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ISSA Project on Sustainable Health Care Systems: Germany

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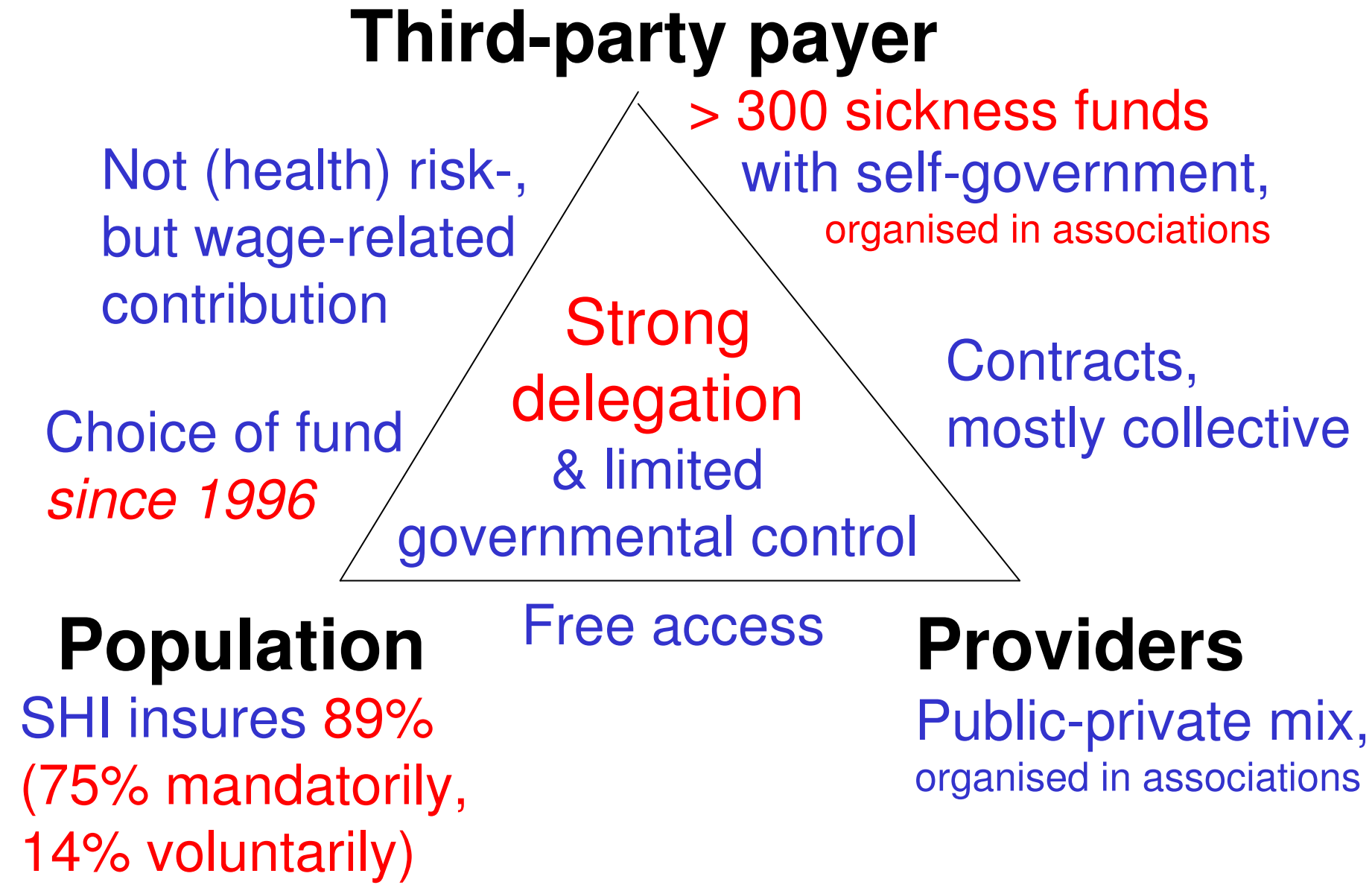
