Financial development and outlook of the statutory health insurance scheme

The health service in Germany represents an important – and fast-growing – part of the national economy. The range of health benefits are largely financed via the statutory health insurance scheme by wage-related contributions from members. The financial development of the statutory health insurance scheme and the resultant changes in the contribution rates have a significant impact on the overall economy.

Despite a considerable rise in the average contribution rate, the statutory health insurance scheme has recorded substantial deficits in the past few years. This development prompted the latest reform of the health service, the aim of which is to help lower the accumulated debt and noticeably reduce the contribution rates in the next few years. Nevertheless, in the longer term this reform will be unable to prevent a further increase in contribution rates, particularly in the light of demographic changes and the cost-boosting effects of advances in medical technology. In considering the additional reforms which are consequently required, key requirements are to limit the levy burden on labour, to separate income redistribution aspects from the equivalence principle and to intensify competition.

Current situation of the statutory health insurance scheme

Persistent deficits despite rising contribution rates

Between 2001 and 2003 the statutory health insurance scheme recorded persistent deficits amounting to between €3 billion and €3½ billion each year even though the average contribution rate was concurrently raised from 13.6% to 14.3%. Given the acute financial problems and the looming danger of a further rise in contribution rates, legislative measures were taken immediately following the German parliamentary elections of 2002 to improve the financial situation in the short term. During 2003 the government coalition parties and the opposition parties CDU/CSU in the Bundestag then jointly adopted the Act modernising the statutory health insurance scheme, which entered into force on 1 January 2004. Besides measures aimed at improving revenue, this notably included moves to limit spending (including raising patient co-payments) but also the outsourcing of individual health benefits. However, no attempt was made to radically reorganise competition among health insurance institutions and health service providers or to fundamentally redesign the financing system.

Second largest social security scheme

With an expenditure volume in 2003 of €145 billion or almost 7% of GDP, the statutory health insurance scheme is the second largest component of the German social security system after the statutory pension insurance scheme. The contribution rate currently averages 14.2% compared with 19.5% for the statutory pension insurance scheme, 6.5% for the Federal Employment Agency and 1.7% for the long-term care insurance scheme.

Special features of the statutory health insurance scheme

The statutory health insurance scheme (like the long-term care insurance scheme) differs considerably from the other social security schemes. The scheme, which provides a comprehensive array of healthcare services and plays an important role in the overall economy, is extensively regulated. Whereas the equivalence principle (ie the broad matching of contributions with corresponding benefits) is of particular importance in the statutory pension and unemployment insurance schemes, this is not the case for the statutory health insurance scheme. Even though, as in the other social security schemes, contributions are proportionate to income up to the defined contribution ceiling, all benefits apart from sickness benefit are non-income related. However, the associated interpersonal redistribution of income is curbed by the far lower contribution ceiling compared with the other schemes and the possibility for high-income earners to switch to private health insurance institutions.[1] Furthermore, the statutory health insurance scheme is characterised by a large number of individual health insurance institutions[2] with differing contribution rates and largely identical benefits; the competition

1 In 2004 the maximum level of income subject to contributions to the statutory health and long-term care insurance schemes is €3,487.50 per month (in both western and eastern Germany). The contribution ceiling for the statutory pension and unemployment insurance schemes amounts to €5,150 in western Germany and €4,350 in eastern Germany. The income threshold from which it is possible to opt out of compulsory membership of the statutory health and long-term care insurance schemes is €3,862.50.

2 At the end of 2003 some 322 health insurance institutions were registered. Owing to mergers, this figure is declining.

among institutions is primarily influenced by risk structure compensation arrangements designed to minimise the incentive to adopt a risk selection policy.

Obligation to achieve balanced budget

Each health insurance institution is obliged to set its contribution rate for the year at a level ensuring that projected revenue will sufficiently cover anticipated expenditure and – where necessary – replenish its reserves.[3] If in the course of implementing the budget it becomes clear that there will not be sufficient revenue, the contribution rate has to be raised during the year. There is no provision for debt financing.

