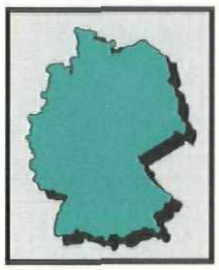


HEALTH REFORM IN GERMANY

An American Assesses the New Operating Efficiencies

BY THOMAS P. WEIL, PhD

Dr. Weil is president, Bedford Health Associates, Inc., Asheville, NC.

On January 1, 1993, mandatory global budgets went into effect in Germany for physician, hospital, dental, and pharmaceutical services, virtually freezing all provider payment rates for three years. The German federal parliament imposed the limits in response to a $5.7 billion deficit among the country's not-for-profit third-party payers (often referred to as "sickness funds"), which previously had been able to negotiate reimbursement rates with providers without direct government intervention.

Late in 1993 I had the opportunity to spend two weeks in Germany to study the rationale for the imposed limits and to assess their effects. I was particularly interested in how Germany expects to accomplish the organizational changes and cost reductions proposed in its reform plan, and what impact these measures would have on consumers and providers.

BENEFITS OVERUTILIZED

Americans have known for some time that the German multipayer system provides nearly universal comprehensive benefits and has a superior record to the United States in constraining health expenditures. In 1990 Germany maintained its health spending at 8.3 percent of its gross domestic product (GDP), one-third less than here.[1]

Nevertheless, Germany, in comparison to U.S. averages, has an excessive supply of all health resources: too many sickness funds, too many small specialty hospitals, roughly twice as many acute care beds, and about a third more physicians per person (see **Table**, p. 26). The federal republic has utilization rates for health services that we would consider excessive—approximately 150 percent more inpatient days and twice as many physician visits annually per person. Yet despite such a comprehensive scope of benefits and high utilization rates, Germany's 1990 health

Summary In 1993, responding to a $5.7 billion deficit among the country's third-party payers, the German parliament imposed mandatory global budgets for physician, hospital, dental, and pharmaceutical services. Although Germany had been able to maintain health spending at a lower rate than the United States, an excessive supply of health resources was beginning to drive prices higher.

During the three years the global budgets are in place, German third-party payers (the "sickness funds") and providers will implement several fundamental reforms. These include:

- Reducing excessive supply of specialists
- Constraining the acquisition and utilization of expensive medical technologies
- Reducing the annual number of physician visits per person
- Reducing average hospital length of stay
- Integrating community- and hospital-based physician services
- Reducing payroll deductions for mandated benefits

The 1993 reforms also impose a budgetary cap at the 1991 expenditure level for drugs prescribed by community-based physicians. In addition, the reforms call for the implementation of community-rated premiums and stipulate that Germans be able to select their sickness fund each year.

Although the reforms make important changes, they leave the basic German healthcare system intact. It is difficult to imagine, moreover, that any of the reforms being implemented will in the foreseeable future place any major element of the health system in serious financial peril; in fact, they will help preserve the system.

expenditure per capita was $1,522, compared with $2,601 in the United States.

Proposed Modifications

The Germans must be doing something right. Yet they are committed to further restructuring and constraining their health expenditures to reduce further increases in their payroll deductions. During the three years the government-mandated global budgets are in effect, the new legislation directs the 1,241 German sickness funds and the providers to implement several fundamental health reforms. These include:

- Reducing excessive use and supply of physician specialists and subspecialists in regions where there is an excess number of such doctors.
- Constraining the acquisition and utilization of expensive medical technologies, particularly those provided on an ambulatory basis in the offices of community-based physicians.
- Reducing the annual number of physician visits per person. (The West Germans in 1990 averaged 11.5 visits per capita compared with 5.3 visits to doctors in the United States.)
- Modifying the fiscal incentives now being used to reimburse Germany's 3,500 acute care facilities in order to reduce their 12.9-day average length of acute hospital stay.
- Integrating community- and hospital-based physician services, which in Germany have traditionally been separate. This barrier has often made it difficult to achieve any continuity of patient care services and to eliminate the duplication of diagnostic testing.
- Enhancing competition among the sickness funds to reduce payroll deductions for mandated benefits. German health insurance now costs, on average, 13.4 percent of payroll, up to a statutory gross income ceiling of about $41,000 per year. This significant expense, a maximum of $5,500 per year, is shared equally by the employee and employer in Germany.