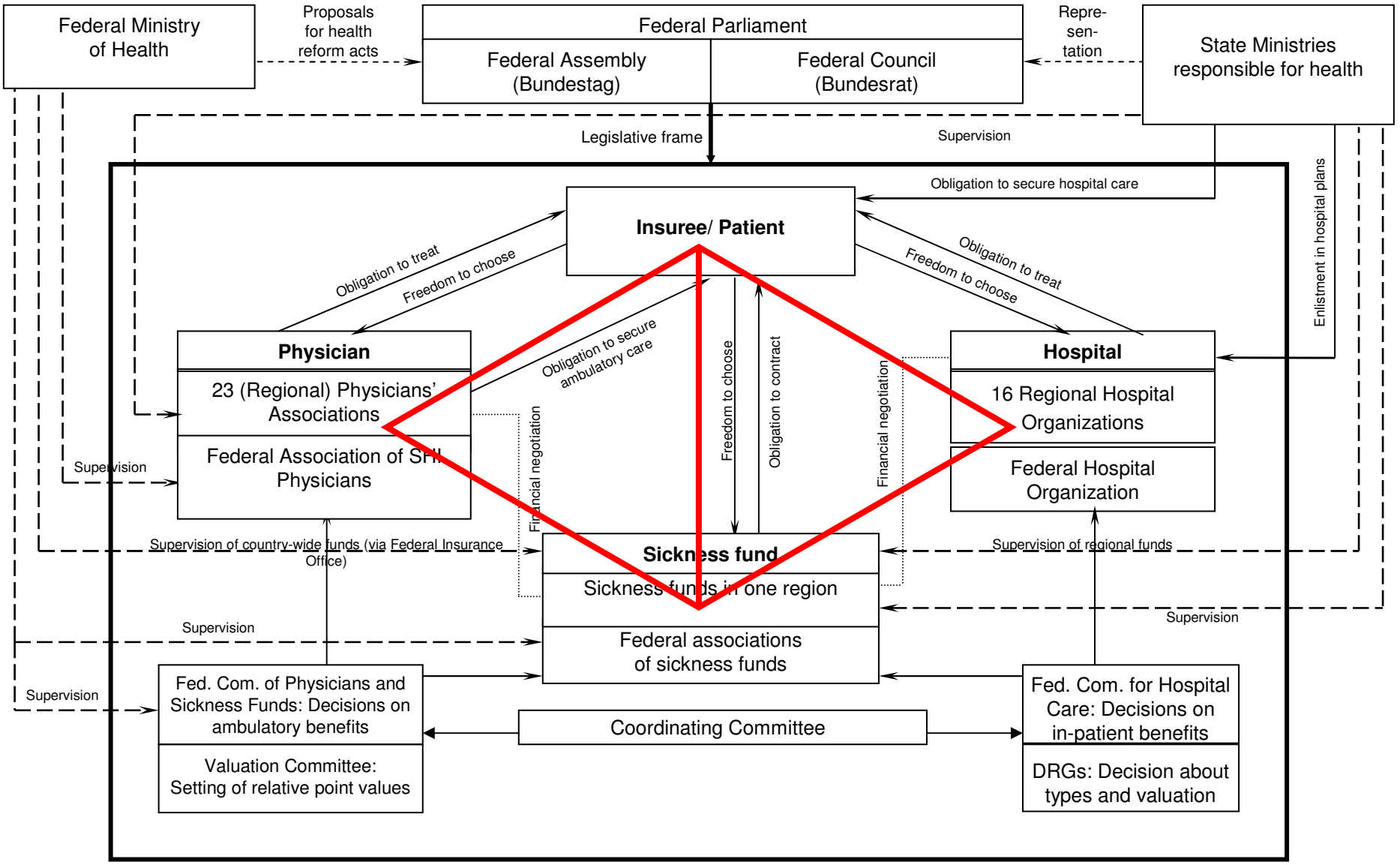
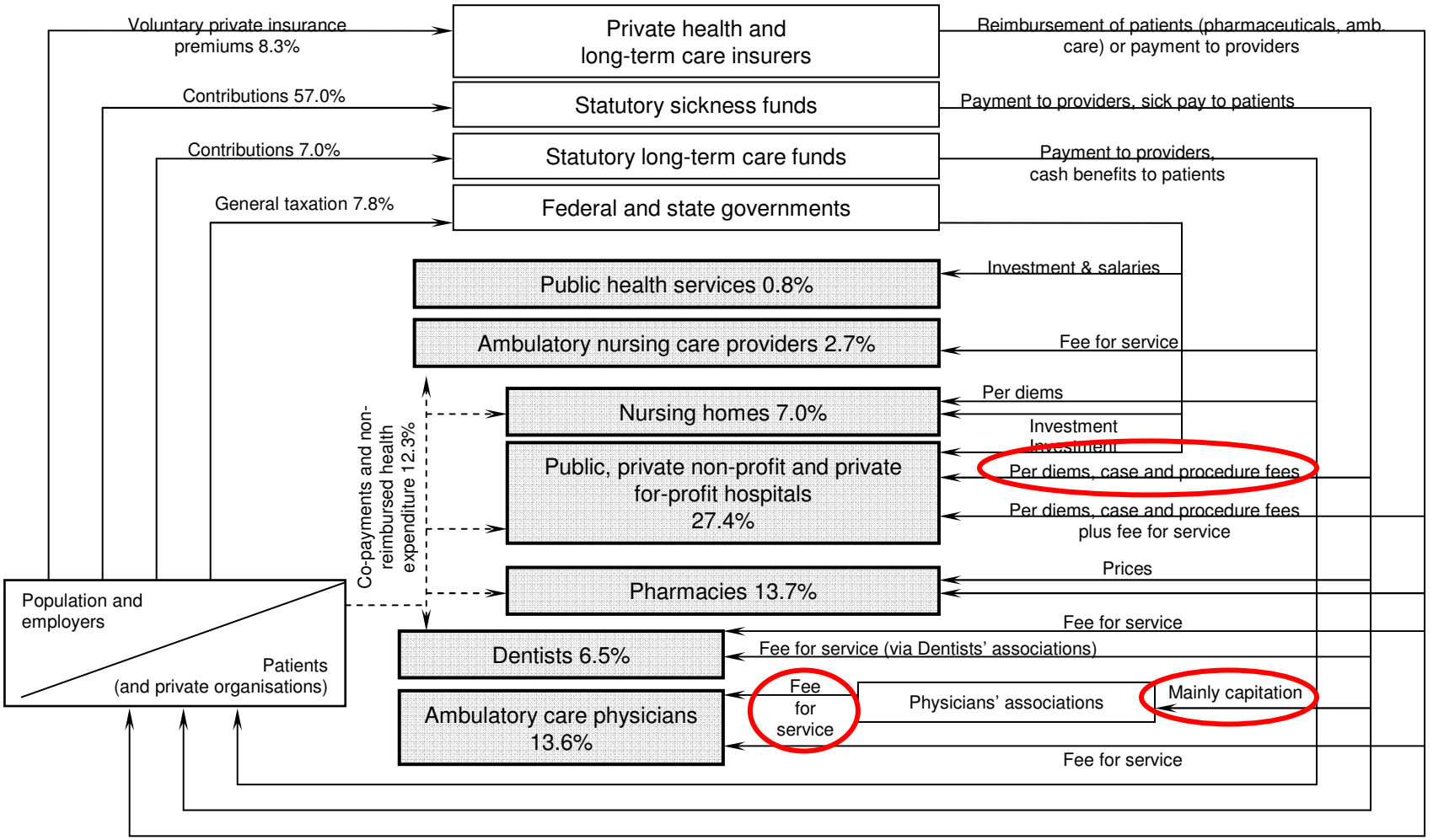
The German system at a glance ...





