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GERMAN HEALTH REFORMS

Changes Result in Lower Health Costs in 1993





United States
General Accounting Office
Washington, D.C. 20548

**Health, Education, and
Human Services Division**

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December 16, 1994

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

Dear Mr. Chairman:

Compared with the United States, Germany has been successful in controlling the rate of growth of health care costs. Since 1980, it has kept its percentage of national wealth expended on health care between 8 and 9 percent of gross domestic product (GDP) while covering a broad range of health care services for virtually the entire population. In contrast, over the same period, U.S. health care costs have risen from 9.2 percent of GDP in 1980 to a projected 14 percent of GDP in 1994, while the portion of the U.S. nonelderly population not covered by insurance is now estimated to be 17 percent. In 1991, the annual cost per person for health care was \$1,659 in Germany compared with \$2,867 in the United States.

Despite this successful history of cost control, the German federal government became concerned during 1992 about growth in health care premium costs in the Statutory Health Insurance System, which covers the great majority of the German population. As a result of this concern, in December 1992 the German federal parliament enacted a health care reform law, the Health Care Structure Reform Act of 1993.¹

The reforms of this law consisted of two major parts. First, it imposed strict nonnegotiable budgets lasting up to 3 years on major sectors of the statutory system, including hospitals, ambulatory care physicians, prescription pharmaceuticals, and dentists. These budgets were intended to hold down expenditures while the details of the second part of the reform, a series of structural reforms intended to control expenditures over the longer term, were crafted and implemented over the remainder of the decade.

While our July 1993 report discussed the nature and intent of these changes,² this report covers the effects of the first year of strict budgets on cost and access to care and briefly discusses the status of some of the

¹The Gesundheitsstrukturgesetz (GSG).

²1993 German Health Reforms: New Cost Control Initiatives (GAO/HRD-93-103, July 7, 1993).

structural changes intended to allow the statutory system to control costs over the longer term.

Background

About 90 percent of the German population obtains its health insurance through one of the more than 900 Statutory Health Insurance Funds, usually called sickness funds.³ Virtually all working Germans with an income below a statutory threshold—Deutsche Mark (DM) 68,400 (about \$44,200) in 1994—are required to join one of these funds, and their nonworking spouses and dependents are also automatically covered.⁴ The sickness funds also cover most retirees and persons receiving unemployment or disability payments. Persons with incomes above the threshold may choose to remain in the statutory system, and many do.

The German Statutory Health Insurance System is mainly financed through an income-based premium, 50 percent paid by employers and 50 percent by employees, on wages up to the statutory threshold amount mentioned above. At the beginning of 1993, this premium, called a contribution, averaged 13.4 percent of wages up to the income threshold in former West Germany. However, this contribution rate can vary across sickness funds, depending on the income and demographic structure of the fund's membership. In 1993, contribution rates varied from 8.5 percent to 16.5 percent.

Contribution Rate Increase Triggered 1993 Reforms

Between July 1991 and the end of 1992, the average contribution rate of the statutory sickness funds rose from 12.2 percent to 13.4 percent. Alarmed by the size and speed of this increase, all the major political parties in Germany agreed that action to control health care spending was needed. The result was the Health Care Structure Reform Act of 1993. This act imposed strict budgets beginning January 1, 1993, for periods of up to 3 years on the major sectors of the statutory health insurance system, including hospitals, ambulatory care physicians, prescription pharmaceuticals, and dentists.

These budgets were designed to stabilize the contribution rate by restricting the rate of increase in spending to the rate of increase in the total amount of workers' wages subject to the contribution. Spending

³For a description of the various types of sickness fund, see 1993 German Health Reforms, page 3, table 1. The total number of sickness funds has declined in the past year.

⁴Throughout this report, when converting Deutsche Marks to dollars, we use the exchange rate of Thursday, September 22, 1994, of DM 1 = \$0.6466.

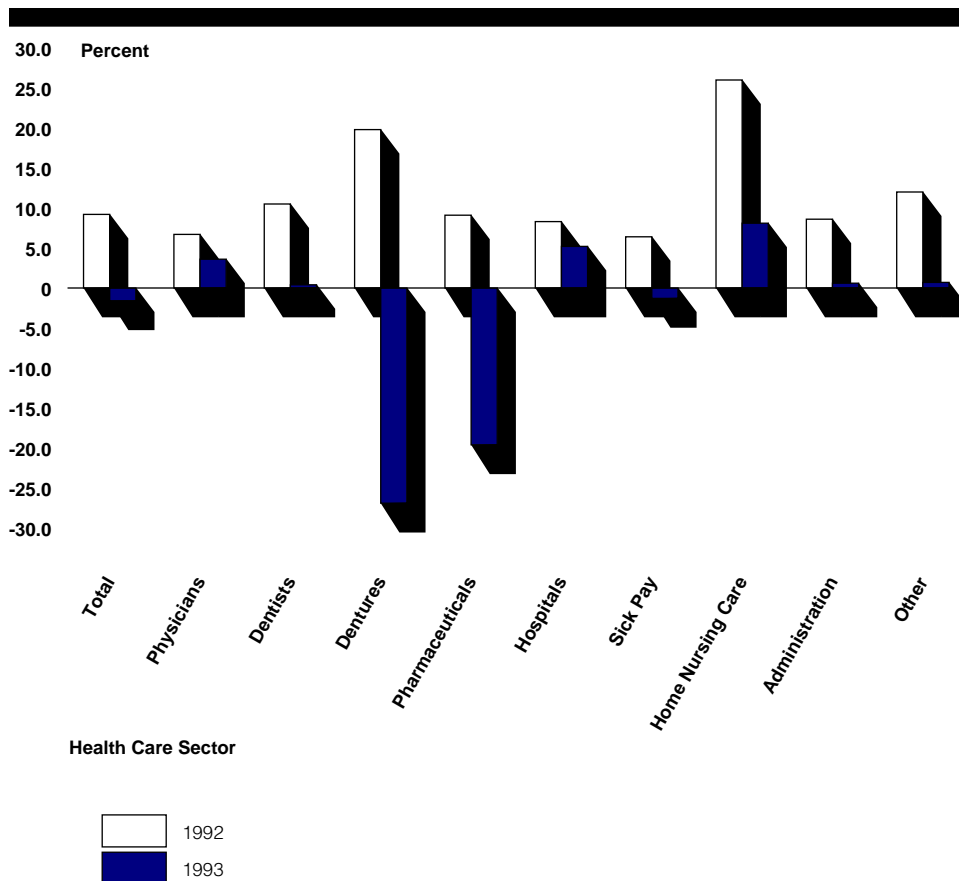
increases in each sector are subject to this restriction. If successful, this would have the effect of stabilizing the contribution rate at its current level. If any sector exceeds its budget, its payment rates may be reduced during the next year to recoup the excess spending.