Limiting Physician Services

Under the 1993 health reform plan, total spending by the German sickness funds for all office-based physician services, which are reimbursed on a fee-for-service basis, will be capped (adjusted for any revenue increases experienced by the third-party payers). In addition, the Federal Ministry of Health proposes to implement several controversial measures to decrease utilization of physician services and constrain the supply of available physicians.

Representatives from the regional associations of physicians and the sickness funds will continue to oversee billing for patient services and will also impose stricter financial sanctions on physicians who exceed average service volumes and prescribing levels. Possibly a more controversial provision in the 1993 health reform law is the requirement that strict population-to-physician ratios (by specialty) be established for each municipality.

Although the federal-level association for physicians has had the authority to limit a doctor from practicing in a specific geographic area with an excess supply of the doctor's specialty, it has not exercised this option. The group has instead focused on providing information on where physicians might most suitably establish new practices. Unless the German supreme court overturns the provision, the federal associations of physicians and sickness funds will be required by 1999 to develop and to implement a system of allocating physician specialties based on population needs and the current availability of medical services.

GERMANY: A DIFFERENT MODEL

The German health system functions under a century-old social insurance concept that represents a middle ground in the spectrum of approaches currently being used by Western industrialized nations to protect their residents from the economic consequences of illness, disability, unemployment, and old age. Germany could be most simply depicted as positioned near the midpoint between the U.S. private-oriented approach and the British "cradle-to-grave" program.

Among Western industrialized nations, Germany's health insurance plan came closest during the 1980s to limiting increases in spending to a rate equal to the growth of its national income.* In the last 45 years West Germany achieved a blend of government-mandated financing by employees and employers, combined with the private provision of care by physicians and controlled hospital expenditures, with benefits administered by not-for-profit third-party payers.† The area's sickness funds paid the same negotiated per diem rate to a specific hospital whatever the patient's diagnosis, an exception being a limited number of tertiary services. In Germany there were no itemized patient bills, no cost shifting among payers, and virtually no one without health insurance.

All Germans have universal access to a comprehensive range of physician and hospital benefits and a free choice of doctor and acute care facilities. Practitioners enjoy a substantial degree of clinical autonomy, although doctors and hospitals are constrained by the caps established by the global budgetary targets. Among its other virtues, the German health delivery system has been traditionally decentralized, pluralistic, and self-governing.†

* George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-Four Countries," *Health Affairs*, Fall 1991, pp. 22-38.

† Lawrence H. Thompson, "1993 German Health Reforms: New Cost Control Initiatives," GAO/HRD-93-103, July 1993; a summary and update of this report is contained in Janet L. Shikles, "1993 German Health Reforms: Initiatives Tighten Cost Controls," Testimony before the Committee on Finance, U.S. Senate, GAO/T-HRD-94-2.

† Thomas P. Weil, "The German Health Care System: A Model for Hospital Reform in the United States," *Hospital and Health Administration*, Winter 1992, pp. 533-547.

SELECTED HEALTH AND HOSPITAL VARIABLES: WEST GERMANY AND THE UNITED STATES (1990)

Variables	West Germany	United States
Healthcare expenditures/total gross domestic product	8.3%	12.2%
Public spending/total health spending	72.8%	42.4%
Per capita spending for health	$1,522	$2,601
Acute care inpatient beds/1,000 patients	7.1	3.7
Annual acute care inpatient days/1,000 persons	2,237.0	910.5
Annual acute care admissions/1,000 persons	173.6	125.5
Acute care average length of stay (days)	12.9	7.3
Annual surgical visits/1,000 persons	102.7	88.1
Full-time equivalent employees/occupied bed	1.4	5.5
Operating expense/discharge	$2,972	$6,535
Operating expense/day	$215	$901
Paid hours/discharge	144.5	321.4
Physicians/1,000 persons	3.1	2.3
Physician contacts/person/year	11.5 ('88)	5.3 ('88)
Physician expenditures/person/year	$193 ('88)	$414 ('88)
Physician expenditures/MD	$67,067 ('88)	$183,281 ('88)
Infant mortality/1,000 live births	7.1	9.1
Perinatal mortality/1,000 births	6.4	9.6
Life expectancy at birth (years)	75.8	75.4
Percentage of population over age 64	15.4%	12.6%
Dependency ratio	57.9	70.1
Pharmaceuticals as percentage of total health expenditures	20.7% ('88)	8.3% ('88)
Pharmaceutical expenditures per capita	$258 ('88)	$182 ('88)

Values are in 1990 or 1988 U.S. dollars. 1990 German figures, for example, were adjusted according to the purchasing power–parity exchange rate of U.S. $1 equals 1.598 DM.