Statutory health insurance 2003

Problem 1: Strict separation between ambulatory and hospital (inpatient) care with different regulatory environment and rules



Problem 2:
Financial incentives vary between sectors/ providers and are changed frequently – „solutions“ to old problems create new ones

Problem 3 (actually No. 1): Increase of contribution rate

Background: no tax subsidies;
sickness funds are not allowed to incur deficits

$$\frac{\text{Expenditure}}{\text{Contributory income}} = \textbf{contribution rate}$$

(wages up to threshold; pensions;
50% of wages for unemployed ...)

Sharp increases (1991-93; 2001-03) have always triggered major reform!

Reform act	**Year passed**
Health Care Reform Act 1989 ("First step")	1988
Unification Treaty (extension of SHI to eastern part)	1991
Health Care Structure Act 1993 ("Second step")	1992
Introduction of Long-term Care Insurance	1995
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

Free choice among sickness funds is accompanied by "risk structure compensation" (RSC)

- sickness funds = contribution collectors + payers
- RSC compensates for contribution base (wages) of fund members and expenditure due to differences in sex, age, work incapacity
- RSC is based on average expenditure per age/sex/incapacity category and carried out by Federal Insurance Office

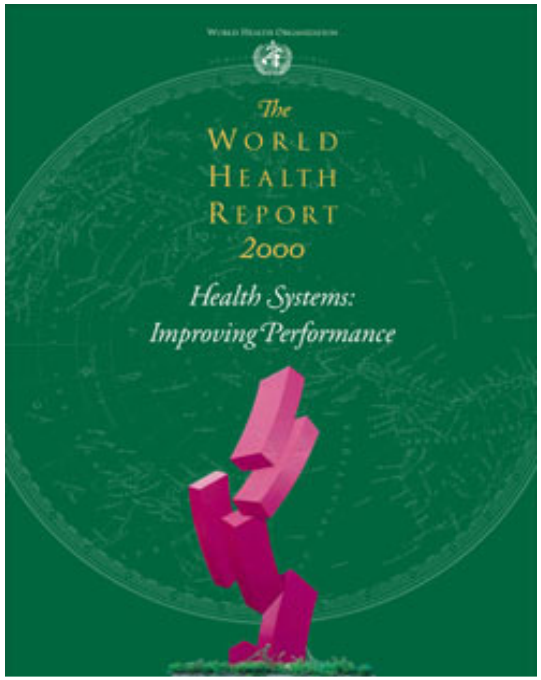
Problem 4:
As the younger and healthier move more often, the overall risk pool has further desegregated

Evidence: RSC transfers have increased as percentage of total expenditure

	West		East		Germany	
	RSC* / expenditure (billion Euro)**	**RSC as % of expenditure**	**RSC* / expenditure** (billion Euro)**	**RSC as % of expenditure**	**RSC* / expenditure** (billion Euro)**	**RSC as % of expenditure**
1995	6.90/ 97.29	7.1	2.36/ 19.70	12.0	9.23/ 116.99	7.9
1996	7.27/ 100.41	7.2	2.51/ 20.47	12.3	9.78/ 120.88	8.1
1997	7.71/ 98.23	7.8	2.63/ 20.05	13.1	10.34/ 118.29	8.7
1998	8.22/ 99.74	8.2	2.80/ 19.97	14.0	11.01/ 119.71	9.2
1999	8.30/ 102.68	8.1	3.29/ 20.52	16.0	11.60/ 123.21	9.4
2000	8.30/ 105.05	7.9	3.73/ 20.89	17.8	12.03/ 125.94	9.6
2001	9.09/ 108.89	8.3	4.43/ 21.75	20.4	13.52/ 130.63	10.3
2002	8.99/ 111.79	8.0	4.53/ 22.54	20.1	13.52/ 134.33	10.1

Problem 5: Quality and cost-effectiveness

- Germany always knew that its health care system was expensive, but was sure it was worth it (“the best system“)
- QA was introduced early but concentrated on structure
- Increasing doubts since late 1990s: Health Technology Assessment introduced in 1999
- World Health Report 2000: Germany only # 25 in terms of performance (efficiency)
- International comparative studies demonstrate only average quality (especially low for chronically ill)