The Health Care Structure Reform Act also provided for a series of major structural reforms to be implemented over the remainder of the decade and intended to build cost control structures and incentives into the Statutory Health Insurance System. Some of these changes are discussed in appendix I.

Results in Brief

During 1993, the strict budgets imposed on most sectors of the German Statutory Health Insurance System were generally successful in controlling the growth of health care costs. Outlays per member fell by more than 1 percent from 1992 levels, although the budgets permitted small increases for wage growth. As shown in figure 1, rates of growth fell significantly from 1992 levels in all major sectors of the system. The most spectacular declines were registered in the categories of dentures, in which spending per member fell by almost 27 percent, and pharmaceuticals, where spending per member fell by nearly 20 percent.

Figure 1: Rate of Growth Per Member in the Statutory Health Insurance System



Source: The German Federal Ministry of Health.

The negative growth rate had enabled the contribution rate for the Statutory Health Insurance System to decline slightly from about 13.40 percent at the beginning of 1993 to 13.25 percent in April 1994. Sustaining this degree of cost constraint seems unlikely. According to one expert, the reduction in spending on dentures and pharmaceuticals was a one-time event, and expenditure growth could be expected to resume in 1994.

There was little evidence that these reductions in the rate of cost growth caused a significant decline in access to appropriate care during 1993. Although there were fears that the sharp decline in pharmaceutical

expenditures meant that some patients were not receiving needed pharmaceuticals, there was little evidence that this had occurred (see pp. 8 to 10).

Although some feared that ambulatory care physicians would attempt to shift potentially costly patients from the physician budget to the hospital budget by unnecessarily admitting them to hospitals, the German government could find no evidence that this occurred to any significant extent. Because hospitals were individually budgeted, others feared that some community hospitals would unnecessarily transfer costly patients to tertiary care hospitals so that they would be on the latter's budget. This may have occurred to some extent.

The budgets are intended as temporary measures to control costs while structural reforms designed to hold down costs in major sectors of the statutory system are worked out and implemented.

Scope and Methodology

We interviewed officials of the German Ministry of Health and key German health experts, obtained relevant health care spending data, and reviewed English and German language literature on the results of the first year of implementation of strict sector budgets and on progress toward implementation of structural changes mandated by the German Health Care Structure Reform Act of 1993. This review also incorporates information from our 1993 review of German health care reforms and from current and past work using other international studies.

Although the German Statutory Health Insurance System covers unified Germany, this report, like our 1993 report, focuses on the results of changes in the former West Germany because it provides a better basis for comparison with the United States and with earlier conditions in Germany.⁵ We conducted this review between June 1993 and June 1994 in accordance with generally accepted government auditing standards.

Strict Budgets Restrained Cost Growth in 1993

During 1993, strict budgets for each health care sector initiated under the Health Care Structure Reform Act restrained growth in expenditures and stabilized the contribution rate in the Statutory Health Insurance System. Table 1 shows that the 1993 rate of growth in all major sectors declined sharply compared with the previous year in former West Germany. Total

⁵The German government keeps separate health care statistics for former Eastern and Western Germany for the Statutory Health Care System.

expenditures in the system in former West Germany declined slightly in 1993.

The major percentage decreases in outlays were in pharmaceuticals and dentures, which declined 19.6 and 26.9 percent, respectively. However, even if pharmaceuticals and dentures are removed, outlays per member of the Statutory Health Care System rose only about 3 percent, easily meeting the Health Care Structure Reform Act's goal of restraining growth to the rate of growth of income of members of the system subject to the contribution rate.

