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Report to the Chairman, Committee on Governmental Affairs, U.S. Senate

July 1993

1993 GERMAN HEALTH REFORMS

New Cost Control Initiatives

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United States
General Accounting Office
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Human Resources Division

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July 7, 1993

The Honorable John Glenn
Chairman, Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

Germany's health care system provides nearly universal coverage for a comprehensive range of health services and has a better record than the United States in constraining the growth of health care costs. Since 1980 Germany has kept health spending below 8.9 percent of gross domestic product (GDP) while U.S. spending escalated from 9.3 to 13.5 percent of GDP.

Initiated in 1993 as a 3-year emergency measure, the German government began imposing mandatory global budget limits on spending in the physician, hospital, dental services, and prescription drug sectors of its health care system. The imposition of these caps by the German government represents a marked departure from its previous approaches in two ways. Previously, global budget targets for physicians and hospitals were negotiated among nonprofit associations of health care providers and the sickness funds that administer health insurance for most Germans. For the next 3 years, the budgets covering hospitals and physicians are set in law. In addition, the German reforms establish global budgets for pharmaceuticals and dental services for the first time.

While the government-imposed global budgets are in effect, the new law directs the provider associations and sickness funds to develop several structural health care reforms designed to further reduce some of the rigidities and cost pressures in the health care system. Some important structural reforms include

- constraining the supply of physician specialists and use of expensive technologies in the ambulatory sector;
- promoting cost-effective services, such as preventive care and outpatient treatments;
- changing the way hospital operating costs are financed and medical care is coordinated; and
- enhancing competition among the sickness funds for members.

To assist in forthcoming deliberations on changes in our health care system, you asked us to examine the recent German health care reform initiatives and report on the

- reasons for the German reforms,
- nature of the reforms,
- initial reaction and expected effects of the reforms, and
- potential implications for U.S. reforms.

Background

Most Germans obtain their health insurance through membership in 1 of 1,241 Statutory Health Insurance Funds, the so-called sickness funds.[1] In 1993 virtually all Germans with salary or wage income below Deutsche Mark (DM) 64,800 (about $41,000) must join one of these sickness funds.[2] Workers above the income threshold can voluntarily join a sickness fund and many do so.[3] The sickness funds also provide coverage for most retirees, the unemployed, and the disabled. Table 1 provides information on the types of German statutory sickness funds and their membership.

[1]The number of funds varies from year to year.

[2]The May 21, 1993, exchange rate of DM 1.58 per U.S. dollar was used for all conversions in this report.

[3]Only about 10 percent of the German population are not members of one of these sickness funds—about half of this group have incomes above the statutory ceiling and choose to purchase private insurance. Most of the rest are civil servants and public employees who participate in a special plan that covers 50 to 80 percent of their health care costs, which is often augmented to 100 percent coverage by supplemental plans provided by private insurers.

Table 1: German Statutory Sickness Funds and Their Membership, United Germany, January 1993

Type of fund	Membership	Percent and number (thousands)
Industrial funds (Betriebskrankenkassen—BKK)	743 funds created by individual companies (with at least 450 employees) to cover employees	11.47% 8,257
Guild funds (Innungskrankenkassen—IKK)	176 funds cover persons practicing certain crafts or skilled trades	5.18% 3,731
Local funds (Allgemeine Ortskrankenkassen—AOK)	270 geographically based funds cover wage earners not covered by other funds and unemployed and disabled workers	43.55% 31,345
Other funds[a]	26 funds cover farmers, maritime workers, and miners	4.41% 3,170
Substitute funds (Ersatzkassen— EK)[b]	26 funds cover salaried workers and some special wage earners who voluntarily join	35.39% 25,467
Total	**1,241 sickness funds exist in united Germany**	**100%** **71,970**

Note: Information provided by the Federal Ministry of Health, Bonn, Germany. Numbers include family members not belonging to other funds because of employment or retirement.

[a]In former West Germany, there are 19 agriculture funds (Landwirtschaftliche krankenkassen—LKK) covering farmers and one national fund each for maritime workers (Seekrankenkassen—See-KK) and miners (Bundesknappschaft—BKnsch).

[b]The substitute funds for salaried workers (Verband der Angestellten Krankenkassen) have almost all the members compared to the substitute funds for wage earners (Arbeiter Ersatzkassen Verband).

German law requires the sickness funds to provide a comprehensive benefits package that covers most health care costs with little or no copayment by members. Covered benefits include ambulatory and hospital care; maternity, dental, physical therapy, and preventive care; drugs; family planning; rehabilitation; eyeglasses; medical appliances; home health care; and fitness tests and work therapy, including spa visits as part of work therapy. The health insurance benefits also include cash allowances for maternity leave, paid leave for care of a sick child, sick leave, and burial allowances. Presently, the sickness funds do not cover long-term nursing home care, but some allowances for home care are made.[4]

Government-mandated contributions shared equally by workers and their employers primarily finance the nonprofit sickness funds. The required

[4]The Ministry of Labor and Social Affairs has pending legislation to address the provision and financing of long-term care. It proposes that the sickness funds collect and disperse funds for this care.

premium contribution operates much like a payroll tax where a fixed percentage of the employee's gross compensation is deducted from each paycheck and transferred directly to a nonprofit sickness fund. The 1993 contribution rate averages about 13.4 percent of wages up to the statutory gross income ceiling of about $41,000 per year, with the employer and employee each paying half of this premium. The contribution rates for individual sickness funds range from 8.5 to 16.5 percent. Under this system, premiums reflect workers' income, and all workers in the same fund pay at the same contribution rate regardless of health status, age, or family size.

German citizens are free to choose their own physician for ambulatory or office-based care. Nonemergency hospital care requires referral by an office-based physician. These physicians are generally not allowed to provide treatments to their patients in the hospital setting. Inpatient care is provided by hospital-employed physicians who conversely may not typically treat patients outside the hospital.

The sickness funds reimburse physicians on a fee-for-service basis and hospitals on a per diem basis. National-level associations representing regional associations of office-based physicians and sickness funds negotiate relative point values for all services. The actual monetary value of each point is negotiated annually at the regional level and thus varies by region. Before the 1993 reforms, daily rates for each hospital, based primarily on previous service utilization, were negotiated annually by each hospital and those sickness funds insuring at least 5 percent of the hospital's patients.

Sickness funds' expenditures on hospital and physician services have been subject to budget controls designed to limit spending. Our earlier work indicated that price controls coupled with stringently enforced expenditure caps helped moderate physician spending in Germany during the 1980s. Hospital spending targets, however, that lacked a strong enforcement mechanism were not as effective in controlling hospital spending growth.[5] A more detailed overview of the German system appears in appendix I.

Results in Brief

Sharp increases in the mandated health insurance premium paid by most workers and retirees through payroll deductions from their pay or monthly

[5]Health Care Spending Control: The Experience of France, Germany, and Japan (GAO/HRD-92-9, Nov. 15, 1991).

pensions triggered the 1993 German health care reforms. Between 1991 and 1992, the average rate for this highly visible premium contribution increased by nearly 1 percentage point. Moreover, many Germans are concerned about the growing disparity in the contribution rates among the various funds given the same statutory health benefits package. Germany found it necessary to introduce tougher cost controls as an emergency measure because the upward trend in the mandated health insurance payments was politically unacceptable when the country faced other economic stresses. These stresses resulted in part from a deepening recession and the high cost of German reunification.

The government-imposed emergency global budget controls will remain in effect for the next 3 years to give the health care industry time to change the structure of the health care sector. These changes are expected to sufficiently reduce cost pressure so that federally imposed budget limits become unnecessary. While the German reforms embody many of the key elements under consideration in the current U.S. reform debate, the Germans do not have the additional challenge of extending coverage to a substantial uninsured population. Germany retains its comprehensive benefits structure covering nearly all citizens and consumer choice of provider while restraining health care expenditures and introducing greater competition among the sickness funds for members.

The government has modified existing global budgeting procedures for the hospital sector by mandating that future budget increases be more closely linked than before to the growth rate of the wage and salary base used to calculate contribution rates. The budget mandated on office-based physicians follows a pattern similar to that produced voluntarily through past negotiations. The reforms also extended global budgets with fixed caps to the pharmaceutical and dental care sectors. The global budget for the pharmaceutical sector caps spending for 1993 at the 1991 level while requiring that many drug prices be lowered by 5 percent for 2 years to compensate for the cost of drugs introduced between 1991 and 1993. In 1994 and thereafter, sickness funds and physician associations will negotiate regional pharmaceutical budgets. Prescribing physicians and the drug industry will be required to bear the costs of any spending that exceeds the negotiated budget caps.

These temporary government-imposed caps are accompanied by several structural health care reforms to further reduce excess utilization as well as rigidities in the current system. Reforms in the physician sector include establishing procedures to identify and impose financial sanctions on

physicians who exceed standards for drug prescribing. The law also establishes procedures to align the supply of physicians and dentists with fixed physician-to-population ratios for each geographic area.

For each hospital, reimbursement within the non-negotiable budget cap will primarily be based on the costs of specific procedures and conditions (akin to the diagnosis-related group (DRG) system used in the U.S. Medicare program) that will replace the daily rate system by 1995. Previous budget targets that tied reimbursement to daily rates encouraged excessive lengths of hospital stay. To reduce incentives for reliance on hospital care, reforms will allow hospital-based physicians to perform some outpatient treatments.

The new reforms also have initiatives to improve equity and stimulate competition in Germany's multiple third-party payer system. Germans currently have free choice of office-based physicians, but, until recently, about half were required to join specific sickness funds. While these funds provide essentially the same statutory comprehensive benefits package, variations in the mandated contribution rates among the sickness funds had raised equity concerns. To reduce disparities in the sickness fund contribution rates, Germany intends to introduce a risk-based fiscal equalization scheme designed to shift resources to sickness funds with a disproportionate share of members with potentially high health care costs.

The reforms are expected to generate net savings of about $6.3 billion or about 6 percent of total sickness fund spending in 1992. The non-negotiable budget caps for the hospital, physician, prescription drug, and dental care sectors were effective immediately. The structural reforms affecting physician supply, unnecessary care and rigidities in the hospital sector, consumer choice of sickness funds, and fiscal equalization are to be phased in over the next few years. The government expects these structural reforms to reduce the need to continue its mandated spending cap after 1995.

Scope and Methodology

We interviewed public officials and key health industry officials in Germany and reviewed available literature on the characteristics of the reform plan, factors leading to the reforms, and potential effects of the reforms. This review also builds on previous GAO studies of the German

health care system and information obtained from our current work on five other international comparative studies for the Congress.[6]

While the former West German health care system now covers the entire country, this report focuses on conditions that existed and changes occurring in former West Germany, which provide a better basis for comparison with the United States. More detailed information on the structure of the German system and the nature and causes of the reforms appears in appendixes I and II. We conducted this review between February and May 1993 in accordance with generally accepted government auditing standards. U.S. experts on German health care as well as health care officials in Germany reviewed the draft report for accuracy. We relied on interviews of German officials and translations of documents supplied by German government and health care officials. We did not independently review the German text of the legislation.

Earlier Cost Containment Efforts Established Framework for 1993 Reforms

The German health care system has evolved to meet changing demographic and economic circumstances as well as shifts in political power. Because the system was created to provide affordable access to care and quality has generally not been questioned, recent reforms have aimed at containing costs. Rising health care expenditures, while capturing a much smaller share of GDP than in the United States, have still required increases in the mandated contributions to the sickness funds for most Germans. Before the comprehensive reforms of 1993, the German government imposed budgetary discipline on its health care system through a series of cost containment acts.