Additional sources of finance for healthcare services

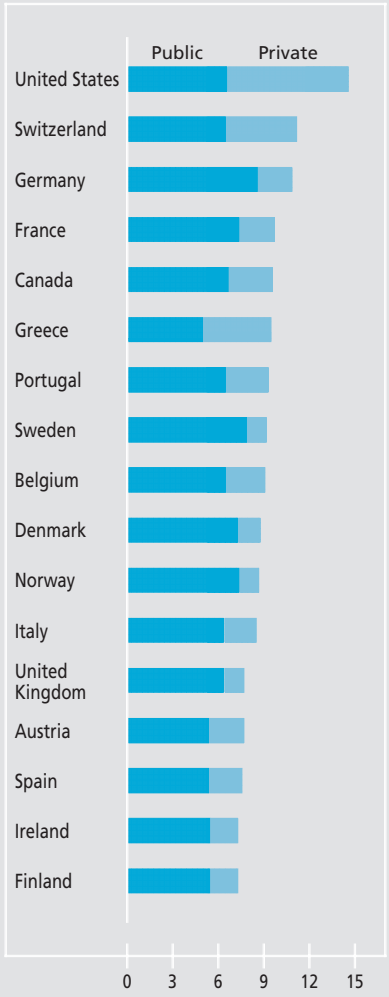
Healthcare services are also financed from other sources besides the statutory health insurance scheme. These include private health insurance institutions which have around 8.1 million fully insured persons, compared with 70.5 million in the statutory health insurance scheme. Furthermore, patient co-payments, healthcare subsidies for civil servants and exclusively private payments for healthcare services play a non-negligible role.

Macroeconomic importance of the healthcare system

The healthcare system in Germany is of considerable macroeconomic importance. In 2002 there were just under 4.2 million people working in the healthcare sector; this corresponds to a share in total employment of 10.6%.[4] Almost 11% of German GDP was spent on healthcare services (including long-term care insurance) in 2002. In an international ranking healthcare spending was higher only in the United States (14½%) and Switzerland (just over 11%) (see adjacent chart). Taking only government spending on healthcare and long-term care, the expenditure ratio in Germany – at 8½% – is the highest, followed by Sweden (just under 8%) and France (7½%).

Healthcare expenditure* in selected countries

As % of GDP; 2002



Source: OECD Health Data 2004. — * Spending on healthcare and long-term care.

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3 An institution's reserves must amount to at least one-quarter of an average month's expenditure and may not exceed one month's average expenditure (section 261 of the Social Security Code Book V).

4 See also Julia Weinmann and Natalie Zifonun, "Gesundheitsausgaben und Gesundheitspersonal 2002", *Wirtschaft und Statistik* 4/2004, p 456.