Table 1: Rate of Change Per Member^a in Outlays by Health Care Sector and Wages Subject to the Contribution (Former West Germany Only)

Sector	Rate of Change	
	1993	1992
Physicians	3.6	6.7
Dentists	0.4	10.5
Dentures	-26.9	19.8
Pharmaceuticals	-19.6	9.1
Remedies and aids	2.2	9.8
Hospitals	5.2	8.3
Sick pay	-1.3	6.4
Home nursing care	8.1	26.0
Administration	0.6	8.6
Other	0.7	12.0
Total	-1.6	9.2
Percentage increase in wages subject to the contribution	3.7	5.3

^aWorkers excluding dependents. However, expenses are for all insured persons.

Source: The German Ministry of Health.

From a 1992 deficit of DM 9.1 billion (about \$5.9 billion) in the area of former West Germany, the Statutory Health Insurance System showed a DM 9.1 billion surplus in 1993.

Contribution rates have stabilized and even declined slightly. From a high of 13.42 percent on January 1, 1993, the average general contribution rate for the system had fallen to 13.25 percent by April 1, 1994.

Pharmaceuticals and Dentures

The largest rates of decrease in expenditures were seen in the sectors of pharmaceuticals and dentures, which had negative growth rates of 19.6

and 26.9 percent, respectively. Of these two, by far the largest absolute decrease was in pharmaceuticals. Pharmaceutical outlays fell from DM 27.1 billion in 1992 to DM 21.9 billion in 1993, an absolute decrease of DM 5.2 billion (about \$3.4 billion).

Several factors contributed to this startling decrease in outlays for pharmaceuticals. First, about 15 percent of the decrease represents a shifting of drug costs to consumers in the form of co-payments for prescription pharmaceuticals. The Ministry of Health ascribes an additional 20 percent of savings to a combination of three factors: the effects of the reference price system for pharmaceuticals, created by the Health Care Reform Act of 1989;⁶ a 5-percent reduction in the price of prescription pharmaceuticals not under the reference price system mandated by the 1993 act; and a mandated 2-percent reduction in the price of over-the-counter pharmaceuticals also mandated by the 1993 act.

The Ministry of Health ascribes the remainder of the decrease—about DM 3 billion—to changes in the behavior of physicians towards prescribing drugs. These changes include

- a decrease in the number of prescriptions;
- increased prescribing of less costly but qualitatively similar pharmaceuticals, including generic drugs and pharmaceuticals with prices under the reference price; and
- reduced prescribing of certain categories of pharmaceuticals, including drugs considered by the Germans to be excessively or inappropriately prescribed, such as vitamins, mineral preparations, and vascularity improving drugs.

Statutory system outlays for dentures fell from DM 6.8 to DM 5.0 billion, about DM 1.8 billion (\$1.2 billion). This decrease was all the more remarkable in that there was no fixed budget for dentures themselves, although there was a budget for general dental services, including the prescribing and fitting of dental prostheses.

Little Evidence of Impaired Access to Appropriate Care

Despite the introduction of stringent budgeting in most major sectors of the German Statutory Health Insurance System, access of patients to appropriate care was not impaired. In particular, fears had been raised that

⁶Under the reference price system, a maximum reimbursement level is set for each drug. If the price of the drug is higher than the reference price, the patient must pay the difference.

- physicians might not prescribe needed pharmaceuticals to their patients;
- physicians might seek to hospitalize costly patients to transfer these costs to the hospital's budget rather than treat them on the outpatient budget where they might affect future payments; and
- hospitals might transfer (dump) costly patients to other hospitals, usually tertiary care hospitals, to move these costs from the transferring hospital's budget to the receiving hospital's budget, which is usually higher.