Since the mid-1970s, health care reform concentrated on stabilizing contribution rates by linking increases in expenditures in some health care sectors to revenue growth of the sickness funds, that is, basing increases on the gross wages and salaries of the members. In 1977 federal law established Concerted Action, a biannual assembly of major players in the health care system, to establish broad guidelines for the nation's health care system.[7] Concerted Action first established global budget targets for regional associations of physicians, though these targets were benchmarks or guidelines and not legally binding. In addition, reforms included a

[6]In addition to published reports, we are conducting international comparative studies of preventive health care for children, pharmaceutical spending controls, long-term care financing, primary care physicians, and patterns of health care for cancer patients.

[7]The Concerted Action committee includes representatives from the sickness funds, private insurers, major associations of providers (including physician, hospital, and pharmacist associations), major unions, associations of employers, the pharmaceutical industry, and state and local governments.

national relative value fee schedule as a prerequisite to meeting the budget targets. These early reforms lacked any regulations affecting cost containment in the hospital, although some cost-sharing occurred in the dental and pharmaceutical sectors. The targets set by Concerted Action in the 1980s have been credited with constraining negotiations between the sickness funds and the physician associations and hospitals.[8]

The limited success of these expenditure targets spurred new reforms in the 1980s to place expenditure caps on the budgets of the regional associations of physicians and budgets for each hospital. If spending trends indicated that the overall expenditure cap would be exceeded during the final quarters of the year, reductions in the amount paid for each physician service would enforce expenditure caps.[9] Budgets were also negotiated between each hospital and the sickness funds based, in part, on prior utilization rates with a small reduction in the reimbursement level for excess hospital days. In addition to expenditure caps, these reforms encouraged more economical practices by physicians and hospitals, shifted some costs to patients by introducing copayments, and instituted quality assurance measures.[10] Our earlier work on German reforms indicated that the tougher budget controls on physician spending helped reduce real spending by as much as 17 percent between 1977 and 1987. Hospital budget controls, however, failed to contain spending because capital costs were excluded and a formal mechanism to ensure compliance was lacking.

Impetus for 1993 Reforms

In the early 1990s, mounting public pressure to stabilize health insurance contribution rates challenged the positions of health care interest groups. The contribution rate is not only clearly visible to workers and retirees but also directly affects their disposable income. Increasing contribution rates coupled with new taxes to support reunification reduced net incomes for most Germans.[11] Germany's large and growing elderly population faced

[8]Uwe E. Reinhardt, "West Germany's Health-Care and Health-Insurance System: Combining Universal Access with Cost Control," Report prepared for the U. S. Commission on Comprehensive Health Care (June 25, 1990), p. 9.

[9]In 1992 expenditure targets were again placed on regional associations of physicians, allowing increases in service volume where justified, and using a prospective rather than retrospective method of valuing services during the year.

[10]These reforms first introduced patient copayments for hospital stays. While the copayments are minimal (usually a few dollars) compared to typical U.S. levels, they were a significant step for Germany given the way most health care is financed.

[11]A so-called "solidarity pact" was recently accepted among the major political parties in Germany to increase income taxes by 7.5 percent in 1995 to help support development in former East Germany.

declines in the real value of their pensions, which are directly linked to the net incomes of those employed. An increase in the average contribution rate for all sickness funds between 1991 and 1992 (from 12.2 percent of gross income to 13.1 percent) and large variations in contribution rates among funds prompted the 1993 comprehensive reform effort.

Although earlier budgets on the office-based physicians and hospital sectors mitigated some health care expenditure increases, their effectiveness was somewhat diminished. This was because the budgets failed to fully address incentives in the system to increase utilization. For example, reductions in physician fees may encourage some physicians to provide more services to maintain income, and the daily rate system for hospitals may encourage longer lengths of stay.

Apparently, by 1992, German health officials concluded that the political risk of federal intervention to stabilize contribution rates by strengthening global budgets and reducing utilization and to enhance equity by redistributing revenues among the sickness funds was perceived as less than the risk of doing nothing.

Mandated Global Budgets Aim to Contain Rising Health Care Costs

The German Health Care Structure Reform Act of 1993 has increased federal intervention in managing the health care system. Existing global budgets for office-based physicians and hospitals are being strengthened and more closely linked than before to revenue growth of the sickness funds. The new reforms have also extended global budgets to the pharmaceutical and dental care sectors.

The government expects these non-negotiable budgets on major health care sectors over the next 3 years to stabilize contribution rates. To stay within these budgets, charges for most physician and dentist services, prescription drugs, and hospital fees will decrease; contribution rates to the sickness funds will not increase. The new reforms aim to produce a net savings to the Statutory Health Care System of more than DM 10 billion (about $6.3 billion) the first year. This savings represents about 6 percent of the total 1992 sickness fund expenditures. While controlling more tightly most areas of health spending, the 1993 reforms do permit increases in spending for preventive care and surgery in an ambulatory setting, which are expected to reduce demands for more expensive treatments.

The law also provides for developing several structural health system reforms, phased in through the next few years, that are designed to reduce pressures for cost growth and eliminate the need for federally imposed caps. The self-governing associations of health care providers and payers will implement these reforms and have considerable freedom in deciding how to accomplish them. In addition to stabilizing contribution rates through cost containment measures, the law also aims to reduce some inequities in the Statutory Health Insurance System during the next few years. The following sections discuss these structural reforms.

Reforms in Physicians Sector Aim to Reduce Excess Services and Physician Supply

Under the 1993 reforms, total spending by sickness funds for office-based physician services will not be permitted to grow faster than sickness fund revenues. While the emergency budget cap is in place, the Federal Ministry of Health will implement several controversial structural reforms to reduce incentives for excess utilization of physician services and to constrain the supply of some physician specialties.

The government and health care industry agree that the oversupply of physicians in Germany is causing an increase in services rendered and thus costs. The Federal Ministry of Health acknowledges that previous reforms may have created an incentive for physicians to increase the volume of services rendered. Some physicians have exceeded their normal range of services to maintain or increase income when the fees paid for services were reduced during the year to meet the expenditure caps or targets. In addition, incentives existed for physicians to provide technical services, such as laboratory tests and diagnostic procedures, because they received additional reimbursements from the sickness funds for these services.

The 1993 reforms aim to reduce excess service volume and overuse of technical services by physicians authorized to treat sickness fund members. To enforce the law, representatives from the regional associations of physicians and sickness funds plan to continue their oversight of billing activities but impose stricter financial sanctions on those physicians who exceed average service volumes and prescribing levels.[12] Physicians who exceed their expected billing and prescribing volumes by more than 15 percent will be reviewed. Those exceeding the average by 25 percent will receive financial penalties unless they can

[12]Average service volumes depend on the physician's specialty, type of patients, and location.

justify the increases.[13] The reforms also encourage suspending remuneration for services provided with high-cost medical equipment used without prior authorization.

The new law also requires that strict population-to-physician ratios be established to deal with the oversupply of physicians, especially the growth of some specialties in certain regions. While the federal-level association for physicians has had the authority to close a geographic area with an excess supply of physicians, it has not exercised this option. Instead, the association has focused more attention on providing information to physicians on where to establish a new practice. The federal associations of physicians and sickness funds have until 1999 to develop and implement a system for allocating physician specialties based on population needs and the availability of medical care.

Reforms in Hospital Sector Aim to Reduce Unnecessary Care

The 1993 reforms attempt to mitigate shortcomings in the budgeting and planning of the hospital sector by reducing incentives for excess utilization and previous disincentives to efficiency. The new law requires that the hospital sector move from its per diem or daily rate system of financing operating costs, which encouraged longer hospital stays and higher costs, to a prospective budgeting system that establishes specific rates for individual procedures and conditions. While the new system is being developed, the law requires each hospital to stay within global budgets negotiated with the sickness funds, with any budget increase directly linked to revenue growth in the sickness funds and new wage settlements.

The Federal Ministry of Health has developed a list of 160 clinical procedures and 40 conditions that will eventually be paid through a relative value case reimbursement system similar to the DRG system used in the U.S. Medicare program. The regional associations of sickness funds and each regional hospital association will negotiate annually the monetary value of each relative value point. By 1995 hospital operating costs will primarily be set on the basis of the expected volume of procedures and conditions that will be treated during the year. The government anticipates that this system will provide a better basis for prospective budgeting and encourage hospitals to reduce their average lengths of stay.

[13]Before the 1993 reforms, physician practices were audited by a joint commission of physician and sickness fund representatives if their billing exceeded 30 percent of their comparable physician specialty group. According to an official of the Federal Physicians Association, about 10 percent of the physicians were audited annually, and about 2 percent could not justify their billings.

To reduce duplicative and unnecessary patient care between the office-based physicians sector and the hospital, hospital physicians will be allowed to perform some outpatient treatments. Before the 1993 reforms, health observers contended that the sharp division between hospital and office-based physician treatments produced higher health care costs for the sickness funds because they often paid for duplicative tests and excessively long hospital stays. To reduce this unnecessary care, hospital-based physicians will now be allowed to counsel and provide 3 treatment days within 5 days of admission and 7 treatment days within 14 days of discharge.

Reforms Extend Global Budgets to Cover Drugs and Dental Services

Germany now sets mandatory global budgets for both the pharmaceutical and dental care sectors. In the absence of budget controls in the past, costs have escalated in both sectors. In fact, in 1988, Germany spent more per person for prescription drugs than did the United States, where total health care costs per person have been nearly twice the German level. Germans also pay more per person for dental services than other comparable countries.

The new law imposes a 1993 global budget for pharmaceuticals fixed at the expenditure level for drugs prescribed by sickness fund physicians in 1991. To compensate for the cost of drugs introduced since 1991, the law mandates a 5-percent reduction for prescription drug prices not previously lowered by reimbursement policies and a 2-percent price reduction in over-the-counter drugs. These mandated price reductions will be in effect for the next 2 years.

The global budget will be enforced by holding the Federal Association of Physicians and the pharmaceutical industry responsible for spending above this global budget. Physician fees for 1994 will be lowered to offset the first DM 280 million in potential overruns. The pharmaceutical industry will have to cover additional overruns up to a further DM 280 million through lowered drug prices. The sickness funds will be responsible for overruns greater than DM 560 million. Representatives of the physicians and sickness funds are currently developing average prescription cost standards for physicians that will take into account their specialty, patient mix, use of technology, and regional location. Physicians who exceed these standards by specified percentages may be penalized. In 1994 and subsequently, the physician associations and sickness funds will negotiate regional prescription drug budgets based on the prescription cost standards. These measures are expected to produce realistic and acceptable pharmaceutical expenditures in place of a federally mandated

prescription drug budget in 1994. In addition, patient copayments for drugs will increase in 1994 and be directly linked to the quantity of drugs prescribed.

Lack of global budgeting of the dental care sector and dental fees among the highest in the European Community prompted setting mandatory budgets on this sector that are again linked to revenue growth of the sickness funds. In addition, the 1993 reforms impose a 10-percent reduction in reimbursement for dentures and orthodontic treatments, a 5-percent reduction in reimbursement for dental technician services, and a requirement that dentists give a 2-year warranty on every filling. Further, the law will reduce the reimbursement for all dental services in excess of the average volume for a practice and for dental prostheses considered medically unnecessary (for example, certain bridges).

Reforms Aim to Reduce Disparities Among Sickness Funds and Allow Greater Choice

The 1993 reforms also aim to reduce disparities among sickness funds. Variations in required contribution rates range from 8.5 to 16.5 percent even though the members receive the same benefits. In addition, the Federal Ministry of Health plans to provide members with greater choice among sickness funds. The government expects these changes to narrow the range of contribution rates, while still allowing some differences to account for more efficient management.[14]

This rate equalization process will transfer resources among sickness funds based on four adjustment factors: the individual sickness fund's payroll tax base, number of insured dependents, and age and sex composition. The Federal Ministry of Health does not intend to consider additional factors for the equalization process.