Sources: George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Spending, Delivery, and Outcomes in OECD Countries," *Health Affairs*, Summer 1993, pp. 120-129; George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Care Systems in Twenty-Four Countries," *Health Affairs*, Fall 1991, pp. 22-38; Thomas P. Weil and William H. Miller, "Germany's Health System—Mrs. Clinton's Managed Competition with Global Budgets," *Healthcare Financial Briefs*, February 1993, pp. 1-8; Thomas P. Weil and William H. Miller, "West German Hospitals: Some Additional Data," *Healthcare Financial Briefs*, April 1993, pp. 1-4; Thomas P. Weil, "An American Macromanaged Health Care System," *Health Services Management Research (England)*, February 1994, pp. 43-55.

Germany rejected the option of limiting medical school enrollment because it would give rise to constitutional challenges and strong local opposition. In the next decades these issues of physician distribution, geographically and by specialty, will obviously need to be resolved in Germany, as in the United States, to enhance our health delivery systems.

Reducing Hospital Expenditures

Historically, German hospitals have been reimbursed almost exclusively on a per diem basis; as a result, average lengths of stay for most diagnoses are approximately twice those in the United States. The 1993 health reform plan calls for a decade-long transition from a per diem approach to a prospective budgeting system for financing acute care facilities. While this new methodology is being developed and implemented, the law requires that hospitals accept the rates negotiated in 1992 with the sickness funds. Any potential revenue increases during 1993 through 1995 would be directly related to the growth in the third-party payers' revenues and any new wage settlements.

The Federal Ministry of Health has developed a list of treatments and conditions for which specific reimbursement rates will be established. Within a few years hospitals will be paid for roughly 25 percent to 35 percent of their discharges through what is called in Germany "a relative value–case reimbursement methodology," which has fiscal incentives similar to those in our Medicare diagnosis-related group (DRG) approach.

By 1996 hospital operating costs in Germany will be set primarily on the basis of the projected annual volume of operative procedures, treatments, and discharges rather than total patient days. The government anticipates that these new reimbursement incentives will offer a better basis for prospective budgeting and encourage acute care facilities to reduce average lengths of stay and more effectively use their resources.

The potentially most far-reaching provision in the 1993 health reform plan for acute care facilities is allowing more hospital-based physicians, who are almost all salaried, to consult with patients on an ambulatory basis. To provide increased continuity of patient care, hospital-based physicians will now be allowed "to counsel and to provide three treatment days within five days of admission, and seven treatment days within 14 days of discharge."[2]

In the past decade, acute care facilities have obtained an increasing percentage of the health dollar at the expense of community-based physicians. As a result, community-based physicians have opposed a reform measure that allows hospital-based doctors to more routinely diagnose and treat patients on an outpatient basis. What is more, as part of the 1993 reform plan, community-based surgical subspecialists have obtained privileges to perform ambulatory surgery in hospitals.

With no immediate fiscal incentive to expand a service beyond the resources allocated through the global budgetary approach, German hospitals and their physicians have tended to work more collaboratively than U.S. providers to ensure that patients are transferred from one facility to another when necessary. By moving toward a more clinically oriented, prospective reimbursement approach, Germany could anticipate some of the same problems experienced here with similar reimbursement incentives—the most obvious examples being "DRG creep" (i.e., assigning the DRG with the maximum reimbursement potential) and the "dumping" of difficult and costly cases.