Pharmaceutical Prescribing Patterns

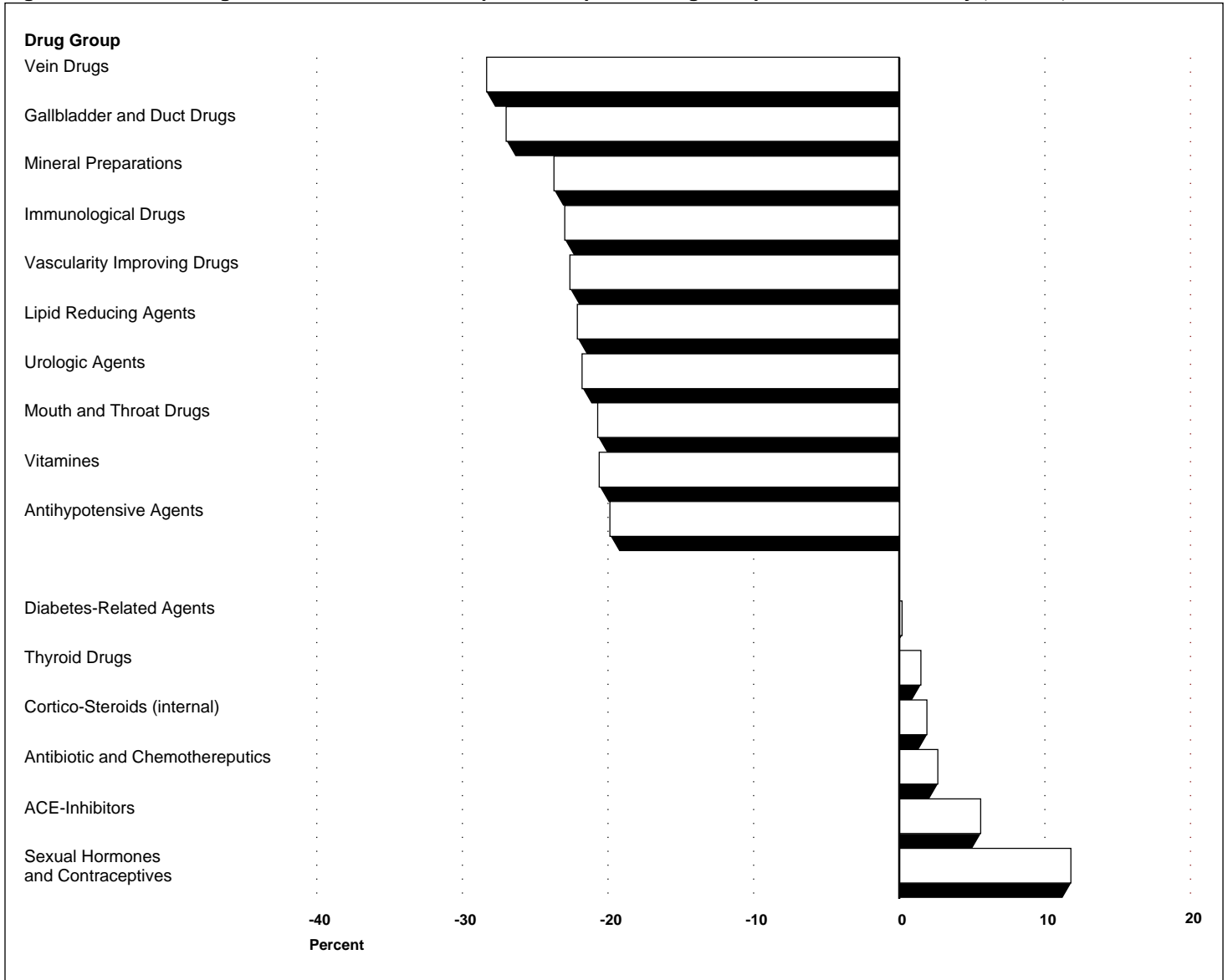
Statistics on prescribing patterns of German physicians suggest that fears that physicians would not prescribe needed drugs to patients did not materialize. According to the German Ministry of Health, preliminary prescription statistics suggest that physicians responded to the budgetary constraints in part by prescribing less expensive but qualitatively similar generic drugs instead of brand-name pharmaceuticals and by decreasing prescribing of pharmaceuticals in categories where some drugs are considered by the Germans to be of questionable therapeutic effectiveness or frequently inappropriately prescribed.⁷

As shown in figure 2, the number of prescriptions in several pharmaceutical groups, including vein drugs, gallbladder and duct drugs, immunological drugs, vascularity improving drugs, urologic agents, mouth and throat drugs, and antihypertensive agents, declined 20 percent or more. Most of these categories contain a relatively high percentage of doubtful or inappropriately prescribed preparations. In contrast, the number of prescriptions for some pharmaceutical groups containing a high percentage of drugs considered to be both therapeutically effective and usually appropriately prescribed, such as diabetes-related drugs, antibiotics, and angiotensin converting enzyme-inhibitors, remained stable or increased slightly in 1993.

⁷According to a German drug expert, such pharmaceuticals, called *therapeutisches umstrittenes Arzneimittel* (therapeutically questionable drugs), fall into several categories; first, pharmaceuticals prescribed for a condition that may not warrant it. An example would be a person with moderately high cholesterol prescribed a lipid-lowering agent without first trying to control the condition through diet. Also falling into this first category are mineral preparations and vitamins prescribed absent some specific condition, such as pregnancy or osteoporosis, which would justify them. Finally, the antihypertensive drugs fall into this category. Many of these drugs are used to treat asymptomatic low blood pressure. A German pharmaceutical expert told us that this usually would not be considered a disease outside Germany.

The second category includes pharmaceuticals not shown to be effective for the conditions for which they are prescribed. Some vein and vascularity improving preparations fall into this category. It should be noted that not all pharmaceuticals in the groups fall into these questionable categories.

Figure 2: Rate of Change in the Number of Prescriptions in Specific Drug Groups for Unified Germany (1992-93)



Note: This chart does not include all recognized German drug groups. Rather, it includes drug groups at the extremes of the distribution for comparison purposes.

Source: Schwabe and Paffrath, eds., Arzneimittel-Report '94 (Gustav Fisher Verlag, Stuttgart, 1994), p. 5.

These statistics do not support the view that the global budget for pharmaceuticals caused widespread problems of patient access to appropriate drugs in Germany in 1993. Independent experts and Health Ministry officials with whom we spoke in Germany generally agreed that the pharmaceutical budget had not caused significant access problems in 1993. Experts from the Research Institute of the Local Sickness Funds said that the pharmaceutical budget can be credited with improving quality of care because the amount of inappropriately prescribed pharmaceuticals has decreased.

However, one physician pointed out that long-term quality effects may eventually become apparent. For example, the decline in prescription of lipid-lowering drugs might simply reflect past overuse of this class of pharmaceuticals or might result in future increases in the incidence of heart attacks and strokes.

Hospital Admission Patterns

Hospital admission patterns suggest that the fears that physicians and hospitals would unnecessarily hospitalize or transfer costly patients did not materialize. The Ministry of Health found no statistical evidence that would support these allegations, such as significant increases in the numbers of hospitalizations or of transfers among hospitals. Furthermore, even when allegations of patient dumping were investigated, few cases could be confirmed.