Closing the gap in the contribution rates among sickness funds will particularly help statutory local sickness funds, which presently have contribution rates above the national average. Mandated memberships contributed to differences in contribution rates because some sickness funds ended up with members with higher actuarial risks. For example, many local sickness funds, because they must enroll all who are not otherwise insured, tend to have higher health risk members, including the elderly, blue-collar workers, and sick. Because it costs more to care for

[14]As of January 1, 1996, substitute and local funds must open membership to everyone. Certain sickness funds will be allowed to consolidate, and local funds that are no longer efficient may close. In addition, the minimum membership criteria for establishment of industrial and guild funds will be increased to 1,000 (up from 450).

these individuals and they tend to earn less, the contribution rates must be fairly high to cover all health care costs.

The 1993 reforms also give German workers greater flexibility in their choice of a sickness fund. By January 1, 1997, most Germans will be allowed annually to choose their sickness fund.[15] It is expected that freedom of choice will motivate sickness funds to provide a broader range of services, such as health promotion, and be more administratively efficient. Some of the sickness funds maintain that they will attract new members through improved services. Opinions vary, however, on how much competition will exist among funds given the comprehensive nature of the mandated benefits, limits on administrative allowances for individual funds, and reduced variation in contribution rates. While the Ministry of Health introduced these reforms primarily to increase equity and competition among the sickness funds, it hopes these reforms will also lead to greater efficiency and thus lowered costs.

Early Effects of 1993 Reforms

The effects of the 1993 health care reforms cannot be fully assessed at this early stage, but some early indicators suggest progress in curbing expenditure increases despite sometimes intense protests by the health care community. Based on advice from regional associations of physicians, physicians have sharply reduced prescribing brand-name drugs and less useful medications to avoid any penalty for exceeding the mandated pharmaceutical budget. In doing so, however, they have suggested that adequate medical care is no longer guaranteed for sickness fund members.

Most health care providers initially denounced the proposed legislation as an end to the traditional German health care system and the beginning of "socialized medicine." Physicians have also announced their intentions to ask for a federal constitutional court ruling on limiting the number of physicians and dentists authorized to treat sickness fund members. Representatives of the dentist associations threatened to terminate cooperation with the sickness funds and indicated that growing numbers of accredited providers might withdraw from the system. According to a Ministry of Health official, however, since enactment of the law, the health care industry has accepted most of the new requirements.

[15]Germans who want to switch funds will have to register their intent to switch during 1996. In 1993 approximately half of the working Germans have a choice of sickness fund. Under the new system, it is estimated that more than 80 percent of Germans enrolled in the Statutory Health Insurance System will be free to choose their insurer.

The pharmaceutical industry and pharmacists are also complaining about the 25-percent decline in sales during January and February of 1993.[16] The sickness funds, however, consider this reduction justifiable because it probably represents a reduction in the prescription of less efficacious drugs and a movement toward the greater use of less expensive generic drugs. The Federal Ministry of Health also contends that patients wasted about 20 percent of the reimbursed drugs because of previous problems with the way they were dispensed. The reform plans to standardize drug prescriptions into three sizes and to graduate the copayment levels to the quantity of drugs prescribed.

Despite the protests of some groups, the Federal Ministry of Health is already considering another round of structural reforms. The Ministry has instructed the expert council to the Concerted Action committee to submit preliminary suggestions by December 1993 on further restructuring of the health care system, with a final proposal due by the end of 1994. The Ministry contends that, while the 1993 cost-cutting measures appear successful, additional reforms must address demographic changes, trends in major diseases, and the introduction of new medical technologies.

Conclusions

Despite an enviable record in health care cost containment and universal coverage, the German government decided to impose emergency budget caps and start a series of structural reforms of its health care system. These reforms build on a series of system changes in the last two decades that helped to constrain cost growth better than did those in most other industrialized nations. Its universal coverage and well-organized administrative mechanism, which make it easier to monitor provider fees and service utilization, enhance Germany's ability to respond to changing health market conditions. But, the country still faces many cost pressures from an aging population, expanding demands for high-technology care, and consumer demands for high-quality care and choice.

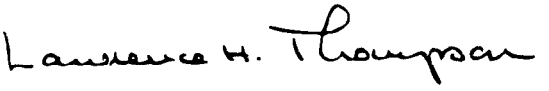
The United States should carefully monitor Germany's past experience and current reforms using global budgets, physician fee schedules, and constraints on resource growth as they unfold over the next 3 years. We may gain insights to their feasibility and success of implementation for our nation's health care reform process. Germany's experience in refining, changing, and adapting some of the same tools being considered in U.S. reform proposals underscores the dynamic nature of the health care

[16]While sales figures for March 1993 are closer to average levels for 1992, concerns still exist about shifts in prescribing habits of physicians.

market. One of the most important lessons from the German experience is that health care reform is a continuous process. As the United States moves toward comprehensive health care reform, it should incorporate enough flexibility in its system to ensure responsiveness to a constantly changing health market.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from the date of this letter. At that time, we will send copies to interested congressional committees and other parties on request. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues. If you or your staff have any questions about this report, please call her on (202) 512-7119. Other major contributors are listed in appendix III.

Sincerely yours,



Lawrence H. Thompson
Assistant Comptroller General

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Abbreviations

AOK	Allgemeine Ortskrankenkassen
BKK	Betriebskrankenkassen
BKnsch	Bundesknappschaft
DM	Deutsche Mark
DRG	diagnosis-related group
EBM	Einheitlichen Bewertungsmaβstab
EK	Ersatzkassen
GDP	gross domestic product
GKV	Gesetzliche Krankenversicherung
IKK	Innungskrankenkassen
KZV	Kassenzahnarztliche Vereinigungen
LKK	Landwirtschaftliche krankenkassen
RVO-kassen	State Insurance Funds
See-KK	Seekrankenkassen

Structure of the German Health Care System

As in many European countries, Germany's health care system is part of a larger set of social structures designed to ensure a minimum level of economic protection and social welfare for all residents. While the federal government provides the statutory framework for Germany's health care system, it delegates most aspects of management to self-governing, but regulated, associations of health care providers and payers. Germany's multiple third-party payer insurance system is primarily financed by equal contributions from employees and employers, with government providing contributions for the unemployed and matching contributions from retiree pensions. By law, this social insurance system provides comprehensive health care benefits to most residents, with little or no patient copayment. Germans freely choose physicians and dentists but must obtain a referral for specialized care in a hospital.

Employee and Employer Contributions Finance Multipayer Health Care System

Three types of health insurance, basically financed by employee and employer contributions, cover the needs of almost all residents in Germany: Statutory Health Insurance, private insurance, and insurance for government employees. Statutory Health Insurance (Gesetzliche Krankenversicherung or GKV), established in 1883 by Chancellor Otto von Bismarck, is the primary system of coverage. While the principle of social insurance supports universal access to health care and the sharing of costs, the government delegates the financial responsibilities of the state, except for hospitals, to associations of nonprofit health insurers or so-called sickness funds.

Most Germans Obtain Health Care Coverage Through the Sickness Funds

By law, virtually all Germans with incomes below a legally defined ceiling, except government employees, are compelled to join a sickness fund.[1] Salaried workers with incomes above the threshold can choose to join a sickness fund or purchase private insurance, but movement in and out of the system is restricted. Blue-collar workers must join a sickness fund even when wage income exceeds the threshold. As of January 1993, united Germany had 1,241 sickness funds, organized by region, occupation or employment relationship, serving about 90 percent of the population. In January 1993, about 58 percent of the population belonged to State

[1]The income ceiling is 75 percent of the income-dynamic ceiling used in the statutory pension insurance plan. In 1993, the income ceiling was DM 64,800 (about $41,000 at an exchange rate of DM 1.58 per U.S. dollar).

Insurance Regulation Funds (RVO-kassen), the so-called primary funds.[2] Most are wage earners who must join specific sickness funds. About 32 percent of the population—largely salaried employees—are free to join substitute funds.[3] The Statutory Health Insurance System, particularly the substitute funds, also includes members who could choose private insurance but opt to stay in the system because readmission is difficult.

The system gives sickness funds the legal responsibility to finance medical care as well as to organize health care services for their members. Independent administrative boards generally comprising employee and employer representatives govern the sickness funds, which are decentralized. They operate within very tight federal statutes, however, that dictate not only basic health benefits but also their governance as well as their fiscal and regulatory relationship with health care providers.[4]

In January 1993 the 270 local funds, organized at the municipal level, provided health insurance to about 39 percent of the population of united Germany. These local sickness funds also serve as a safety net for the unemployed and disabled.[5] The sickness fund contributions of the unemployed and the disabled comes from Social Security, which also pays half of retirees' contributions. The other half of retirees' contributions come from the wages and salaries of the employed members, with cross-subsidies among funds to equalize the burden of supporting these people.[6]

[2]In January 1993 there were six types of primary funds, that is, 743 industrial or company funds (Betriebskrankenkassen), 176 guild funds (Innungskrankenkassen), and 270 local funds (Allgemeine Ortskrankenkassen). The remaining 26 funds are for agricultural (Landwirtschaftliche krankenkassen), maritime (Seekrankenkasse), and mining (Bundesknappschaft) workers.

[3]In January 1993 united Germany had 26 substitute funds. In former West Germany, there were six national and one regional white-collar funds (Verband der Angestelten Krankenkassen), and five national and three regional funds for special blue-collar workers (Arbeiter Ersatzkassen Verband).

[4]Sickness funds must submit financial information to the Federal Ministry of Health in a specified format, including administrative costs, which averaged about 5 to 6 percent in 1990. While the Ministry has no specific authority over administrative costs, federal regulations require sickness funds to operate efficiently.

[5]As of June 1990, approximately 1.8 million unemployed persons and their dependents (7.4 percent of the labor force in former West Germany) continued to be insured by sickness funds that covered them while they were employed.

[6]Funds with a high proportion of retired members receive compensating contributions from a national reserve fund (Krankenversicherung der Rentner).

Private Insurance Available to Some Germans

Of the approximately 10 percent of the population not covered by the sickness funds, almost all obtain private insurance for either full coverage or to supplement their government health insurance coverage.[7] In 1989 more than half of this group chose private insurance because they were above the income threshold. Most of the remainder are civil servants and public employees who have a special form of comprehensive health insurance that covers 50 to 80 percent of their health care costs.[8] Private insurance companies pay health care providers at about twice the rate for services as do the primary funds. The physicians are also typically paid by patients, who are later reimbursed by their insurance company. As such, the privately insured may have better access than sickness fund members to their preferred health care provider and special hospital services, such as a private room.

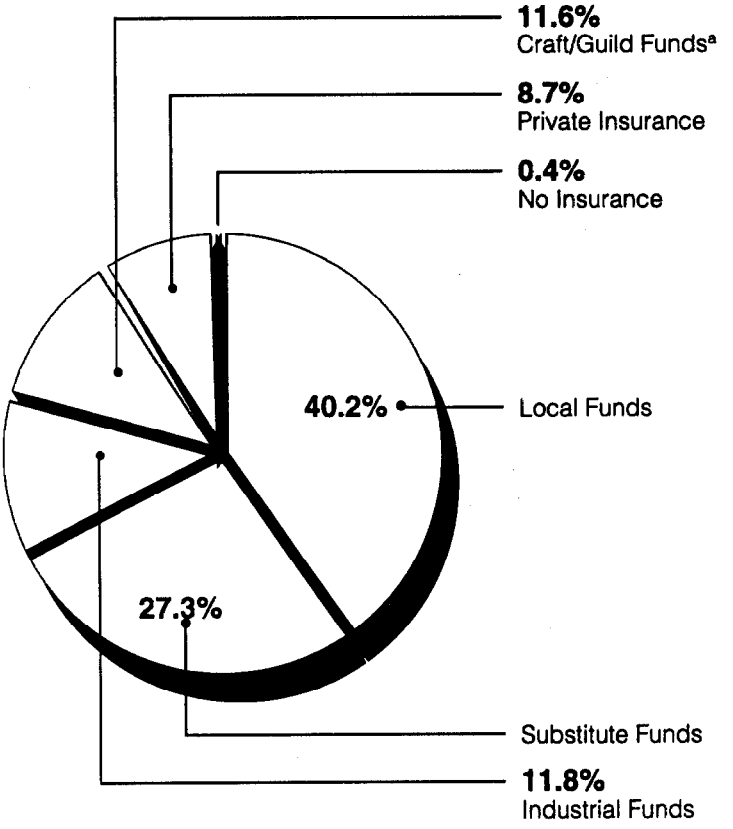
Other government programs cover a small percentage of the population (for example, through welfare offices or the armed forces) or they are uninsured. In addition, less than one-half of a percent of the population in 1992 was not covered by health insurance because they had the financial means to cover their health care costs.

