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Health care reform in Germany – past, present and future

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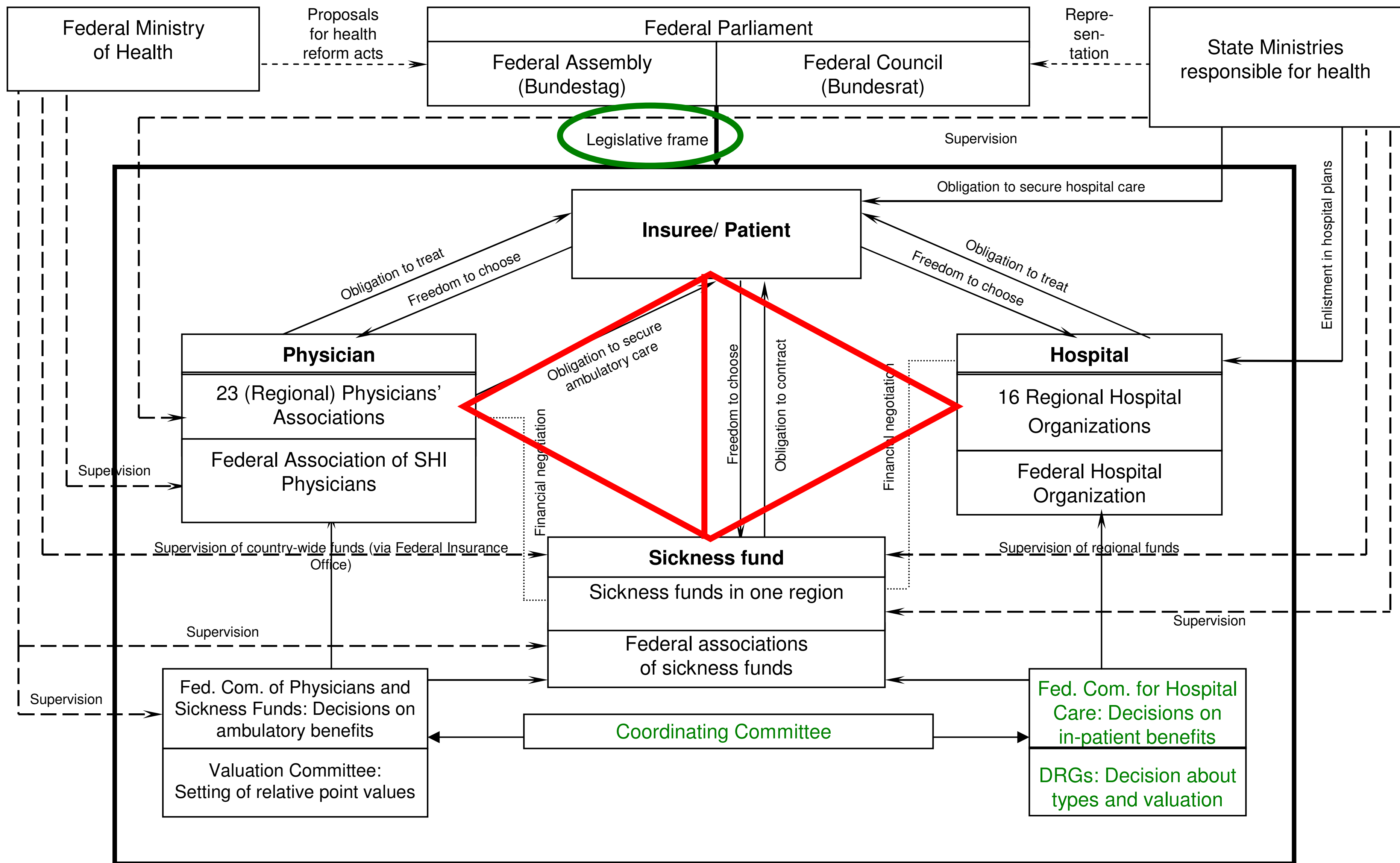
European Observatory on Health Care Systems

Reform act	Year passed
Health Care Reform Act 1989 ("First step")	1988
Health Care Structure Act 1993 ("Second step")	1992
Health Insurance Contribution Rate Exoneration Act	1996
1st & 2nd Statutory Health Insurance Restructuring Act ("Third step")	1997
Act to Strengthen Solidarity in Statutory Health Insurance	1998
Reform Act of Statutory Health Insurance 2000	1999