The Ministry noted that in Bavaria, for example, the number of cases in the university clinics, tertiary care hospitals that often receive transferred patients from lower-level hospitals, fell about 2 percent, while cases in hospitals offering only basic care rose about 2 percent, and cases in hospitals offering intermediate levels of care rose 3 percent. Also, the Ministry found that in the state of Rhineland-Palatinate there were 215,000 fewer billable bed days than had been budgeted for in 1993. Furthermore, when surveyed by the Hesse Association of Sickness Fund Physicians, 82 percent of hospital-based physicians in that state responded that they had observed “no admissions or transfers because of cost,” and 17 percent responded that they “very seldom observed such transfers.”

According to the Ministry of Health, many university clinics did not reach their budgeted level of bed days. For example, the Bonn University Clinic was some 27,000 bed days and the Münster university clinic about 7,000 bed days below budgeted levels. This means that both clinics will receive more payments per patient than they otherwise would have during 1994

because under the fixed budget, if hospitals do not bill up to their budget, they are paid the difference between their billed amounts and their budgeted amounts during the following year.

While most experts we talked to agreed that unnecessary referrals to hospitals by ambulatory care physicians had not been a significant problem, some believed that transfers of costly patients among hospitals had occurred but the extent was not yet known.

Bed Closures in Münster

One potential reaction of hospitals to the fixed budgets would be to eliminate types of services, especially those serving costly patients. The only reported case of such closures was at the Münster University Clinic, a tertiary care center, which closed some acquired immunodeficiency syndrome (AIDS) and pediatric oncology beds. The clinic management stated that because of a rise in the number of cases in these areas the clinic's budget was too low.

The German Federal Ministry of Health was critical of this decision to close beds because the Münster clinic ended the year with fewer bed days than they were budgeted for. A representative of the Local Sickness Funds told us that the AIDS and pediatric oncology patients were probably admitted despite the closed beds but into other departments. She viewed this episode as an attempt on the part of the clinic to obtain additional money from the sickness funds.

Will German Reforms Control Cost Growth in 1994?

Data available at the time of our work were too scant to permit any firm predictions regarding the future success of the budgets and reforms in controlling cost growth in 1994 and future years. But the second year of imposed budgets will not likely be as dramatically successful in controlling costs as the first. Rates of decrease in expenditures experienced by pharmaceuticals and dentures are probably unsustainable at the 1993 rates.

One expert told us that the cost of pharmaceuticals and dentures had also fallen dramatically in response to earlier cost control efforts, and had resumed their rate of growth in 1994. Also, some of the 1993 decrease in expenditures may have been due to increased spending on pharmaceuticals and dentures in December 1992 in anticipation of implementation of the Health Care Structure Reform Act. Moreover, since pharmaceutical expenditures for 1993 were well under the budget limits, the disincentive for drug prescribing by physicians is less threatening and

may not have as constraining an effect on physicians. In addition, few of the structural reforms intended for long-term cost control are yet in place, and those that are have not had time to exert much effect.

German government data from the first quarter of 1994 suggest that the reforms were still controlling cost growth at that time. Although spending for dentures, and to a lesser degree pharmaceuticals, was well above levels for the first quarter of 1993, overall spending was only 5 percent above 1993 levels. Furthermore, comparison with the first quarter of 1993 may be somewhat misleading because spending in that quarter was depressed due to anticipation of the effects of the Health Care Structure Reform Act. Compared with the first quarter of 1992, 2 years previously, first quarter spending was up only about 4 percent, and it was down about 3 percent from the last quarter of 1993, the quarter immediately previous. However, these data are inadequate to permit drawing conclusions for 1994.

Long-Term Cost Control Through Structural Reforms

The Health Care Reform Act of 1993 set up the temporary global budgets to control health care expenditures while structural reforms intended to control costs over the longer term could be worked out and put into place. The act contains structural reform measures for most sectors of the German Statutory Health Care System. These reform measures include

- risk-adjustment among the sickness funds;
- broadened choice of sickness fund for members of the statutory system;
- lowering barriers between the ambulatory and inpatient sectors of the health care system;
- a complete restructuring of the inpatient hospital reimbursement system; and
- a system for auditing physicians' pharmaceutical prescribing practices.

Some of these reforms are yet to be implemented. Others have not been in place long enough to have a significant impact. These reforms are discussed in detail in appendix I.

We plan to send copies of this report to the appropriate congressional committees and interested parties. We also will make copies available to others on request.

This report was prepared under the direction of Mark V. Nadel, Associate Director, and Michael Gutowski, Assistant Director, Health Financing and Policy Issues. If you or your staff have any questions about this report, please contact me at (202) 512-7115. Other major contributors to this report are listed in appendix III.

Sincerely yours,

A handwritten signature in black ink that reads "Sarah F. Jaggar". The signature is written in a cursive style with a long, sweeping underline that extends to the left.

Sarah F. Jaggar
Director, Health Financing
and Policy Issues

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Abbreviations

AIDS	acquired immunodeficiency syndrome
DM	Deutsche Mark
DRG	diagnosis related group
GDP	gross domestic product
GSG	Gesundheitsstrukturgesetz
PMC	patient management category

Major Structural Reforms

The Health Care Structure Reform Act of 1993 contains a series of reform measures intended to control costs in most major sectors of the health care system that will be implemented over the remainder of the decade. The current status of selected reforms, primarily those that have been or will soon be implemented, are discussed below.