Figure I.1 shows the sources of health insurance coverage by the percentage of the total population in former West Germany in 1990.

[7]As of April 1993, 55 private insurance companies provided full or partial health care coverage to self-employed persons, persons with incomes above the threshold, civil servants, some pensioners, and sickness fund members who chose to supplement their statutory health benefits.

[8]The government employer-financed health insurance can be augmented to 100 percent coverage by supplemental insurance packages provided by private insurers.

Figure I.1: Sources of Health Insurance Coverage by Percentage of Total Population in Former West Germany in 1990



[a]The category Craft/Guild funds also includes agricultural, maritime, and miners' funds.

Source: Franco, Celinda, The German Health Care System, Washington, D.C.: Congressional Research Service, June 25, 1992, p.4.

Employee and Employer Contributions Equally Finance Sickness Funds

Contributions of employees and employers to the sickness funds finance the majority of health care expenditures in Germany. A percent of an employee's gross income, ranging from about 8.5 to 16.5 percent among the sickness funds in February 1993, is deducted from each employee's paycheck and transferred directly to the member's sickness fund. The employee and employer each contribute 50 percent of the premium, and an income threshold limits payments.[9] These sickness fund premiums

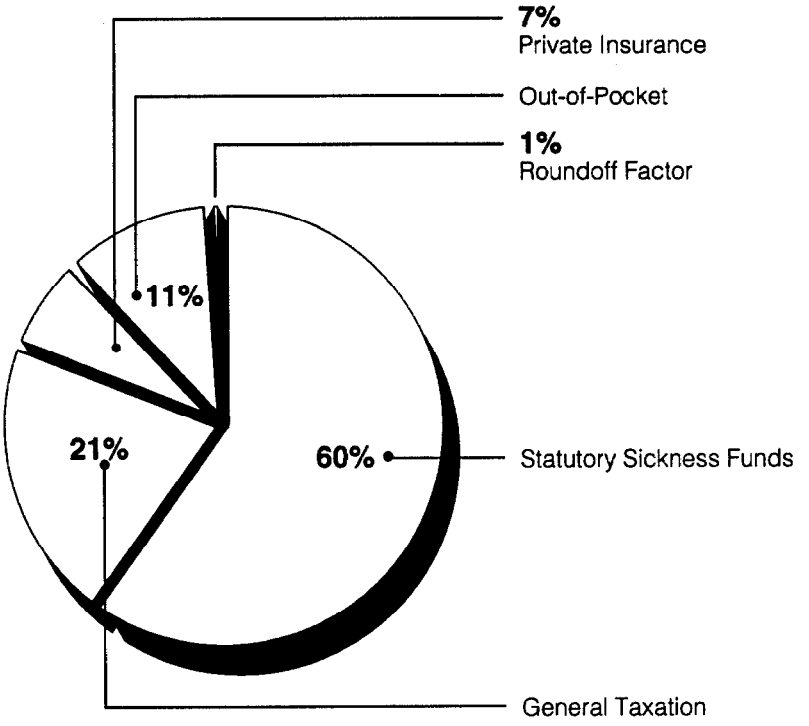
[9]In 1993 the maximum amount any employee or employer will pay per month to a sickness fund is about DM 362 (about $229), based on an average contribution rate of 13.4 percent and a statutory income threshold of DM 5,400 (about $3,418) per month.

reflect members' incomes as opposed to their actuarial risk, as is the case with private insurance. In addition, a member's premium (a function of the sickness fund's contribution rate and the member's income) covers the entire family, regardless of size. Finally, the law forbids any risk selection by the sickness funds.

In contrast, the premiums of the privately insured reflect actuarial risk and family size. Private insurance must provide at least the same benefits as the sickness funds, and the Federal Insurance Office regulates their premiums. Unlike the members of the sickness funds, the privately insured usually pay for physician services and then are reimbursed by their insurance company.

Figure I.2 describes the percent of funding of the health care system by source.

Figure I.2: Percent of Health Care System Funding by Source



Source: OECD, The Reform of Health Care: A Comparative Analysis of Seven OECD Countries, Paris, France: Organization for Economic Cooperation and Development, 1992, p. 59.

Comprehensive Health Care Benefits Required by Law

Germans have one of the most comprehensive health insurance benefits programs in the world. Health care services are virtually free at the point of service delivery, with little or no copayment. According to the health insurance law (Reichsversicherungsordnung), sickness fund benefits include ambulatory, dental, hospital, physiotherapeutic, maternity and preventive care; drugs; family planning; rehabilitation; eyeglasses; and medical appliances. All insured persons are by law covered for all medical services as long as they are necessary. Cash benefits from the sickness funds include payments for sick leave, subsidies for dentures and inpatient rehabilitation treatment; lump-sum payments for home confinement; maternity allowances; and burial allowances.

The statutory benefits include several benefits typically excluded from American health care plans and from health spending in this country. These include

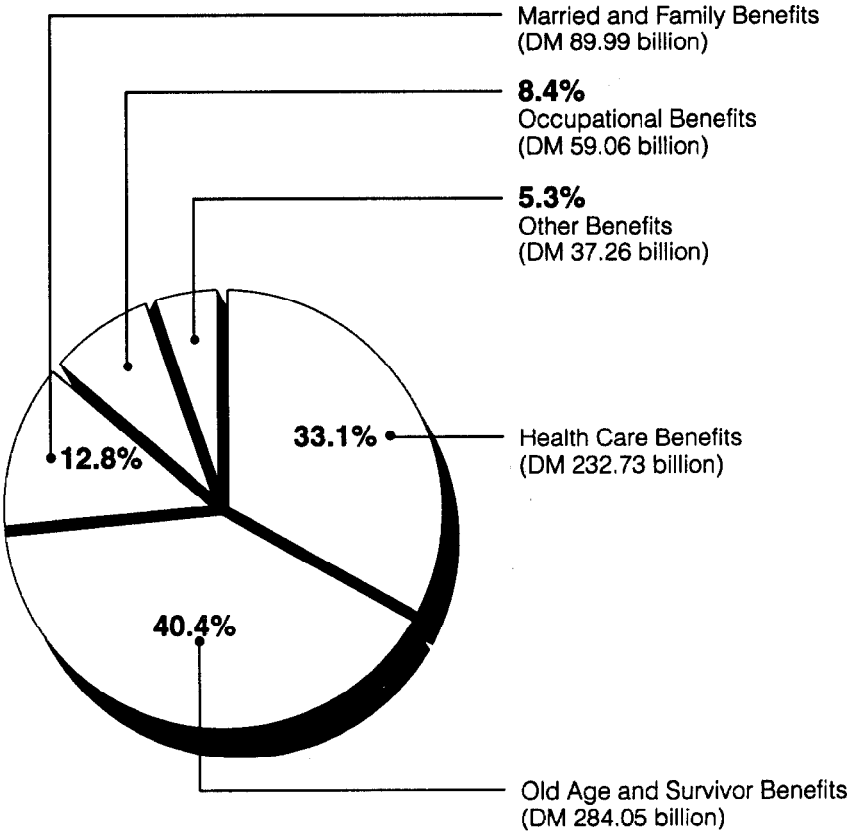
- a sickness benefit, after the employer has paid the employee's wages or salary for a 6-week period, amounting to 80 percent of the income lost for a maximum of 78 weeks within a period of 3 years;
- a sickness benefit for up to 10 days of paid leave per year for parental care of each sick child under the age of 12, with additional days provided to single parents and families with more than one child;
- a maternity benefit of DM 25 (about $16) per day for 6 weeks before the birth and 8 weeks after the birth from a sickness fund, with the employer paying the difference between the benefit and the employee's net wage or salary for this period;
- assistance in taking care of the home while the member is in the hospital or under treatment at a sanitorium as well as allowances for home nursing if a hospital stay is avoided; and
- fitness tests and work therapy, including spa visits as part of rehabilitative services.

Absent from this comprehensive health benefits package are any allowances for long-term nursing home care. Because of a shortage of nursing homes in Germany and their high cost, most long-term care still occurs in the home. For those Germans who enter nursing homes, the costs are covered through welfare assistance benefits after individuals have exhausted their own financial resources.[10] Physicians are presently authorized to place individuals into nursing homes; however, families often pressure them to put patients into hospitals so that the patient's sickness fund covers the costs. Germany's aging population and a decline in the ability of families to provide long-term care in their home have prompted pending legislation to address the provision and financing of long-term care services, as discussed in appendix II.

Figure I.3 shows the budget for social security benefits, including health care benefits, in 1990.

[10]In addition to social assistance through the welfare system, Germany has private long-term care insurance for those who can afford the premiums.

Figure I.3: Former West German Budget for Social Security Benefits in 1990



The total budget for social security in western Germany in 1990 was DM 703.1 billion ($445 billion).

Source: Federal Association of Statutory Health Insurance Physicians (Kassenaerzliche Bundesvereinigung), Grunddaten zur kassenaerztlichen Versorgung in der Bundesrepublik Deutschland, 1992, p. 1-2.

German Health Care System Provides Ready Access to Medical Care

For the most part, the German health care system affords ready access to medical and dental care.[11] Germans have free choice of office-based physicians or dentists (both general practitioners and specialists) for most health and preventive care. Health care observers contend that these office-based physicians are well equipped with medical apparatus and that virtually all diagnostic and many therapeutic procedures can be performed

[11]A shortage of specialized nurses and available services has impeded access to some expensive new medical treatments, such as bone marrow transplantation. Some states have delayed construction of new treatment centers, and sickness funds are sometimes slow to approve reimbursement for new services.

in an ambulatory setting. These observers also contend that Germans have access to well-equipped, university-based hospitals in major cities in former West Germany.[12] Unlike the ambulatory sector, however, access to a hospital typically requires a referral by an office-based physician, and sickness funds normally require that these referrals be to the closest suitable hospital.[13] In addition, office-based physicians generally do not treat patients in the hospital, and very few physicians employed by the hospital are allowed to see patients after they leave the hospital.[14] Dental care is also readily available, but patients must make a copayment that covers 40 to 60 percent of the dental services. Patients also pay a small copayment for pharmaceuticals, with the remainder covered by their sickness fund.