WHY GERMAN ACUTE CARE EXPENSES ARE LOWER

A number of factors help explain why the average 1990 discharge cost at a German hospital was 55 percent less than the average cost at a U.S. hospital:

- German hospitals had an average of 1.4 full-time equivalent (FTE) personnel per occupied bed, compared with an average of 5.5 FTEs in American hospitals.
- Germany's 16 state governments pay for most hospital capital expenditures via grants.
- An average 400-bed hospital in Germany has an 82 percent occupancy rate and employs only 25 FTEs for administrative and fiscal services.
- The same size hospital has a computed tomography scanner, but no magnetic resonance imager, no cardiac catheterization unit, no open-heart surgery program, and no radiation therapy capabilities.
- The 400-bed hospital averages 10,000 to 15,000 emergency department visits per year, mostly for trauma patients requiring admission or for complicated ancillary testing.
- The average 400-bed hospital delivers limited outpatient services compared with those in the United States.
- Patients and employees enjoy fewer amenities in German hospitals than in American hospitals.
- The average age of the physical plant at a German hospital is about 15 years, roughly twice that of an average American hospital.
- German hospital-based physicians are salaried, and they perform many of the functions that in the United States are provided by nurses. There are 40,000 to 45,000 unemployed or underemployed physicians in Germany, so there is intense competition for the available hospital positions.

Controlling Pharmaceutical Expenditures

The 1993 health reform plan imposes a budgetary cap at the 1991 expenditure level for drugs prescribed by community-based physicians. To compensate for the cost of pharmaceuticals introduced since 1991, the law mandates a 5 percent reduction through calendar year 1994 in prices for prescriptions that were not lowered by previous reimbursement policies and a 2 percent price reduction in over-the-counter drugs.

> Germans wish to eliminate abuses and unnecessary expenditures.

To keep spending below levels set by this global budget for drugs, the plan holds the federal association of physicians and the pharmaceutical industry responsible for a portion of expenditures above the federally mandated cap. Physician fees are to be reduced to offset the first $175 million in potential overruns, the pharmaceutical industry is to cover the next $175 million in overruns, and the sickness funds are responsible for payments exceeding $350 million of overruns. However, because the $175 million potential penalty is equivalent to only 1 percent of all physicians' expenditures, it will have limited effect in reducing total health costs.

Representatives of the associations of physicians and sickness funds are currently developing average prescription cost standards for doctors that will take into account their specialty, patient mix, use of technology, and region. German physicians who exceed these standards by specified percentages could be penalized financially. Starting this year, as associations of physicians and sickness funds negotiate regional drug budgets and prescription cost standards, individual doctors will be responsible for controlling prescription costs.

Toward Community Rating

Implementing community-rated premiums is a topic of intense interest both in Bonn and in Washington. Variations in required contribution rates for health insurance by employees and employers range in Germany from 8.5 percent to 16.5 percent per payroll dollar, even though the enrollees receive almost identical benefits.[5] The Federal Ministry of Health plans to provide subscribers with a greater choice among sickness funds and thereby anticipates it will narrow the range of payroll costs for its national health insurance plan.

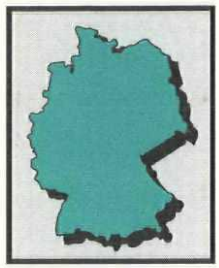
In implementing community-rated premiums, the German sickness funds will be allowed four adjustments to account for differences in the risk of the population covered by a specific plan: the individual sickness fund's payroll tax base, the number of insured dependents, the age distribution, and the sex composition. This reengineering should most assist the local statutory sickness funds, since many of them are responsible for insuring the nation's most expensive groups, including the elderly, the permanently disabled, and blue-collar workers.

By January 1, 1997, most Germans will be allowed to select their sickness fund each year. This freedom to choose a third-party payer should encourage development of preventive services, more efficient administration of benefits, and more competitive reimbursement negotiations between sickness plans and providers. Whether and how these community-rating concepts might reduce expenditures in Germany is a matter of conjecture. The Germans I interviewed, ranging from experts to ordinary citizens, expressed limited optimism that community-rated premiums would reduce total health expenditures because of the comprehensiveness of their existing mandated benefits, the limitations on reducing individual sickness funds' administrative expenses, and the reduced variation in employee-employer contribution rates after community-rated premiums are implemented.

An Intact System

Germany's 1993 health reforms were driven by a need for overall economic restructuring, a part of which entailed constraining the increasing cost of "social solidarity" benefits. In 1994 it is estimated that for every dollar expended for salaries, another 39 cents will be expended for retirement benefits, health and unemployment insurance, and other mandated coverage. For the young worker this is an increasingly important issue, particularly in light of estimates that by the year 2030 there will be more Germans drawing social security cash benefits than there will be workers in the active labor force.