Risk-Structure Equalization and Freedom of Choice

On January 1, 1993, the German Statutory Health Insurance System implemented the first phase of the so-called risk-structure equalization. This risk-adjustment process is intended to compensate for the differing demographic and income compositions of sickness funds, and so reduce the wide differences among the contribution rates of the funds. This is being done partly to increase equity among the funds and partly as a necessary preparation for the extension of the right of blue-collar workers to choose among sickness funds, due to become effective January 1, 1997.

The German risk-adjustment process is somewhat different from others because it includes an adjustment for sickness fund income as well as for risk of health care expenditures. This is both possible and necessary because of Germany's income-based premium structure.⁸ If a sickness fund has a disproportionate percentage of low-income members, its income will be low (or its contribution rate high) relative to a fund with a large percentage of high-income members.

The adjustment on the expenditure side is relatively simple, covering only age and sex. In this adjustment process, all persons insured by the sickness fund (including co-insured family members, but excluding pensioners for the time being) were divided into 1-year groups by age and sex. A national average expenditure amount for each year and sex group was computed. For example, the average expenditure was computed for 20-year-old females and 60-year-old males. These amounts were then multiplied by the number of persons in each group in each sickness fund and added together to obtain the risk-adjusted financial requirements for each sickness fund. The same calculation was done to develop the risk-adjusted financial requirement for all sickness funds.

On the income side, the total income subject to the contribution rate was determined for each sickness fund and for all sickness funds together. The ratio between the risk-adjusted financial requirements and the total income subject to the contribution rate of all sickness funds together

⁸Risk adjustment in insurance programs that utilize flat rate or risk-adjusted premiums, as is customary in the United States, need only adjust for health risk factors in the insured population because the insurers' incomes are unrelated to the incomes of the insured.

constitutes the uniform equalization rate. The same ratio is then calculated for each sickness fund individually, and compared with the uniform equalization rate. If the fund's equalization rate is lower than the uniform equalization rate, it must pay into the equalization fund. If higher, it receives payment from the fund.

It is too early to tell how effective the system will be in reducing the variation in contribution rates among sickness funds. However, a ministry official noted that after 4 months experience, the range of contribution rates had declined from between about 8 percent and 16 percent to between 9 percent and less than 15 percent. He noted that the intention of this reform was not to make all price differences among the funds disappear. While Germany does not want the funds to compete by excluding sick persons from coverage, he said that the government does want some price competition to force the sickness funds to become more efficient.

Hospital Reforms

The German Health Care Structure Reform Act contains two important structural changes for hospitals. First, it partially lowered the barrier between ambulatory care and hospital physicians by permitting the latter to perform ambulatory surgery and to care for patients for short periods before and after inpatient admissions. Second, it provided for a major reform of hospital reimbursement for inpatient services to be fully implemented by 1996. These are long-term structural reforms intended to give hospitals incentives to reduce lengths of stay and operate more efficiently.

Lowering Barriers

The German health care system has long had a barrier between inpatient hospital care and ambulatory care. For the most part, hospital physicians have not been allowed to see ambulatory patients, and ambulatory physicians have not been allowed to practice in hospitals. This has created some perverse incentives for hospitals. Hospital physicians often had to admit patients early because they could not have medical tests done on an outpatient basis and keep their patients in hospital longer than necessary to oversee their recovery. In addition, patients who would be treated as outpatients in the United States were often admitted to the hospital in Germany because the hospital physicians were not allowed to treat them on an outpatient basis. The Health Care Structure Reform Act began to break down this barrier between the inpatient and ambulatory sectors.

Ambulatory Surgery

The act permits hospitals to open ambulatory surgery departments. The government expects this change to reduce the amount of unnecessary inpatient care and improve cooperation between the ambulatory and hospital sectors, for example, with ambulatory care surgeons using hospital surgical facilities.

Despite an implementation agreement of March 22, 1993, among the sickness fund associations, the German Hospital Association, and the Association of Sickness Fund Physicians, the provisions of the Health Care Structure Reform Act of 1993 for ambulatory surgery in hospitals remained largely unused. Thus, these provisions had little effect on German hospital costs in 1993.

According to the hospitals, the major reason for the lack of implementation of this agreement is that any income will be counted against the fixed hospital budget. In addition, they feared that increased provision of ambulatory surgery would lead to reduction in the fixed budget because of decreased need for inpatient care resources.

New hospital payment regulations, which the hospitals will have to adopt by 1996, provide that the income from ambulatory surgery will no longer be included in the hospital budget. Rather, the ambulatory surgery area will form an independent income source for the hospitals. The Ministry of Health believes that this change will encourage the hospitals to realize the possibilities for cost reduction related to ambulatory surgery.

Preadmission and
Postdischarge Care

Previously, for the most part, hospital physicians could not see patients before admission or after discharge. This frequently led to early admissions for tests and to retaining patients in the hospital after they could be safely discharged so that hospital physicians could oversee their convalescence. The Health Care Structure Reform Act of 1993 set out to change this pattern by permitting hospital-based physicians to see patients for as many as 3 days within the 5-day period before an admission and up to 7 days within a 14-day period after discharge. The act specified that reimbursement was to be agreed upon between the hospitals and the sickness funds on the state level. The government expected that this change would shorten length of stay and, thus, increase the efficiency and lower the costs of hospitals.