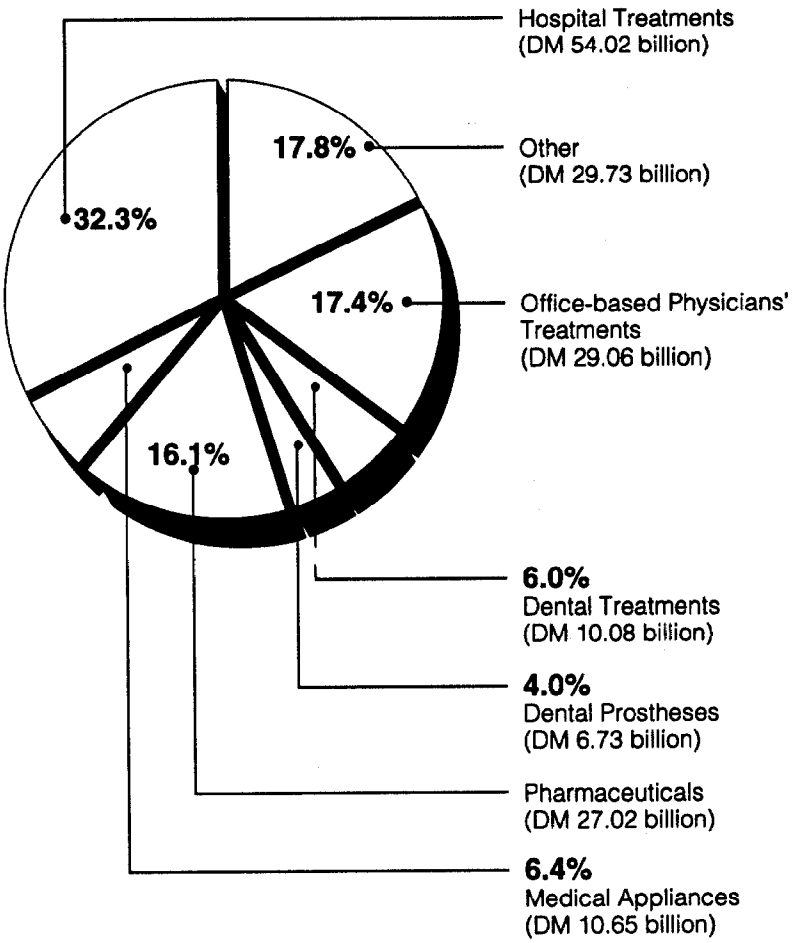
Figure I.4 shows the percent of Statutory Health Insurance System expenditures by health care sector in 1992.

[12]The Ministry of Health recognizes that the hospital infrastructure in former East Germany needs improvement. The federal government plans to invest DM 21 billion between 1995 and 2004 to update this sector.

[13]Sickness fund members can go directly to a hospital in an emergency situation, and about 15 percent of the hospital admissions of sickness fund members are for emergency treatments.

[14]The exceptions are heads of departments, who are allowed to have private practices.

Figure I.4: Percent of the Statutory Health Insurance System Expenditures in Former West Germany by Health Care Sector in 1992



(Figure notes on next page)

Total expenditures by the Statutory Health Insurance System for former West Germany were DM 167.293 billion (about $104.558 billion) in 1992.

Source: Association of Statutory Health Insurance Physicians (Kassenaerzliche Bundesvereinigung), Grunddaten zur kassenaerzlichen Versorgung in der Bundesrepublik Deutchland, 1992, p. G-12 (updated for 1992 data).

Most Office-Based Physicians Accept Standardized Fees to Treat Sickness Fund Members

Most office-based physicians in Germany accept regulation, including standardized fees, and oversight from the sickness funds and the regional Associations of Sickness Fund Physicians to treat sickness fund members. In Germany all physicians must be members of a State Chamber of Physicians to obtain a license to practice medicine (similar organizations exist for dentists and pharmacists).[15] All office-based physicians can accept privately insured patients, but physicians must be authorized to treat sickness fund members and join a regional Association of Sickness Fund Physicians (Kassenärztliche Vereinigung).[16] By law, these associations assume responsibility for providing medical care in each region to all sickness fund members. They also negotiate fees with the sickness funds, distribute remunerations to physicians for services, and monitor service utilization.

The total Statutory Health Insurance System budget for services provided by members of regional Associations of Sickness Fund Physicians is based on a standard allowance for each sickness fund member in the region.[17] A sickness fund physician's income derives from the number of services rendered annually and the level of reimbursement for each service. The Uniform Evaluation Standard (Einheitlicher Bewertungsmaβstab or EBM), defines a schedule of charges for medical services and their relative point value to one another.[18] The nationally determined Uniform Evaluation Standard is the basis for negotiations between regional Associations of

[15]In 1991 a total of 202,020 physicians practiced in former West Germany—77,547 office-based physicians (3,400 only treated privately insured patients), 99,884 hospital physicians, and 24,589 physicians active in other areas, such as public health. In addition, other nonphysician practitioners may perform specific services and provide certain treatment.

[16]In December 1991 a total of 83,000 sickness fund physicians practiced in former West Germany and 19,400 in former East Germany. In the former west, this number includes about 8,900 hospital-based physicians also authorized to treat sickness fund members.

[17]In 1991 expenditures per insured member in the Statutory Health Insurance System for ambulatory medical care amounted to about DM 700 (about $443) with an average per patient fee of about DM 80 (about $51) per quarter.

[18]The Uniform Evaluation Standard is a relative value scale similar to the Resource-Based Relative Value Scale that is used as a basis for the Medicare Fee Schedule for physician services. The processes for determining the relative values, however, are dissimilar for the two scales.

Sickness Fund Physicians and funds on overall expenditure targets for the physicians' budget and the conversion factor.[19] Conversion factors are determined for three categories of services and are adjusted during the year if expenditure targets are likely to be exceeded.[20]

Regional Associations of Sickness Fund Physicians use the resulting schedule of charges, which vary somewhat among the sickness funds, to reimburse member physicians on a fee-for-service basis.[21] Traditionally, the substitute funds have a somewhat higher conversion factor than that used by the primary funds. A review committee of seven representatives from both the Federal Physicians Association and the Federal Associations of Sickness Funds periodically updates the Uniform Evaluation Standard to include new services, remove outmoded services, and reevaluate the services' relative values.[22] Because of regional differences in the revenue bases of the sickness funds, the conversion factor also varies by region.

Patients provide physicians with payment vouchers from their sickness fund, valid for a calendar quarter, to pay for services. In 1988 Germans visited a physician, on average, 11.5 times per year versus an average 5.3 physician contacts per year in 1989 for Americans. According to an official from the Federal Association of Local Sickness Funds, additional vouchers are available on request during a given quarter. If a patient desires a second opinion, the physician with the original voucher must provide the referral. Patients may go directly to a specialist with their payment voucher, but a disincentive exists for doing so.[23] Finding a physician specialist is not a problem in Germany because about 60 percent of the office-based physicians are specialists, and, according to government and industry officials, Germany has an oversupply of physicians for the population.

[19]The conversion factor translates the points into a schedule of charges that are used as a standard reimbursement schedule for more than 1,850 physician services as of 1987. It is calculated by dividing the total sickness fund physicians' budget in each region by the total number of points for services expected to be rendered.

[20]If, for example, growth in sickness fund physicians' expenditures during the first two quarters would be greater than the growth in income per sickness fund member, then an adjustment is made in the third and fourth quarters for the category, such as laboratory tests or consultations, that had an excess expenditure.

[21]In 1991 the average net income for an internal medicine doctor in Germany was about DM 174,000 (about $110,000) after 55 percent of the gross income is taken out for practice costs and taxes.

[22]The committee must reach unanimous agreement on any modification; if not, it is broadened with five additional members and decisions are made by majority vote.

[23]Patients who use their quarterly voucher for a specialist will need to request an additional voucher to visit their primary care physician or any other specialist during a quarter. Alternatively, if the patient gives the voucher first to a primary care physician, the same voucher can be used for any subsequent referrals during the quarter.

Sickness Funds Primarily Finance Hospital Sector

Hospital cost control has been difficult for the sickness funds because authority for hospital planning and capital investment rests with the states. The mounting deficits in the hospital sector and the way hospitals were financed and planned led to the Hospital Financing Act of 1972, which separated capital investment expenditures from hospital operating costs. The government (federal, state, and local) took responsibility for covering investment and depreciation costs through general taxation, including the cost of new construction, remodeling, and purchasing high-cost medical equipment. The act also charged each state, in consultation with the hospital association and sickness funds, with preparing regional hospital plans. This was done to distribute equipment and specialized beds among the various types of hospitals (publicly owned—34 percent, not-for-profit—34 percent, private for-profit—32 percent in 1992).[24] The support for hospital capital investment varies among the German states. Although the sickness funds received responsibility for covering operating costs, they have little influence over hospital management, planning, and service utilization.

Sickness fund and private insurance reimbursements cover about 70 percent of the hospital budget. The sickness funds are obligated to meet hospitals' historic operating costs, but, at the same time, hospitals are obligated to provide necessary and economical services. Since 1986 payments to hospitals have been based on a prospective budget negotiated by each hospital and the sickness funds. According to a hospital official, only those funds with at least 5 percent of the hospital's patients were allowed to negotiate daily rates.[25] The state then approved all hospital budgets. Budgets were determined through a detailed review of operating costs (about 70,000 items), including physicians' salaries and expected occupancy, in conjunction with reviews of comparably efficient hospitals. In addition, recommendations of the hospital association and Concerted Action guidelines are also taken into account.[26]

[24]State or local governments run public hospitals, and churches or other charitable organizations run not-for-profit hospitals. In 1992 about half of all hospital beds were in publicly owned hospitals.

[25]The 1985 Hospital Financing Act and the 1986 Federal Hospital Payment Regulation Act implemented a prospective budget system for all operating costs, based on both inclusive costs and anticipated occupancy rates.

[26]Since 1973 the Federal Hospital Rate Regulation (Bundespflegesatzverordnung) has dictated the costing and pricing of hospital operating expenses. According to an official of the German Hospital Federation, detailed information on operating expenses is prepared on a standard form (Krankenhausrecht) and made available to the sickness funds 6 weeks before the negotiation sessions, which usually last no more than a day.

A daily rate fee for each patient-day derives from the negotiated prospective budget covering each of the roughly 3,500 hospitals in Germany.[27] This daily rate, plus a small patient copayment, is expected to cover all hospital services, with the exception of a few high-cost procedures that carry special fees.[28] Private insurance companies negotiate somewhat lower daily rate charges than the sickness funds because the treating physician for privately insured patients is usually the head of the department who may receive separate reimbursements for services. Each hospital typically has about 16 procedures that have special fees. Hospitals that perform a greater number of special procedures tend to have lower daily rate charges and thus are somewhat more competitive than smaller hospitals that must charge higher daily rates to cover costs.

Budgets for each hospital are enforced by lowering the daily rate fee to 25 percent of the negotiated rate for each patient-day exceeding the budgeted level and by providing only 75 percent of the rate for each day under the budgeted level. This is done because about 75 percent of the hospital's operating costs are considered to be fixed and independent of bed utilization.

Compared to U.S. hospitals, German hospitals have a higher ratio of beds-to-population, higher average length of stay, and higher occupancy rates. In 1991 former West Germany had about 11 hospital beds per 1,000 population versus about 5.1 in the United States in 1990. Germany also has a higher average length of hospital stay, 13.1 days for acute care hospitals in 1991, compared to 7.2 days for the United States in 1990. Further, German hospitals have a higher bed occupancy rate (86.5 percent in 1990) than average U.S. hospitals (69.7 percent).

Health care observers have attributed lengthy hospital stays and high occupancy rates to the needs of an aging population (about 15.3 percent of the German population was over age 65 in 1987 compared to 12.2 percent in the United States) coupled with the shortage and high cost of nursing home care; restrictions on out-patient care by hospital-based physicians; and, given the fixed daily rate charge, the need to cover the cost of intense care during the first days in a hospital with longer stays. An official from the German Hospital Federation contends, however, that counteracting the longer hospital stays in Germany are lower hospital staffing ratios

[27]For additional services (private room, television, extra food, treatment by a doctor of one's free choice, and so on), patients are charged directly.

[28]In 1991 sickness fund members had a copayment of DM 10 (about $6) per day for 14 days a year of full hospital care.

(1.31 per occupied bed compared to 3.21 for the U.S. in 1989) and lower average daily costs (about DM 321 or about $203 in 1990) compared to the United States ($687 in 1990).