The Germans claim their country is the most



costly worldwide in which to do business, and they—like the United States—are experiencing industrial restructuring from a manufacturing to a more service-based economy. Over and over again, Germans emphasized their commitment to maintain a responsible safety net of government-mandated health and social services, but they also wish to eliminate abuses and unnecessary expenditures.

Germany's reform efforts could lead U.S. conservatives to conclude that the country's quasi-private, quasi-public approach has failed and that it is now moving to a more procompetitive mode. This conclusion would be false. No one predicted that the nation's overall global budgetary caps on health expenditures would be lifted. The health system proposed by the federal parliament still retains the overall conceptual framework outlined by Bismarck more than 100 years ago.

A more accurate assessment of the 1993 German health reform plan is that, after maintaining its GDP for health at or below 8.8 percent for several decades, Germany must tinker at the micromanagement level to obtain additional operating efficiencies. Germany will continue to provide universal comprehensive benefits with global budgetary caps. The 1993 plan is more a readjustment of the traditional German multipayer system than a package of major health reforms as we now envision it in the United States. It has far narrower implications and impact on consumers and providers than the proposed Clinton administration health reform plan would have.

It is difficult to imagine, moreover, that any of the approaches now being discussed will in the foreseeable future place any major element of the German health system in serious financial peril. Germany's overutilization of physician and acute care services and overspending on pharmaceuticals present an obvious opportunity to cut costs without lowering quality of care. Another factor suggesting that the health system will continue to thrive is Germans' social solidarity. The Germans believe that universal comprehensive health benefits should be accessible to all citizens within the nation's global budgetary caps.

The option to purchase private health insurance coverage also adds flexibility to the German system. Roughly 10 percent of the population, who are of upper income, opt out of the mandated plan. Pluralism, self-governance, and decentralization are traditional, ingrained elements of the German health system, so the private insurance option will remain viable for the foreseeable future.

Many have suggested eliminating a benefit allowing persons to spend two weeks at a spa every other year. This coverage costs roughly 2 percent of the nation's health dollar, and it is estimated that the spa industry provides 1 million jobs to German workers. It is improbable that this benefit will be eliminated, since spa care is such as integral part of a century-old social insurance concept. In fact, it is hard to imagine that any currently mandated benefit will be removed, except for possibly drugs known to have limited therapeutic value. Nor will existing copayments, which are now minimal, be increased.

More likely German providers will be required, as in the United States, to deliver more care at lower reimbursement per unit of service. Thus cost constraints will have a major impact on physicians and hospitals both in Germany and in the United States during the coming decade. □

NOTES

1. George J. Schieber, Jean-Pierre Poullier, and Leslie M. Greenwald, "Health Spending, Delivery, and Outcomes in OECD Countries," *Health Affairs*, Summer 1993, pp. 120-129.
2. Lawrence H. Thompson, "1993 German Health Reforms: New Cost Control Initiatives," GAO/HRD-93-103, July 1993, p. 46.
3. Thompson, p. 4.

SINGLE PAYER VERSUS MULTIPAYER: A REAL ISSUE?

My comparative research has led me to conclude that selecting a single-payer rather than a multipayer system to constrain American health costs makes little political and substantive sense. Proponents of the Canadian model focus on its monolithic approach, but this country's ability to contain its health costs is based on the power of its provinces to impose global budgetary caps on their providers.

Americans often overlook the fact that Canada has the second most expensive health system in the world. In 1990 three countries with multipayer systems maintained their expenditures for health as a percentage of gross domestic product (GDP) below Canada's 9.5 percent (France at 8.8 percent of its GDP; Germany at 8.3 percent, and Japan at 6.7 percent). The central issues are how tight to set global budgetary caps and how to allocate available health resources.

Government mandates establishing total healthcare expenditures pose significant risks for any system, whether single payer or multipayer. A major argument against implementing global budgets in the United States is that doing so may place the entire health delivery system in financial peril. U.S. consumers and providers fear that public officials may fail to consistently pass legislation required to raise revenues enough to finance needed medical care services.