The National Associations of Sickness Funds and the German Hospital Association developed an advisory agreement on reimbursement, which was made retroactive to July 1, 1993. Under this agreement, preadmission

care would be paid a lump sum amount of 1.8 times the hospital's general daily rate. Postdischarge care would be reimbursed at a rate of 0.6 times the general daily rate per visit. However, these amounts would be payable only if the services were not already covered by other payments to the hospital.

Despite this agreement, Ministry and other experts we talked to said that hospitals had not adopted this preadmission and postdischarge care to a significant extent. They generally agreed that the hospitals did not have a sufficient incentive to change their long-standing practices.

Hospital Payment Reforms

Under the Health Care Structure Reform Act, the predominant existing German hospital reimbursement system of a single negotiated daily rate for each hospital, supplemented by special payments for a few categories of costly procedures, will be replaced by a system comprising three types of payment. First, approximately 60 procedures (as of Jan. 1, 1995) will be paid using a prospective case payment system similar to the U.S. Medicare diagnosis related group (DRG) payment system. Payment for these 60 procedures will cover all hospital care.

Second, another approximately 155 procedures (also as of Jan. 1, 1995) will be paid using a system of special payments.⁹ Under this type of payment, the principal medical services for the admission will be paid by a prospectively fixed lump-sum amount. Other costs, such as administrative overhead and room and board, will be covered by the hospital-specific basic daily rate and a reduced departmental daily rate, both discussed below.

All other types of cases will be reimbursed by a combination of two hospital-specific daily rates. Medical costs will be covered by a departmental daily rate, which will vary depending on the medical department that admits the patient. That is, a cardiac patient may be reimbursed by a daily rate different from that of a general internal medicine patient. Nonmedical services, including food and housekeeping, will be reimbursed by a basic daily rate common to all departments.

Reimbursement rates for both case payments and special payments will be set using a combination of national relative value scales and conversion factors negotiated on a statewide basis. Thus, all hospitals in a German

⁹This system of special payments—Sonderentgelte—has been in use for some time in some hospitals for a few high-cost procedures.

state will receive the same prospective lump sum payment for a given procedure under these two types of payment.¹⁰ If the costs for the services covered by the payment type are lower than the payment rate, they may keep the difference. If higher, they are at risk.

One group of experts told us that the method of determining the special payment rates resulted in more generous rates than that for the case payment system. They noted that over time it is expected that the rates will be made consistent.

German hospitals have the option of choosing to be reimbursed under the new system beginning January 1, 1995. All hospitals must be reimbursed using this system beginning January 1, 1996. Hospitals choosing the new reimbursement system for 1995 will be released from the strict budget limits of the Health Care Structure Reform Act.

The Ministry of Health expects that this new reimbursement system will give hospitals effective incentives for improved efficiency and for reducing lengths of stay. However, health care experts at the Research Institute of the Local Sickness Funds (Wissenschaftliches Institut der Allgemeine Ortskrankenkassen) believe that the case payments were set too high because of problems with data on length of stay. They believe that correcting for the length-of-stay problem would save about DM 450 million annually.

The New German Case Payment System

The new German case payment system is conceptually similar to the prospective payment system used for most U.S. Medicare hospital payments. However, the categories used to separate patients into payment classes in the German System are not DRGs, as in the U.S. Medicare system, but patient management categories (PMC). This system was developed during the early 1980s by Wanda Young of the Pittsburgh Research Institute, the research institute of Blue Cross of Western Pennsylvania.

In contrast to DRGs, which are mainly defined in terms of principal diagnosis and procedure, each PMC has an associated patient management path, which is the expected clinical strategy, defined in terms of a bundle of related tests, procedures, and other interventions, that physicians typically utilize to diagnose and treat that type of case. The Germans used this bundle of related services associated with each PMC to develop related

¹⁰In a few cases, the same procedure is payable under both the case payment and special payment systems. In these cases, the special payment, of course, is lower. We were told that in these cases, the special payment amount would only be used to cover treatment for a secondary diagnosis.

cost weights for each PMC corresponding to the 60 procedures initially to be covered by the full case payment system.

The PMC system also differs from DRGs in two other important respects. First, PMCs are tightly defined around a specific illness, whereas DRGs group patients whose treatments are expected to consume similar levels of hospital resources. As a result, the number of PMCs is nearly twice as large as the number of DRGs (848 vs. 494). Second, the PMC system permits assigning more than one PMC to a patient, based on unrelated comorbid conditions. The DRG system, in contrast, permits assignment of a patient to only one DRG.¹¹ These two differences may permit the PMC system to better adjust for severity of illness than the DRG system. On the other hand, one group of experts with whom we spoke indicated that they believed that PMCs are easier for providers to manipulate to maximize reimbursement than are DRGs.

Experts told us that the ultimate intent of the German government is to bring most hospital inpatient care under the case payment system. However, they indicated that further implementation of the system would probably not take place until Germany had some experience with the new system.

Pharmaceutical Reforms

The Health Care Structure Reform Act provided that the fixed budget for pharmaceuticals would be lifted in 1994 and 1995 if the sickness funds and physicians agreed on a system of auditing physicians' prescribing practices on the basis of pharmaceutical guidelines. Physicians who exceeded the guidelines by more than 15 percent were to be audited, while payments to physicians exceeding the guidelines by more than 25 percent were to be automatically reduced.

