the German health system." *Health Care Analysis* 5(3): 244-9.**

**Sullivan, N., R. Redpath, et al. (2002). "Public hospitals: who's looking after you? The difficulties in encouraging patients to use their private health insurance in public hospitals." *Australian Health Review* 25(3): 6-14.**

*Abstract* Private health insurance (PHI) is an important part of the Australian health system. During the introduction of the recent PHI reforms it was argued that, without the reforms, the public hospital system would undoubtedly collapse under the increased demand for public health services. The increase in PHI coverage might also have been expected to result in an increase in the revenue earned by public hospitals as a result of treating privately insured patients. However, the decline in numbers of privately insured patients using their PHI in public hospitals has continued, with adverse impacts on public hospital budgets in some states. This article addresses the complex interactions between various policy instruments and their impact on public hospitals, and reports the results of a study conducted at the Austin & Repatriation Medical Centre (A&RMC) which examined the reasons for privately insured patients electing not to use their insurance in public hospitals, and methods by which they might be overcome.

**Teil, E. (1997). "[Head outside--feet inside. How do patients from other cultures experience the German health care system?]." *Pflege* 10(4): 193-8.**

*Abstract* More migrants in a country mean also more patients from other cultures. Therefore, it is possible that cultural differences or institutional conditions become the origin of conflicts between patients and nursing personnel. Transcultural studies have mainly investigated problems of German nurses with foreign patients. The aim of the present study is to get to know the patients' own views as experts in their situation: "What are the experiences of migrants with the German Health Care System, especially with hospital nursing care?" The results of the study point out that the main sources of conflicts in hospital are located in institutional conditions rather than in cultural differences of patients.

**Vogt, W. (2000). "Total quality management in laboratory medicine - The model of the European foundation for quality management. [German]." *Laboratoriums Medizin* 24(2): 86-97.**

*Abstract* The German health system continues to face considerable challenges. It is to be expected that modified forms of Managed Care and quality considerations will become increasingly important. To be successful in future it will be necessary to provide optimum quality at low prices. Quality Management in a total sense has to be proved, and as in other developments, medical laboratories can show the way. Important elements of Total Quality Management

(TQM) are zero-defect thinking, customer orientation and system management. Customers are all those who receive a product or services, and quality is measured in terms of their long-term satisfaction. TQM avoids the strictly formal criteria of European or ISO standards. A declared goal of health policies is to increase competition between hospitals, thus sinking prices and increasing quality. Competition involves comparison, and TQM attaches importance to benchmarking, and comparing performance with best-in-class organization.

**Vogt, W. (2001). "Quality management in medical laboratories. [German]." *Psycho* 27(4): 223-228.**

*Abstract* The German health system continues to face considerable challenges. It is to be expected that modified forms of Managed Care and quality considerations will become increasingly important. To be successful in future it will be necessary to provide optimum quality at low prices. Quality in a total sense has to be proved, and as in other developments, medical laboratories can show the way. Important elements of Total Quality Management (TQM) are zero-defect thinking, customer orientation and system management. Customers are all those who receive a product or services, and quality is measured in terms of their long-term satisfaction. TQM avoids the strictly formal criteria of European or ISO standards. A declared goal of health policies is to increase the competition between hospitals, thus sinking prices and increasing quality. Competition involves comparison, and TQM attaches importance to benchmarking, and comparing performance with best-in-class organizations.

**von der Schulenburg, J. M. (1986). "Profile of the West German health care system." *Journal of Medical Practice Management* 1(4): 282-9.**

*Abstract* The health care system of the Federal Republic of Germany is characterized by comprehensive statutory insurance coverage, regulated fees for physicians' and hospitals' services, and strict separation between hospital care and ambulatory care provided by office-based physicians. This separation results in excessively long hospital length-of-stay, complicated by a non-uniform financing system of setting hospital rates on the basis of retrospective costs. While equal access to care is guaranteed under the health insurance scheme, reform proposals advocate modifying the system in the direction of increased competition.

**von der Schulenburg, J. M. (1991). "The German health care system: a close-up view." *Internist* 32(5): 10-2.**

**von der Schulenburg, J. M. (1994). "The German health care system at the crossroads." *Health Economics* 3(5): 301-3.**

**von der Schulenburg, J. M. (1997). "Management of cost and utilization of pharmaceuticals in Germany." *Health Policy* 41(Suppl): S45-S53.**

*Abstract* The German health care system has had a series of reforms in its pharmaceutical sector, starting in 1988 with the introduction of a reference pricing scheme. A major new reform was introduced in 1993, which established a ceiling for all outpatient pharmaceutical expenditures along with substantial monetary sanctions for breaching that ceiling. A study of that reform, reported here, suggests that outpatient physicians may have responded to this ceiling by increasing their rate of patient referrals to hospitals. New health system reform measures should be constructed with an eye to their overall financial impact on the entire health system.

**Wagner, R., V. Manicavasagar, et al. (2002). "Challenges and early experiences in the development of an anxiety clinic in the public health sector." *General Hospital Psychiatry* 24(6): 406-11.**

*Abstract* This paper argues the importance of establishing specialist anxiety clinics within the public sector of the Australian health system. It describes the development of such a service and summarizes the characteristics of the first 1000 clients. Factors such as staffing, utilization trends, referral patterns, assessment and treatment procedures, and the clinical and demographic characteristics of the first 1000 cases are reviewed and discussed. The model of the clinic, which operates in partnership with community mental health and an academic research unit, has proven itself to be a suitable, cost-effective and efficient prototype in the treatment of anxiety disorders. Anxiety disorders exact a high social and economic cost. At a time of global funding cuts and savings in the mental health system, it is vital to think ethically as well as cost-efficiently, considerations that require that we offer the most efficient treatment to the greatest number of people.