Dental Services Sector Requires Higher Copayments

Dental services in Germany have emphasized prosthetic-technical dentistry over preventive measures and have required higher copayments than other medical care. The ratio of about 60 dentists per 100,000 population is about average for western Europe; however, the number of dental laboratories and dental technicians is higher.[29] According to one health observer, these ratios reflect the importance of prosthetic treatments and the relatively weak emphasis on preventive measures. While the patient copayment is now 40 to 60 percent of total dental services, incentives exist to obtain regular dental check-ups.[30]

Similar to sickness fund physicians, dentists must join regional Associations of Sickness Fund Dentists (Kassenzahnärztliche Vereinigungen or KZV), which authorize them to treat sickness fund members. These associations also negotiate fee structures and covered services with the sickness funds, but unlike the office-based physicians, their budgets are not tied to the revenue base of the sickness funds. In 1988 about 75 percent of dentists' income came from treating sickness fund members, and dentists have been the highest paid professional group in Germany.[31] The regional sickness fund dentists' budgets are calculated according to a relative value scale, and remunerations are distributed among the dentists of a region.

Sickness Fund Reimbursements for Pharmaceuticals Used to Reduce Drug Prices

Manufacturers are free to set pharmaceutical prices in Germany; however, the Reference Price System (Arzneimittelfestbeträge), instituted in 1989, affects the prices of many prescription drugs. The referenced price is the price at which the sickness funds set their reimbursement allowance for outpatient prescription drugs. Before this system, Germany was one of the leading industrialized countries in both per capita drug consumption and

[29]In 1993 about 25,000 of the 40,000 dentists in united Germany were authorized to treat sickness fund members.

[30]Sickness funds reduce patient cost sharing by 10 percent for check-ups at regular intervals and an additional 15 percent if patients make routine visits for a 10-year period.

[31]In 1986 gross annual income for dentists averaged about DM 238,680 ($151,063), compared to DM 192,480 ($121,823) for physicians and DM 87,830 ($55,589) for engineers.

high drug prices.[32] In 1988 the sickness funds paid 62 percent of the payments to pharmacies for nonhospital drugs, while private insurance paid 3 percent and beneficiaries paid 35 percent out of pocket.[33]

Germany has used a two-step process to establish reimbursement prices for prescription drugs. Representatives from the physicians and sickness funds have held hearings with scientists, manufacturers, and pharmacists to group drugs into three classes.[34] The sickness funds then proposed a reference price for each grouping of drugs, followed by hearings with manufacturers and pharmacists to finalize the prices.

Before the 1993 health care reforms, patients paid nothing for the drugs priced at or below the referenced price but had to pay for any costs above the reimbursement level. Patients also had to pay a nominal copayment of DM 3 for all drugs not included under the reference price system.

While the original goal was to classify most prescription drugs under the reference price system, by 1993, about half of the pharmaceutical market in Germany was priced at a referenced level.[35] Manufacturers have generally lowered the price of referenced priced drugs to the reimbursement level, in part, because companies that did not lower their prices quickly lost their previous share of the pharmaceutical market for their referenced priced drugs. In 1991 generic drugs accounted for 26.6 percent of the total prescription drug market for the Statutory Health Insurance System, and only half of the prescription drug sales were brand names when a generic equivalent existed.

According to sickness fund officials, in 1991, the reduction in drug prices, through the reference price system, lowered the anticipated rise in prescription drug costs to the sickness funds (due to increased consumption as well as changes in therapies and higher prices) by almost

[32]The German pharmaceutical market is lucrative to both foreign and domestic manufacturers. In 1990 the German pharmaceutical industry ranked third behind the United States and Japan in expenditures on research and development.

[33]The number of pharmacies in former West Germany increased from 11,526 in 1970 to 18,301 in 1988, including 520 in hospitals.

[34]Drugs are classed by similar active ingredients (Class 1); therapeutically comparable active ingredients (Class 2); or therapeutically comparable actions (Class 3). About 35 percent of the prescription drugs are Class 1—representing most of the drugs for which reference prices have been established.

[35]The exceptions to the referenced price system are specified drugs under the German Drug Act, for example, vaccines, pharmacy-made drugs, brand-name drugs whose patent had expired within the last 3 years, and patented prescription drugs with a new active ingredient representing a therapeutic improvement or having fewer side effects than existing drugs.

40 percent. In expenditures, these officials estimated that the anticipated DM 3.3 billion (13.5 percent) increase in the DM 24.4 billion (about $15.4 billion) expected expenditures for pharmceuticals in 1991 were reduced to only a DM 2 billion (8.2 percent) increase as a result of the reference price system. Despite lowered prices on some drugs, the Federal Ministry of Health contends that expenditures have risen because

- consumption increased due to the lowering of some drug prices that did not include a patient copayment,
- the price of drugs not covered by the reference price system increased, and
- larger than necessary prescription sizes were dispensed.

Further, the Ministry contends that too many physicians are prescribing drugs that have little useful clinical value.

Opinions about the effects of the reference price system on investment in pharmaceutical research and development vary. Some sickness fund officials contend that drug manufacturers have profited under the reference price system, partly through higher revenues from increased drug consumption, and that this profit could support more research and development.[36] Some pharmaceutical industry officials claim that the reference price system has adversely affected research and development, especially of drugs that provide incremental therapeutic improvements over existing drugs. These drugs are important revenue sources because they provide financial support for research and development of more innovative products.

[36]Sickness fund officials mention that three factors have shared responsibility for the increase in expenditures on pharmaceuticals—the number of drugs prescribed per prescription (49 percent), the increased number of prescriptions (37 percent), and the increased price of prescriptions (14 percent).

1993 Health Care Reforms: Tougher Cost Containment

The German health care system has evolved to meet changing economic circumstances. Because the system was created to afford access to care and quality has generally not been questioned, recent reforms have aimed at cost containment. While health care spending in Germany as a percent of GDP is well below that of the United States, rising medical costs have been a concern in recent years because of their effects on contribution rates to the Statutory Health Insurance System. Political concern over an erosion of average net incomes in Germany, due in part to rising contribution rates and higher taxes to cover the cost of German reunification, prompted significant health care reforms in 1993.

Earlier Attempts to Stabilize Contribution Rates Through Expenditure Targets

Earlier German reforms attempted to stabilize the sickness fund contribution rates through expenditure targets. Since the mid-1970s, health care reforms have aimed at creating a statutory framework for stabilizing the employer-employee contribution rates to the sickness funds. This has been a long-term objective of German health care policy. An increase in contribution rates between 1975 and 1976 of almost 1 percentage point prompted the introduction of global budget targets, formulated through the National Health Conference, the so-called Concerted Action committee, and linked to revenue growth in the sickness funds.[1] The Concerted Action committee was created in 1977 to help reach agreement on a uniform, nationwide operating framework for the health care system.[2] A national relative value fee schedule was also introduced as a prerequisite to establishing global budget targets for sickness fund physicians. The reforms, however, did not address regulations affecting cost containment in the hospital sector, although some cost sharing was introduced in the dental and pharmaceutical sectors.

A failure to meet expenditure targets and to stabilize contribution rates prompted additional and more rigid cost containment reforms in the 1980s.[3] Legislation in the mid-1980s imposed expenditure caps on the budgets of regional Associations of Sickness Fund Physicians and budgets on hospital expenditures. To more tightly control costs, the legislation

[1]The Health Care Cost Containment Act of 1977 introduced global budget targets. Expenditure targets were based on health care costs for the previous year, with adjustments for such factors as demographic and wage rate changes and the introduction of high-cost medical equipment.

[2]The committee consists of approximately 70 representatives of all the major health care interests and meets twice a year to work out national guidance for the operation of the system in place of government intervention. Although the agreements reached during these meetings are nonbinding, they significantly influence negotiations at the regional level.

[3]Average contribution rates to the sickness funds rose from 10.47 percent of pay in 1975 to 12.9 percent in 1988.

placed expenditure caps on various services, including basic services, laboratory services, and special services. Reducing the value of the conversion factor for a relative value point in the final quarters of the year was how the Associations of Sickness Fund Physicians and sickness funds stayed within the expenditure caps. In turn, any increases in these caps were tied to revenue growth in the funds. Some reforms in the late 1980s concentrated on improving quality assurance for both the ambulatory care and hospital sectors, enhancing preventive care, and improving coordination between the sectors.

Starting in 1990 several actions increased the predictability of physician incomes. First, the Federal Associations of Sickness Fund Physicians and the sickness funds agreed to a fixed reimbursement rate for about 20 percent of the services, including preventive care, that could not be lowered during the year because of volume increases. In 1992 the Federal Association of Sickness Fund Physicians successfully sought a new approach to negotiating conversion factors with the sickness funds based on a prospective rather than retrospective budgeting process. Under the retrospective budgeting process, physicians tended to increase the number of services provided to compensate for any decrease in their fees during the year. The new prospective budgeting process established expenditure targets linked to the anticipated volume of services during the year as well as to the recommendations of the Concerted Action committee on acceptable growth rates in physician incomes.

In a similar way, budgets for each hospital were established to control operating costs, and state hospital planning was instituted to regulate the distribution of services and high-cost medical equipment during the mid-1980s. Budgets were to be enforced by a reduction in the daily rate provided by the sickness funds if anticipated patient-bed days were not realized. Further, special fees for some high-cost procedures were introduced as well as increased monitoring, including the statistical tracking of patient care. Subsequent reforms shifted greater costs to patients, improved coordination of inpatient and outpatient care, and increased emphasis on quality assurance. For example, the sickness funds were given authority, with the approval of the state planning agency, to terminate service contracts with hospitals that were not efficiently managed.[4]

[4]Regional lists of hospital prices and services were also compiled and distributed to office-based physicians to encourage more cost-effective referrals.

While these earlier reforms slowed the escalation in expenditures in some health care sectors, overall spending increases raised contribution rates in the 1990s and deficit spending by the sickness funds.[5] Between 1991 and 1992, average contribution rates rose almost 1 percentage point, and the sickness funds faced a deficit of about DM 10 billion (about $6.3 billion).[6]

Public Pressure a Continuing Force Behind Health Care Reforms

Public pressure to stabilize contribution rates as well as an awareness that structural change was needed to reduce excess utilization and rigidities in the system forced the series of reforms. Health care observers in Germany have pointed out several conditions that prompted these reforms:

- The public is aware of the cost of health care because expenditures that exceed increases in wages and salaries of sickness fund members are generally covered by higher contribution rates. Also, because of differentials in the income structure and health care needs of individual fund members, some sickness funds had to increase contribution rates more than others to cover the costs of providing the same statutory benefits package.
- Many also perceived that escalating sickness fund contribution rates were jeopardizing the financial standing of the pension system and the competitiveness of German industry. Politicians were concerned that these increases were offsetting gains from gradual reductions in income taxes, thus causing the net incomes of employees and pensioners to go down. In addition, a rise in contribution rates tended to increase already high labor costs in Germany and thus the price of products.
- The sickness funds recognized that their budgets for prescription drugs and dental care were rising too rapidly due to high prices and excessive volume.
- A concern existed that expenditures in the hospital sector were excessive due to a lack of incentives to control costs. Past reforms to improve hospital management were not very effective because of states' reluctance to close hospitals and physicians' reluctance to alter referral patterns.

In the late 1980s, most people generally recognized that all health care sectors needed to be more cost conscious. Heightened public pressure particularly from retirees to stabilize rising contribution rates, a slowdown

[5]The 1989 health care reforms reduced expenditure growth in the Statutory Health Insurance System from 5.8 percent per year in 1988 to 3 percent in 1989. Between 1991 and 1992, however, average contribution rates increased from 12.2 percent to 13.1 percent of income.

[6]A deficit occurred in the Statutory Health Insurance System because sickness funds have to pay for all services rendered even though the expenditure caps are exceeded. The sickness funds, however, can only carry a deficit for 6 months.

in the economy, and the high costs of reunification all forced enactment of the most broad-based reforms to the German health care system in nearly 50 years.