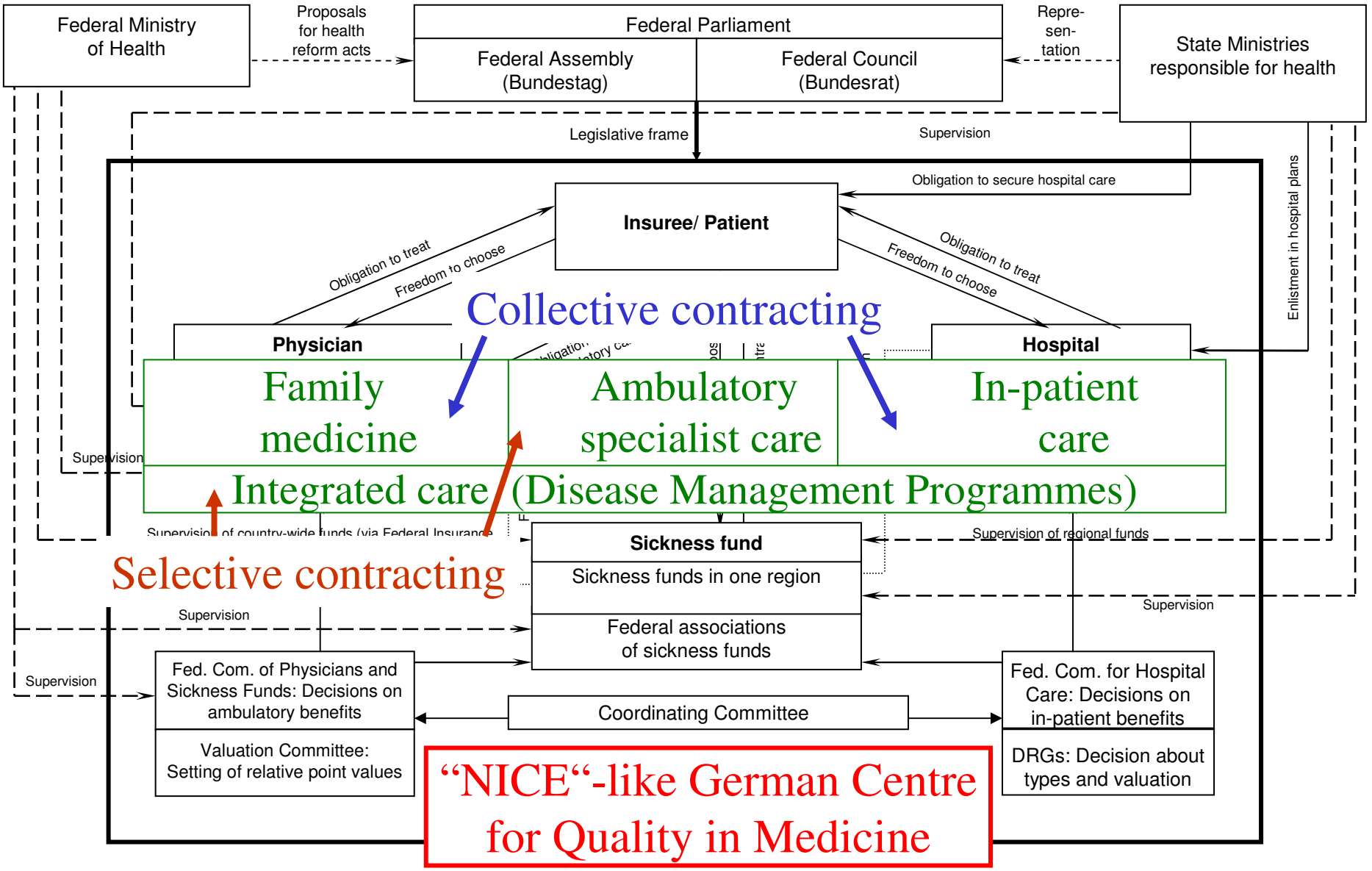
Solution 1 (introduced 2002): Disease Management Programmes

- Compensate sickness funds for chronically ill better (make them attractive) = reduce faulty incentives to attract young & healthy
- Address quality problems by guidelines/ pathways
- Tackle trans-sectoral problems by “integrated“ contracts
- = introduce Disease Management Programs meeting certain minimum criteria and compensate sickness funds for average expenditure of those enrolling (new RSC categories)

double incentive for sickness funds:
potentially lower costs + extra compensation!

2003: The SHI Modernisation Act

- Background: rising contribution rates (from 13.6% in 2001 to 14.4% now) + perceived quality problems
- original core elements (government bill):
  - "patients rights",
  - "German Centre for Quality in Medicine" (incl. 4th hurdle),
  - re-organisation of contractual relationships between sickness funds and providers,
  - moderate cost-shifting (sick pay)