**Wahner-Roedler, D. L., P. Knuth, et al. (1997). "The German health-care system." *Mayo Clinic Proceedings* 72(11): 1061-1068.**

**Walter, U. (2004). "Population-based and individual-centered prevention. Strategies and effectiveness. [German]." *Internist* 45(2): 148-156.**

*Abstract* In the German health system up to now prevention takes only a marginal position. To tap the full preventive potential in future population-based and riskgroup-strategies must be systematically extended, combined with individual strategies in clinical preventive medicine and integrated in health care. This report gives international and national examples for these strategies and shows that such preventive programmes could be effective as well cost-effective.

**Weber, A. and G. Lehnert (1999). "Social medicine - Why? A plea for the social dimension in human medicine. [German]." *Arbeitsmedizin Sozialmedizin Umweltmedizin* 34(11): 492-498.**

*Abstract* Taking social medicine to be the science of the interaction between disease/health and the whole social system/individual, the representatives of clinically oriented social medicine would like to see the subject given more emphasis in science and practice. The increasing importance of social medical issues for the German health system is made clear by the following four arguments: - Social welfare is not possible without competence in social medicine - Social change requires competence in social medicine - Competence in social medicine is becoming ever more important in medical care - Molecular medicine produces a growing need for social medicine in its totality. In the concluding acknowledgement it is emphasised that social medicine contains more than purely health economics and aspects of public medicine. It must embrace the changes in social structures and individual living conditions, and also fulfil ethical-social duties to be able to do justice to the complexity of the social dimension in medicine and the challenges of the future.

**Weil, T. P. (1992). "The German health care system: a model for hospital reform in the United States?" *Hospital & Health Services Administration* 37(4): 533-547.**

**Weil, T. P. (1995). "State health services commissions German style." *Hospital Topics* 73(4): 29-35.**

*Abstract* After the health networks tied to HMOs are organized into oligopolies, and eventually fail to provide adequate access, social equity, and cost containment, public pressures will demand that state health services commissions be established to regulate market share, the scope of health services, reimbursement rates, and allowable profits. The German health system is multipayer, multitier, decentralized, self-governing, and allows providers and insurers to negotiate reimbursement rates without direct government involvement. Such a model would offer more competition among providers and less government regulation. [References: 49]

**Weil, T. P. (1999). "German health care system: an option uber alles?[comment]." *Managed Care Quarterly* 7(1): 59-60.**

**Wiesmann, F., D. Heinrich, et al. (2003). "Documentation in the cardiac catheterization laboratory using electronic databases - Experiences in 176 German cath labs. [German]." *Zeitschrift fur Kardiologie* 92(7): 571-580.**

*Abstract* Due to the introduction of a variety of new features to the German health system, such as a new reimbursement system for inpatient work based on diagnosis-related groups, an obligation to detailed documentation for total quality management, as well as due to the continuing increase in the amount of imaging and other data within invasive cardiology, the use of electronic databases for documentation in the cardiac cath lab is of significant importance. The user-friendliness and robustness of the software system for daily clinical practice is

crucial for the acceptance of electronic documentation systems by physicians, nurses and technicians. This survey was aimed to explore the current practice and experiences of German cardiac catheterization labs with electronic databases particularly designed for documentation in invasive cardiology, including report generation of cath studies, risk and complication management and logistics for medical material ordering for the cath lab. Of the 176 hospitals and practices having agreed in taking part in this surveillance 165, are currently using an electronic database for administration of medical data and study reports. In 64% of the cath labs, a sub-specialized software system for detailed documentation of the course and the results of an invasive procedure, the human and material resources used, generation of the cath report, and documentation of procedural and post-procedural complications for total quality management is used. The acceptance and satisfaction with the software solutions currently available reveals to be rather inhomogeneous. While user-friendliness and flexibility of a number of software products were positively mentioned, main issues, such as missing hardware or software interfaces with the hospital information system for patient administration, missing stability of several systems, image management too complex and report configuration too inconvenient for daily clinical practice, were criticized. In general, in the light of continuing increase of the amount of clinical and imaging data as well as due to the legal obligation of detailed procedural documentation in all areas of invasive cardiology, a documentation system based on electronic databases bears the potential of an enormous economization of the daily workload of a cardiac cath lab. Prerequisites for the acceptance of such a system in clinical practice is not only the stability and reliability of the system but also the ability to link such a sub-system to existing databases via suitable interfaces and the flexibility of the system for modification of its features to meet the individual requirements of each user.

**Zorn, U. and G. Ollenschlager (1999). "[Quality assessment of medical care-a standardized scheme for the development of quality indicators]." *Zeitschrift fur Arztliche Fortbildung und Qualitätssicherung* 93(2): 123-8.**

*Abstract* A reliable and valid assessment of the quality of medical interventions is an indispensable prerequisite for any initiatives targeting at quality improvement in the health system. Quality indicators are well suited tools for such tasks, e.g. in the setting of a continuous monitoring. In the German health system, previous experiences concerning the use of quality indicators are limited. Available knowledge from medical services of other nations is mainly focused on the hospital sector. Therefore, it appears to be desirable to be able to provide a highly universal and standardized way for the definition of indicators of quality, enabling measurements of performance in any kind of health sector or disease treatment. Based on the demand for continuous quality monitoring in the sector of outpatient care recognized by the Central Institute of Panel Physicians, an indicator development scheme is demonstrated.