Stronger Government Intervention Introduced to Stabilize Health Care System

The Health Care Structure Reform Act of 1993 (Gesundheits-strukturgesetz, 1993), adopted in December 1992, mandated global budgets and the introduction of other structural reforms for all health care sectors. The law is expected to stabilize contribution rates, introduce contribution rate equity and competition among the sickness funds, and begin improving the efficiency and cost-effectiveness of the system. The new reforms are intended to produce a net savings to the Statutory Health Insurance System of more than DM 10 billion (about $6.3 billion) in the first year or 6 percent of the 1992 Statutory Health Insurance System budget of DM 167 billion (about $106 billion).[7] Savings estimates reflect a reduction in expenditures in all health care sectors, increased patient copayments, and additional revenues from voluntarily insured retirees and the self-employed.[8]

Table II.1 summarizes the expected fiscal effects of the 1993 health care reforms.

[7]Health care providers will bear about 77 percent, or DM 8.2 billion of the 1993 gross savings, of health care through a freeze or cut in expenditures by the Statutory Health Insurance System. Patients will have to pay the remainder (about DM 2.5 billion) through increased patient copayments for pharmaceuticals, hospital care, and dental treatments.

[8]Voluntarily insured retirees are those who join a sickness fund even though their incomes exceed the ceiling. As of 1993 the contributions of new pensioners will be based on their total income and at the full rate.

Table II.1: Projected Fiscal Effects of 1993 Health Care Reforms

Billions of DM

Category	Savings[a]	Increased revenues	Additional expenditures
Sickness fund administrative costs	0.24		
Dental care sector	2.11		
Hospital sector	3.29		
Office-based physician sector	0.75		
Pharmaceutical sector	3.36		
Medical supplies and other remedies	0.56		
Self-employed and voluntarily insured pensioners		0.35	
Ambulatory surgery			0.04
Personnel and administration			0.34
Preventive measures			O.27
Subtotal	**10.31**	**0.35**	**.65**
Total Net Savings	**10.01 (about $6.3 billion)**		

Source: Based on Federal Ministry of Health projections.

[a]The Federal Ministry of Health estimates that an additional DM 2.5 billion savings to the Statutory Health Insurance System will come from increased copayments for dental services, hospital stays, pharmaceuticals, and other remedies.

Mandated Global Budgets Used to Contain Rising Health Care Costs

Starting January 1, 1993, the federal government imposed non-negotiable ceilings on the budgets of the office-based physician, hospital, dental care, pharmaceutical, and physical therapy sectors. With the exception of the pharmaceutical sector, these budgets will be closely linked to sickness fund revenue growth for the next 3 years. Several exceptions in the budgets, however, are made for services seen as cost-effective, such as allowing up to a 10-percent increase in expenditures for ambulatory surgery and a 6-percent increase for physician examinations and other preventive care. While the law mandates global budgets, it still requires the Associations of Sickness Fund Physicians and Dentists and each hospital to negotiate the details of operating within these budgets with the sickness funds.

Of particular interest among the exceptions is a provision for increased expenditures on preventive health care measures. To emphasize prevention, as well as to reduce overall health care expenditures, the 1993 reforms promote a new category of primary care physicians. According to an official from the Federal Association of Sickness Fund Physicians, the

government wants to promote a ratio of 60 percent primary care physicians to 40 specialists in the office-based sector.[9] Physicians currently in general practice, pediatrics, and internal medicine will have until December 31, 1995, to decide whether to become "family" doctors (Hausärzte) or remain specialists. Physicians finishing their hospital residency programs had to decide about their medical specialty by January 31, 1993.

The 1993 reforms call for an increase in reimbursement for family physicians. The Federal Ministry of Health anticipates that additional income will come from increasing the reimbursement level for some family doctor services, such as their consultation fees.[10] Even with higher consultation fees, some health observers expect family doctors to provide more cost-effective services to patients because they tend to rely less on costly diagnostic and treatment procedures. The Associations of Sickness Fund Physicians and the sickness funds will together determine the range of reimbursable services that family doctors can provide and the corresponding fee schedule.

The Federal Ministry of Health also anticipates that funding for the new primary care fee schedule will come from a reduction in the relative values of technical diagnostic services. The Ministry considers the use of laboratory services to be excessive and a byproduct of too many specialists overusing costly diagnostic procedures. Even the National Medical Council, representing all German physicians, contends that the additional reimbursement that office-based physicians received for these services is one of the reasons that doctors have obtained specialized equipment for their office-based practice.

Some health care observers consider the creation of a new class of primary care physician another step toward managed care in Germany because sickness funds may eventually require members to obtain a referral from them for specialized care. Those sickness funds that can reduce expenditures by using a gatekeeper-type system may be able to attract or retain members through lower contribution rates. Instituting such a managed care system, however, will meet strong resistance because Germans prefer to choose their own physician, and, unlike some

[9]As of December 1991, the ratio was already 52 percent primary care to 48 percent specialists, including those already practicing general medicine, pediatrics, and internal medicine. The ratio for all physicians in Germany, including hospital physicians, is similar to that for the United States, that is, more than two-thirds are specialists.

[10]Physicians who deliver primary care have typically spent more consultative time with each patient than is reflected in their set consultation fee.

other European countries, they have ready access to specialists in the ambulatory sector.

Initiatives to Reduce Excessive Services and Number of Physicians in the Office-Based Physicians Sector

The Federal Ministry of Health contends that the oversupply of physicians in Germany is causing an increase in services rendered and thus in costs. The Ministry acknowledges that, even though fees were reduced during the year to meet the expenditure caps or targets, previous reforms may have increased costs by creating an incentive for physicians to increase the number of patients seen and services provided. Incentives also existed for physicians to provide technical services in their offices because sickness funds paid for these services.

The 1993 reforms aim to reduce excess patient volume and overuse of technical services by sickness fund physicians, as well as limit the number of physicians authorized to treat sickness fund members. In contrast to prior reforms, the new law will not allow budget increases to exceed revenue growth of the sickness funds between 1993 and 1995. In addition, 1991 was chosen as the base year so that physicians would not be able to increase their volume of services during 1992 to increase their revenue base. The Federal Association of Sickness Fund Physicians acknowledges that some physicians provide excessive services. It intends, however, to let each regional association determine how to sanction their physicians, either as a group or individually. In addition, this association acknowledges that, while accepting a limit on the number of sickness fund physicians is difficult, this will help retain acceptable incomes for physicians currently authorized to treat sickness fund members.

To stay within the new budget limits, the Association of Sickness Fund Physicians and sickness funds plan to impose stricter sanctions on those physicians who are exceeding average service volumes and prescribing standards. An audit commission will review physicians who exceed standards for their group by more than 15 percent.[11] Those physicians exceeding standards by 25 percent will receive sanctions unless they can justify excess services and prescribing. The reforms also encourage nonreimbursement for services provided with high-cost medical equipment used by physicians or hospitals without prior approval. Regional Associations of Sickness Fund Physicians and the sickness funds

[11]Billing activity will continue to be overseen jointly by representatives from the sickness fund physicians and sickness funds using existing data to compare physician practices. Before the 1993 reforms, audits were done on physician practices that exceeded standards for their group by 30 percent. About 10 percent of the physicians were audited each year, and only 2 percent could not justify their services.

will continue to monitor physician activity, with the latter authorized to collect and review a 2-percent sample of all claims.[12]

The new law requires that population-to-physician ratios be established to deal with the oversupply of physicians, especially the growth of some specialties in certain regions. According to a Federal Association of Sickness Fund Physicians official, the Association has had the authority to close a geographic area with an excess supply of physicians to new entrants but has not done so. Instead, it has focused more on providing information to physicians about where to locate a practice.

The Federal Associations of Sickness Fund Physicians and the sickness funds have until 1999 to develop and implement a system for allocating physician specialties based on the needs of the population and the availability of medical care. The Federal Association of Sickness Fund Physicians will propose establishing, as a baseline ceiling, the present mix of specialty distributions across existing planning zones.[13] The 1993 reforms allow a planning zone to exceed its ceiling by up to 10 percent before the region is closed to new practices (approximately 60 percent of the zones remain open at this time). The difficult task of determining appropriate population-to-physician ratios for 12 specialties (including general practitioners) for each planning zone, however, must still be negotiated by the regional Associations of Sickness Fund Physicians and the sickness funds.

Limiting the number of sickness fund physicians' practices will have its most immediate effect on physicians who have been working in hospitals as part of their residency programs or specialty training. The law allowed hospital physicians until January 31, 1993, to elect to be grandfathered into an office-based practice. The Federal Association of Sickness Fund Physicians expects that this clause in the law will produce a net increase of from 10,000 to 11,000 sickness fund physicians and a critical shortage of experienced hospital physicians.[14] Because many of these physicians

[12]Computer billing and the use of identification cards will replace the paper voucher system in 1995. These "smart cards" will have information about the patient but will not retain treatment information.

[13]Germany has 328 planning zones designated according to 1 of 10 population density categories.

[14]Preliminary data from the Federal Association of Sickness Fund Physicians indicated that by January 31, 1993, more than 13,000 senior hospital physicians had submitted their applications for sickness fund licensing.

eventually plan to leave the hospital to establish an office-based practice, any restrictions on their right to practice will be controversial.[15]

Enforcement of strict physician-to-population ratios may mean that, in some regions with an excess supply, new openings for specialty practices will occur only because of population growth and the mandatory retirement of physicians by age 68. Because of the potential effect of population-to-physician ratios on new physicians, this aspect of the 1993 health care reform law is expected to be challenged in court.[16]

Initiatives to Reduce Excess Utilization in the Hospital Sector

The 1993 reforms will attempt to mitigate shortcomings in the hospital sector's budgeting and planning to reduce excess utilization and previous disincentives to be efficient. The new law requires that the hospital sector move from the daily rate system of financing operating costs, which encouraged longer hospital stays and higher costs, to a prospective budgeting system based on specific reimbursements and case payment.

Each hospital will be required to stay within a budget negotiated with the sickness funds, with budget increases linked to revenue growth in the sickness funds for the next 3 years.[17] The Federal Ministry of Health plans to introduce a case reimbursement financing scheme, similar to Medicare's DRG system, to replace the daily rate system. Between 1993 and 1995, hospitals must complete the transition from a strictly daily rate financing of operational costs to one primarily based on reimbursements for specific procedures and treatments, although department and basic treatment rates will be allowed for remaining services.[18] The Ministry has already developed a list of 160 specific procedures and 40 conditions. According to a senior Ministry official, the relative point values for each procedure and treatment condition are not yet established. Once established nationally, however, the associations of sickness funds and hospitals in each region will negotiate conversion factors for each point. The Ministry anticipates

[15]All medical school graduates (about 12,000 a year) must have a minimum of 3 years of specialty training primarily in a hospital before they may establish an office-based practice.

[16]The Marburger Bund, a labor union that represents hospital staff and postgraduate medical students, plans to oppose limitations on the number of physicians on the grounds that the law is unconstitutional because it restricts the freedom of physicians to practice medicine where they choose.

[17]Allowance for exceeding the individual hospital budgets will be made for the additional costs of nursing staff, psychiatric care, midwives, as well as additional hospital-related expenditures approved by the states.

[18]Department treatment rates will be for doctoral and nursing care, while basic treatment rates will be for other services, such as accommodation, administration, and maintenance costs.

that such a system will provide a better basis for prospective budgeting and also encourage hospitals to reduce their average length of stay.

Additional changes will be made in the way capital costs are financed and the amount of patient copayments. The Federal Ministry of Health anticipates that the sickness funds will become more involved in financing new capital costs for each hospital in the future. Also, a small increase in cost-sharing will occur. The flat patient copayment rate for each day of hospital care or stay in a rehabilitation clinic, up to 14 days annually, will increase from DM 10 per day to DM 11 in 1993 and to DM 12 in 1994.