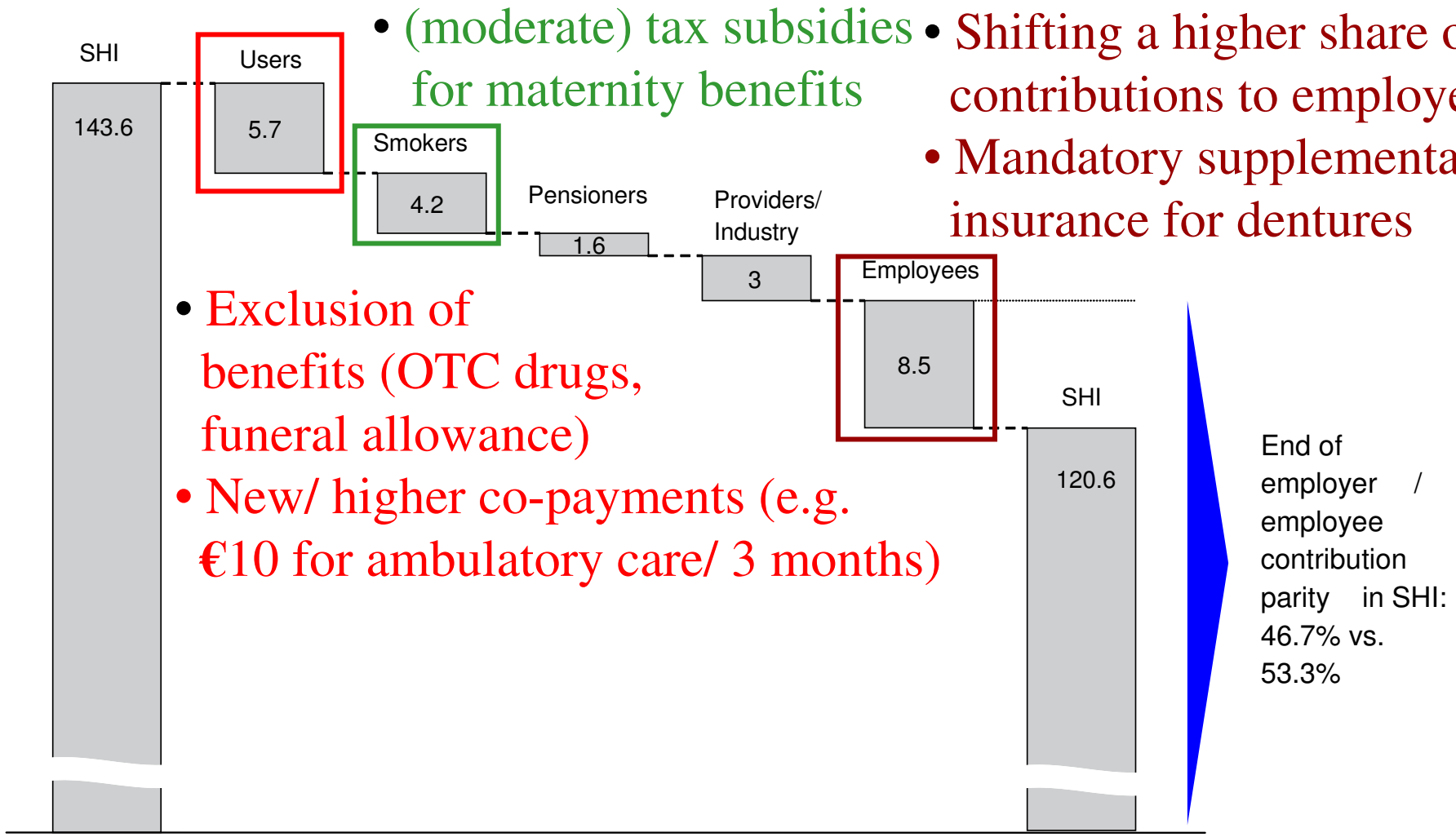


Health Care System Modernisation bill – the plan

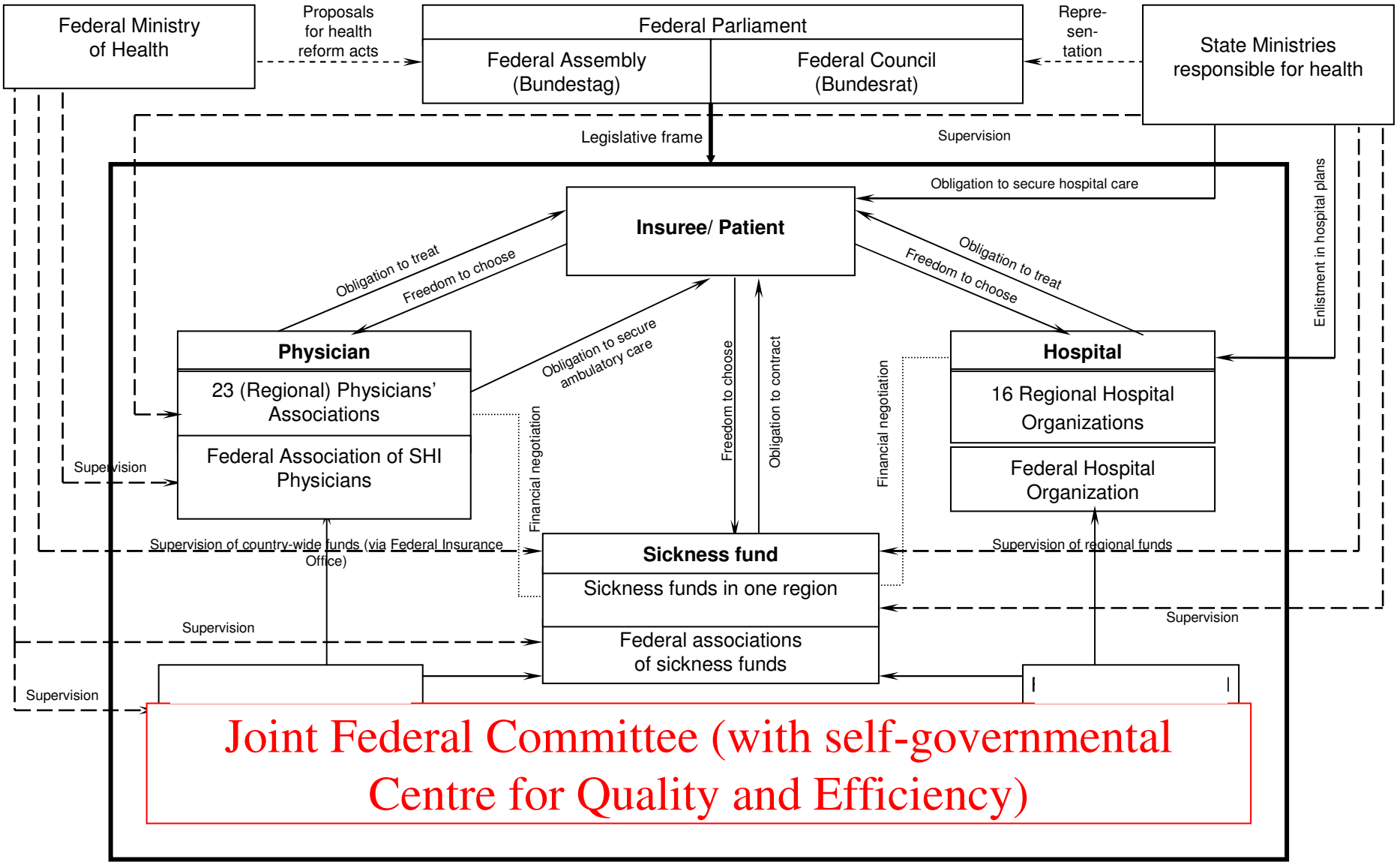
2003: The SHI Modernisation Act – continued

- Opposition threatened to block Modernisation bill
- All-party negotiations in July
- Result: shift in emphasis from re-organisation of contractual relationships to cost-shifting; major re-organisation of delegated decision-making

SHI Modernisation Act: Anticipated cost-shifting from employers and healthy employees to users of healthcare, smokers, pensioners, providers and industry, and the *de facto* end of contribution parity in SHI (in billion €)



Source: Gericke, Wismar & Busse (2003)



SHI Modernisation Act – the outcome

Discussion about funding basis
(mainly SHI, to a lesser degree LTCI)

- *Extension of SHI to entire population*
- Option 1: Extension of contributory basis (to non-wage income, higher threshold)
- Option 2: Change from income-dependent contribution to community-rated *(or age-dependent?)* per-capita premia
    - *Partial complement of pay-as-you-go principle through capital stock*

Financial effect of the two options 1. per-capita premium (with varying level of tax subsidies for low income) and 2. universal contributory insurance (with varying level of upper threshold for contributions) on household income