However, this system has not yet been implemented, at least in part because the sickness funds and the Associations of Pharmacists could not agree on prescription reporting requirements necessary for setting and administering the guidelines. Thus, the strict global pharmaceutical budget remains in effect for 1994 and possibly beyond.

Meanwhile, the Federal Association of Sickness Fund Physicians and the National Associations of Sickness Funds have reached an advisory agreement that the total 1994 outlays for pharmaceuticals, dressings, and

¹¹A number of DRGs are specifically designed for patients with comorbid conditions. However, they only exceptionally provide additional payments specifically for treatment provided for these comorbid conditions.

Appendix I
Major Structural Reforms

remedies in former West Germany should be set at about DM 27.7 billion (\$14.9 billion), which corresponds to the sum of these budgets for 1993.

Outlays of the German Statutory Health Insurance System (1989-93)

Table II.1: Outlays by Sector (1989-93)

DM in billions					
Sector	Year (no. of members, in thousands ^a)				
	1989 (37,229)	1990 (37,939)	1991 (38,704)	1992 (39,246)	1993 (39,459)
Physicians	DM 22.7	DM 24.4	DM 26.7	DM 28.9	DM 30.1
Dentists	7.6	8.2	9.1	10.2	10.3
Dentures	4.9	4.8	5.6	6.8	5.0
Pharmaceuticals	20.2	21.8	24.5	27.1	21.9
Remedies and aids	7.8	8.4	9.7	10.8	11.1
Hospitals	40.8	44.6	49.1	53.9	57.0
Sick pay	7.8	9.8	11.4	12.3	12.2
Home nursing care	•	•	1.8	2.3	2.5
Administration	6.6	7.3	7.9	8.7	8.8
Other	11.5	12.4	14.0	15.9	16.1
Total	DM 129.9	DM 141.7	DM 159.8	DM 176.9	DM 175.0

^aExcludes co-insured family members.

Source: The German Federal Ministry of Health.

Table II.2: Outlays Per Member (1989-93)

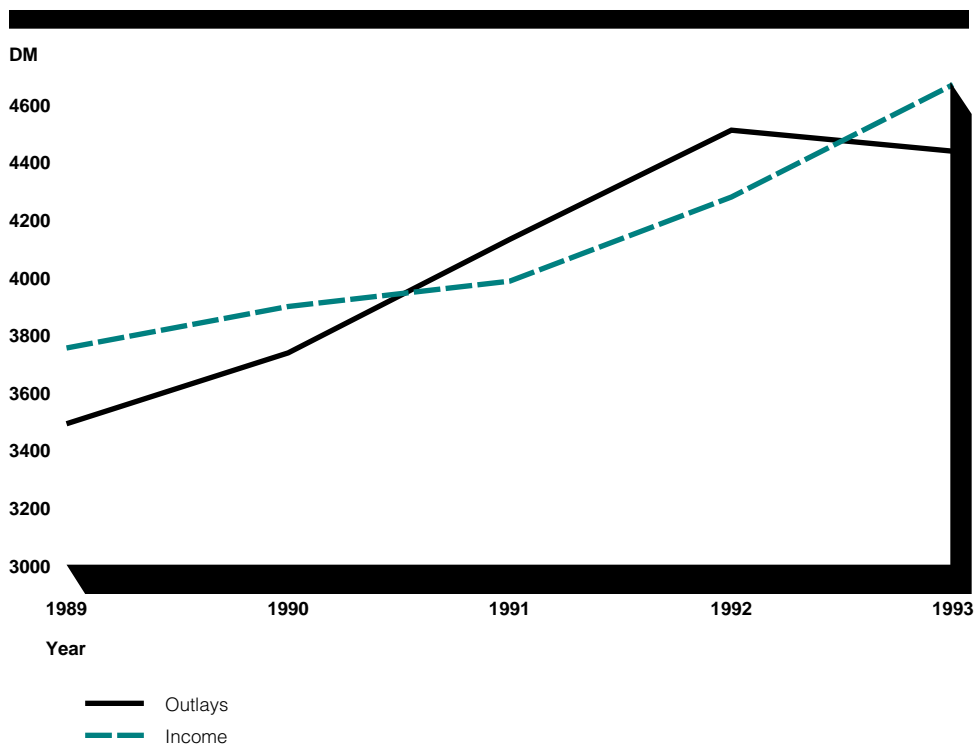
In DM					
Sector	Year (no. of members, in thousands ^a)				
	1989 (37,229)	1990 (37,939)	1991 (38,704)	1992 (39,246)	1993 (39,459)
Dentists	DM 204	DM 216	DM 235	DM 260	DM 261
Dentures	132	127	145	173	127
Pharmaceuticals	543	575	633	691	555
Remedies and aids	210	221	251	275	281
Hospitals	1,096	1,176	1,269	1,373	1,445
Sick pay	210	258	295	313	309
Home nursing care	•	•	47	59	63
Administration	177	192	204	222	223
Other	309	327	362	405	408
Average per member	DM 3,489	DM 3,735	DM 4,129	DM 4,508	DM 4,435

^aExcludes co-insured family members.

Source: The German Federal Ministry of Health.

Appendix II
Outlays of the German Statutory Health
Insurance System (1989-93)

Figure II.1: Income and Outlays Per Member (1989-93)



Source: The German Federal Ministry of Health.

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