To enhance the continuity of care and reduce unnecessary care, such as duplicative laboratory tests, between the office-based physicians and hospital sectors, hospital physicians will be allowed to perform some outpatient treatments. Before the 1993 reforms, health observers contended that the sharp division between hospital and office-based physician treatments produced higher health care costs for the sickness funds because hospital physicians tended to keep patients in the hospital longer to observe their progress after treatment, and some procedures and tests were duplicated by the two sectors. Hospital physicians will now be allowed to counsel and provide three prehospital visits within 5 days of admission and seven posthospital visits within 14 days of discharge.

Finally, new controls over medical technology and hospital management will be in effect. The new law requires joint planning and use by doctors and hospitals for high-cost medical equipment. Compensation by the sickness funds will gradually decrease with increased use of the equipment. In addition, sickness funds now have greater authority to terminate contracts with inefficiently run hospitals. Such an action will be acceptable if the appropriate state hospital planning authority does not object within 3 months of notification. The sickness funds will also have greater involvement in hospital planning through their financing of capital costs.

Initiatives to Reduce Fees and Technical Services in the Dental Sector

Lack of global budgeting of the dental care sector and commensurate high fees prompted the setting of mandatory budgets for this sector. Similar to other sectors, the dental services budget will be closely linked to revenue growth of the sickness funds for the next 3 years. In addition, the law reduced payment rates for dentures and orthodontic treatments by 10 percent and by 5 percent for dental technicians. Dentists are also required to give a 2-year warranty on every filling. Further, reduced fees

for all dental services in excess of the average volume for a practice will occur. In addition, dental prostheses considered to be medically unnecessary (for example, certain bridges) will be removed from the reimbursable list.[19] While the Free Association of German Dentists threatened a mass exodus of members over the reforms, the Federal Ministry of Health announced plans to open the system to foreign dentists if this occurs.

Initiatives to Reduce Prices and Volume in the Pharmaceutical Sector

Increases in expenditures for pharmaceuticals, due to high prescription drug prices and excessive volume, prompted 1993 initiatives to control costs in this sector. In 1992 the sickness funds estimated that about 20 percent of their pharmaceutical reimbursements were for therapeutically questionable medications. In addition, the Federal Ministry of Health estimated that about 20 percent of the drugs obtained by patients were wasted because prescriptions were often dispensed in amounts larger than were medically necessary. The new reforms aim to reduce pharmaceutical expenditures through mandated drug budgets for the regional Associations of Sickness Fund Physicians, an expanded reference price system, increased cost-sharing by patients, and regulation of prescription sizes.[20]

The new reforms call for the 1993 sickness fund physicians' budget for pharmaceuticals to be fixed at 1991 expenditure levels of about DM 24.4 billion (about $15.4 billion). This global budget will be enforced by holding the regional Associations of Sickness Fund Physicians and the pharmaceutical industry responsible for covering any overruns up to a maximum of DM 560 million. The physicians will have to account for the first DM 280 million in overruns in 1993 by reduced fees for 1994, and the pharmaceutical industry will have to cover the next DM 280 million by lowering drug prices. The sickness funds will have to cover any overrun greater than DM 560 million.

According to a Federal Association of Sickness Fund Physicians official, the association and sickness funds are working on a system of average prescription cost standards for physician specialties. These standards will take into consideration the physician's specialty, patient mix, use of technology, and regional location. This system is expected to produce

[19]Orthodontic benefits will also be limited to children up to age 18, and benefits for children's prophylaxis starting at age 6 (previously, it was age 12) will be expanded.

[20]Preliminary 1993 data from the sickness funds revealed that the total volume of prescribed medication declined about 25 percent in January and February compared to the previous year; however, the March 1993 sales volume resumed normal levels.

realistic and acceptable prescription expenditures in place of federally mandated budgets. Once the system is established in 1994, the sickness fund physicians and the pharmaceutical industry will be responsible for the total cost of any subsequent overruns of pharmaceutical budgets negotiated with the sickness funds.

The other reforms of the pharmaceutical sector relate to changes in the reference price system. The reforms will simplify the rules for classifying drugs under the reference price system, enabling the government to set a reimbursement price for more drugs. The goal is to place 70 to 75 percent of the prescription drugs under the system. Manufacturers will also be required to reduce their nonreferenced-priced prescription products by 5 percent and their over-the-counter products by 2 percent during 1993 and 1994. In addition, a 2-year freeze on these drugs' prices, once lowered, will occur. Finally, a new institute will be established to develop a detailed list of the drugs for which the Statutory Health Insurance System will pay beginning January 1, 1996.

Under the new reforms, sickness fund members will be required to pay higher copayments for prescription drugs. The Ministry of Health is doing this more to shift some of the costs to consumers rather than to lower consumption. Under the old system, drugs with a referenced price had no copayment, but now they will. In 1993 the copayment will be DM 3 (about $1.90) for prescription drugs with a price of under DM 30; DM 5 (about $3.16) for prescription drugs ranging in price from DM 30 and DM 50; and DM 7 (about $4.43) for prescription drugs over DM 50. In 1994, however, the copayment will be related to the quantity of the drugs purchased—that is, DM 3 for a small-sized package, DM 5 for the medium size, and DM 7 for a large one. A ceiling will be placed on the amount of out-of-pocket expenses paid during the year. According to a senior Federal Ministry of Health official, low-income members of the Statutory Health Insurance System will continue their exemption from paying a copayment for prescription drugs. Presently, about 25 percent of the sickness fund members do not pay a copayment.

Improved Equity Through Equalization of Sickness Fund Contribution Rates

The 1993 reforms also made two structural changes in the Statutory Health Insurance System that aim to reduce variation in sickness fund contribution rates. The growing disparity in contribution rates among the funds prompted these changes. The reforms will create a new contribution rate equalization scheme among the sickness funds and expand Germans' choice of sickness fund.

The Ministry of Health plans to introduce a risk-based contribution rate equalization scheme among the sickness funds, which, over time, should reduce the disparities among contribution rates and even the number of sickness funds.[21] This process will start in 1994, and it will supersede the current process of redistributing retiree costs in 1995.[22] Because the Ministry of Health wants to encourage competition for members among sickness funds, some differences in contribution rates will be allowed for added services, such as health care promotion and more efficient management.

Closing the gap in contributions rates among sickness funds will particularly benefit statutory local sickness funds, which presently have contribution rates above the national average. Because a substantial portion of the work force is required to join particular sickness funds, some funds ended up with members tending toward higher actuarial risks. This was one cause of the large variation in contribution rates among the sickness funds. For example, many local sickness funds, because they must take all who are not otherwise insured, tend to get the higher health risk members, including the elderly, blue-collar workers, and sick. Because it cost more to care for these individuals and they tend to earn less, the contribution rates must be relatively high to cover all health care costs.

The fiscal equalization process will consider the payroll tax base, the number of insured dependents, and the age and sex composition of a sickness fund's membership. Under this system, most local sickness funds will be the net recipients of revenue and the other funds' net payers, although some local funds with low contribution rates will also have to transfer some funds. According to a senior Federal Ministry of Health official, the government does not intend to suggest the use of additional factors in the equalization process because it wants to retain some differences in contribution rates to encourage competition among the funds.

The second reform will allow sickness fund members the freedom to select their own fund. By January 1, 1997, the substitute funds and local funds will have to accept all categories of workers as members after notification by the prospective member the previous year. Industrial and guild funds may open up membership outside of their organization as of

[21]In the past this mechanism applied automatically only to sickness funds that operated at a national level, such as the substitute sickness funds.

[22]The statutory sickness funds also collect and distribute benefits to retirees and disabled workers.

January 1, 1996, but they are not required to by law. Regional and legal limitations to consolidation will be removed for many funds. Supervisory authorities will be allowed to close local sickness funds that no longer operate efficiently. In addition, the minimum number of employees required to establish an industrial or guild sickness fund will increase to 1,000 from the previous 450. The Federal Ministry of Health anticipates that giving sickness fund members the right to choose their insurer will result in more equity, improve the quality of services, and produce greater administrative efficiencies as the sickness funds begin competing for members on a national basis. According to a senior Ministry official, about half of the population already has a choice of sickness fund.

Future reimbursement contracts between sickness funds and physicians and dentists will also change. The 1993 reforms require that these contracts be submitted to a federal health insurance authority for review. Arbitration decisions, in those rare situations in which health care providers and payers cannot reach agreement during contract negotiations, must also be submitted to this authority. In addition, special contractual conditions for the substitute funds will be dropped. All sickness funds will now be required to negotiate separate regional contracts, avoiding standardized contracts and affording more intraregional diversity.

Proposed Legislation Aims to Improve the Provision and Financing of Long-Term Care

Because of an aging population and growing budget pressures caused by reunification, the need for long-term care services and an adequate way to fund them has heightened this political issue in Germany. While the debate on the need for long-term care reform has been ongoing in Germany for 20 years, it was not included in the 1993 health care reforms. The government recognized, however, that contribution rates to the sickness fund had to be stabilized before consideration of any additional expenditures to finance long-term care needs.

In 1992 the Federal Ministry of Labor and Social Affairs submitted first a proposal to Parliament that would require mandatory long-term care insurance as part of Germany's social security system.[23] The government considered such an approach necessary to cover the only remaining major gap in Germany's comprehensive social insurance system. The present proposal calls for phased implementation of a system for financing long-term care. The first step, beginning in January 1994, would provide

[23]The Federal Ministry of Labor and Social Affairs is responsible for all social assistance, including long-term care services.

expanded home care benefits. Inpatient nursing home care would be covered beginning January 1996. A compulsory payroll contribution equally divided between worker and employer would finance these benefits. Initially, this contribution would be set at 1 percent of gross wages and salaries, up to the statutory income ceiling, rising to 1.7 percent in 1996.[24]

Most long-term care is currently funded much like it is in the United States: individuals must deplete their income and assets and, to some extent their families', to pay for care before the social welfare system will cover the costs.[25] For example, health insurance will cover the hospital care of an elderly person who suffers a stroke but does not pay for most long-term, nonmedical care once the person returns home.

The proposed legislation aims to emphasize outpatient care over inpatient care, support families in giving home care, remove those in need of long-term care from the stigma of welfare, and shift much of the burden of paying for long-term care away from the welfare system. According to a senior Labor Ministry official, the Ministry prefers funding long-term care through contribution rates rather than income taxes (which pay the cost of welfare support) because the rates are identifiable cost items for both employers and employees.[26] Removing long-term care financing from welfare services also means that this expenditure will not have to compete each year with other funding priorities. Currently, of the estimated 1.65 million people in need of long-term care, 1.25 million (76 percent) are over 60 years old. Approximately 450,000 elderly are in nursing homes, while 7.2 million are cared for at home by family members. Most of those in nursing homes (about 70 percent) depend on welfare to cover the cost.[27]

The German parliament has agreed in principle to this proposal with goals for implementation by January 1, 1996; however, proposals on how to compensate industry for the increased costs remain controversial. The government's current proposal would exempt employers from paying for

[24]According to a senior Ministry official, Germans who are presently privately insured for health care will need to obtain private coverage for long-term care benefits.

[25]The Statutory Health Insurance System does not cover most nursing home care, but it does provide some support to families who provide long-term care in the home to discourage the hospitalization of patients who do not need medical services.

[26]Many agree that the sickness funds are in the best position to administer the collection and dispersal of funds for long-term care because they already effectively do this for health care, pensions, and some nonobligatory services.

[27]The cost of nursing homes averages from DM 2,500 to DM 5,000 per month but may easily reach DM 12,000 or more depending on individual circumstances.

the first 2 days of sickness leave, up to a total of 6 days per year. Germany's unions, however, strongly oppose this proposal.

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