Reform acts = modification of rules for self-governing actors

Best example: extension to hospital sector from 2000

Budgets and spending caps since 1989

<table>
<tr><th></th><th>Ambulatory care</th><th>Hospitals</th><th>Pharmaceuticals</th></tr>
<tr><td>1989 to 1992</td><td>negotiated regional fixed budgets</td><td>negotiated target budgets at hospital level</td><td>no budget or spending cap</td></tr>
<tr><td>1993</td><td rowspan="3">legally set regional fixed budgets</td><td rowspan="4">legally set fixed budgets at hospital level</td><td>legally set national spending cap</td></tr>
<tr><td>1994</td><td rowspan="4">negotiated regional spending caps</td></tr>
<tr><td>1995</td></tr>
<tr><td>1996</td><td rowspan="2">negotiated regional fixed budgets</td></tr>
<tr><td>1997</td><td rowspan="2">negotiated target budgets at hospital level</td></tr>
<tr><td>1998</td><td>(target volumes for individual practice)</td><td>negotiated target volumes for individual practices</td></tr>
<tr><td>1999</td><td rowspan="3">negotiated regional fixed budgets with legally set limit</td><td rowspan="3">negotiated target budgets at hospital level with legally set limit</td><td>legally set regional spending caps</td></tr>
<tr><td>2000</td><td>negotiated regional spending caps</td></tr>
<tr><td>2001</td><td>negotiated target volumes for individual practices</td></tr>
</table>

The insured moved from fund to fund – and risks *de*-mixed

	West		East		Germany	
	RSC[1]/ exp.[2] (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure	RSC/ exp. (billion DM)	RSC as % of expenditure
1995	13.49/ 190.29	7.1%	4.61/ 38.53	12.0%	18.05/ 228.82	7.9%
1996	14.22/ 196.39	7.2%	4.90/ 40.03	12.2%	19.12/ 236.42	8.1%
- 1 January 1997: First opportunity to change between funds -						
1997	15.07/ 192.13	7.8%	5.15/ 39.22	13.1%	20.22/ 231.35	8.7%
- 1 January 1998: Second opportunity to change between funds -						
1998	16.07/ 195.07	8.2%	5.47/ 39.06	14.0%	21.54/ 234.13	9.2%
- 1 January 1999: Third opportunity to change between funds -						
1999	16.24/ 200.83	8.1% (8.7%)*	6.44/ 40.14	16.0% (13.0%)*	22.68/ 240.97	9.4%
- 1 January 2000: Fourth opportunity to change between funds -						
2000	16.23/ 205.46	7.9% (9.2%)*	7.29/ 40.86	17.8% (11.1%)*	23.52/ 246.32	9.6%

• Act to Newly Regulate Choice of Sickness Fund • Act to Introduce the Residency Principle for Physicians' and Dentists' Reimbursement • Act to Reform the SHI Risk Adjustment Mechanism • Act to Adjust Reference Price-Setting Regulations • Pharmaceutical Spending Cap Lifting Act	2001 **Health care reform a la Ulla Schmidt**
• Act to Limit SHI Pharmaceutical Spending • Act to Introduce a Case Fees-System in Hospitals	2002

DRG introduction

- from 2003 (voluntarily)/ 2004 (mandatorily) hospitals will be reimbursed based on DRGs (diagnosis related groups) with uniform prices per DRG and *no* budgets (instead of current target budgets and per diems which differ by hospital)
- confusing ping-pong between law-makers (introduction of DRG system), delegation of system selection to self-government, new law regulating what self-government had proposed (plus possibly some issues on which no agreement could be achieved), failure of self-government to agree on price list, and ordinance to set price list

Risk structure compensation/ disease management programmes

- idea of minimum contribution rate dropped
- after changing sickness fund, new minimum membership duration of 18 months
- RSC to include high-risk pool and new categories for enrolees in DMP (incentives?)
- Coordinating Committee proposes diseases (first two: diabetes, breast cancer), criteria for enrolment and minimum standards

Risk structure compensation/ disease management programmes

- MoH passes ordinance based on these proposals (the first with >100 scientific citations)
- Federal Insurance Office accredits programmes offered by sickness funds

Up to now rapid development but total mix of actors´ roles!

Main dispute: who should get which data

Pharmaceuticals 2001/02

- spending cap lifted
- pharmaceutical expenditure sharply up
- new act limits prices, increases discount for sickness funds, introduces “Aut-idem“
- hotly debated: contribution of pharmaceutical industry to avoid price cuts
- reference price setting to be done by MoH, rather than sickness funds in 2003/04

Post-election reforms 2002: short term

- raising the income threshold for mandatory insurance by ca. 15%; thereby more people will be forced to stay with SHI and are not allowed to opt for private health insurance
- one-year freeze in the remuneration for the hospital sector and for the ambulatory medical and dental sectors
- inclusion of patented pharmaceuticals into the reference pricing system, introduction of higher discounts on pharmaceuticals for sickness funds
- freeze in contribution rates for sickness fund (-31.12.03)

Post-election reforms 2002: medium term

- sickness funds shall be allowed to make selective contracts that have clearly defined quality standards with providers of health care
- more disease management programmes (DMPs) for chronic illnesses
- Establishing a 'German Centre for Quality in Medicine'
- prevention = autonomous pillar besides acute care, rehabilitation and long term care
- strengthening patients rights
- expert commission with the task to develop reform proposals for sustainable health care funding

quality and expenditure first

funding afterwards

Report from 2000 available at www.observatory.dk

A new version will be available in the first half of 2003.