Key data on the financial development of the statutory health insurance scheme

Item	1995	1996	1997	1998	1999	2000	2001	2002	2003
	in DM billion				in € billion				
Revenue from contributions [1]	226.6	234.7	239.4	243.1	127.5	130.1	131.9	136.2	138.4
Other revenue	8.8	8.6	7.4	6.8	3.7	3.8	3.9	3.5	3.3
Revenue, total [2]	235.4	243.2	246.7	249.9	131.2	133.8	135.8	139.7	141.7
Expenditure on health, total	228.8	236.4	231.3	234.9	123.2	125.9	130.6	134.3	136.2
of which									
Hospital treatment	79.7	80.9	82.8	85.2	43.7	44.5	45.0	46.3	46.8
Out-patient treatment [3]	38.5	39.3	40.1	40.6	21.2	21.5	21.9	22.3	22.9
Dental treatment	21.2	23.0	23.3	21.2	11.0	11.2	11.6	11.5	11.8
Pharmaceuticals [4]	32.0	34.2	32.9	34.7	19.2	20.1	22.3	23.4	24.2
Therapeutic treatment and aids [5]	16.2	17.7	16.8	18.5	9.2	9.4	9.8	10.4	10.9
Rehabilitation	5.1	5.3	4.3	4.8	2.6	2.7	2.7	2.7	2.6
Travel expenses	3.8	4.0	4.1	4.3	2.4	2.5	2.6	2.8	2.9
Sickness benefit	18.4	18.2	14.4	13.8	7.1	7.1	7.7	7.6	7.0
Death benefit	1.6	1.6	1.6	1.6	0.8	0.8	0.8	0.8	0.4
Administrative costs	12.0	12.8	12.6	13.3	7.2	7.3	7.6	8.0	8.2
Other expenditure	1.7	1.0	1.1	1.0	0.5	0.6	0.5	0.7	0.7
Expenditure, total [2]	242.5	250.2	245.1	249.3	130.9	133.8	138.8	143.0	145.1
Balance of revenue and expenditure	– 7.2	– 6.9	1.7	0.5	0.3	0.0	– 3.1	– 3.3	– 3.4
Risk structure compensation scheme [6]									
Revenue	20.5	22.6	22.3	24.5	13.1	14.0	15.2	15.8	16.6
Expenditure [7]	20.3	22.4	22.9	23.9	13.5	13.9	14.9	15.9	16.8
Memo item									
Basic wage total [8]	1,714.4	1,739.0	1,751.7	1,769.1	923.9	943.0	955.8	960.4	954.7
	in million								
Members	50.7	50.8	50.8	50.7	50.9	51.0	51.0	51.0	50.8
Insured persons	71.7	72.0	71.7	71.3	71.4	71.3	71.0	70.8	70.5
	Annual average as %								
Contribution rate	13.2	13.5	13.6	13.6	13.6	13.6	13.6	14.0	14.3
Western Germany [9]	13.2	13.5	13.5	13.6	13.5	13.5	13.6	14.0	14.4
Eastern Germany	12.8	13.5	13.9	13.9	13.9	13.8	13.7	14.0	14.1
	Year-on-year change (%) [10]								
Revenue from contributions	0.9	3.6	2.0	1.5	2.6	2.0	1.4	3.3	1.6
Revenue, total	1.3	3.3	1.4	1.3	2.7	2.0	1.5	2.9	1.4
Expenditure on health, total	5.3	3.3	– 2.1	1.5	2.6	2.2	3.7	2.8	1.4
of which									
Hospital treatment	4.2	1.5	2.4	2.9	0.4	1.8	1.0	2.9	1.1
Out-patient treatment	4.2	2.2	1.9	1.4	2.0	1.5	1.8	1.9	2.5
Dental treatment	2.9	8.6	1.2	– 9.0	1.1	2.4	3.3	– 0.9	2.8
Pharmaceuticals	9.8	6.6	– 3.7	5.4	8.4	4.8	11.0	5.0	3.3
Therapeutic treatment and aids	5.8	9.4	– 5.4	10.5	– 3.4	3.0	3.5	6.6	4.3
Rehabilitation	18.3	3.6	– 18.4	11.2	7.9	2.2	– 0.8	– 0.6	– 3.5
Travel expenses	9.9	5.1	1.7	5.1	7.7	3.8	5.1	6.9	3.4
Sickness benefit	15.6	– 1.1	– 20.6	– 4.6	1.4	– 1.2	9.3	– 2.0	– 7.8
Death benefit	– 1.0	1.6	– 2.8	– 1.3	– 0.6	– 2.0	– 1.8	– 0.8	– 44.8
Administrative costs	2.3	6.7	– 1.4	5.6	5.2	1.7	4.7	4.9	2.3
Expenditure, total	5.6	3.2	– 2.1	1.7	2.7	2.2	3.7	3.0	1.4
Memo item									
Basic wage total	.	1.4	0.7	1.0	2.1	2.1	1.4	0.5	– 0.6
Members	0.2	0.2	0.0	– 0.3	0.5	0.2	– 0.1	0.0	– 0.4
Insured persons	0.2	0.4	– 0.4	– 0.5	0.0	– 0.1	– 0.4	– 0.3	– 0.5

Source: Federal Ministry of Health and Social Security, statutory health insurance scheme statistics KJ1 and KM1 as well as Bundesbank calculations. — **1** Revenue from contributions in 2003 includes contributions for "mini jobs" amounting to an estimated €0.9 billion. — **2** Excluding payments under the risk structure compensation scheme. — **3** Excluding dialysis costs. — **4** Pharmaceuticals from pharmacies and other sources. — **5** Including dialysis costs but excluding pharmaceuticals from other sources. — **6** From 2001 including revenue and expenditure for the risk pool. — **7** In 2003 excluding contributions for "mini jobs". — **8** Including revenue from compulsory contributions paid by pensioners. — **9** Including eastern Berlin. — **10** Figures up to 1998 converted using the fixed euro conversion rate of DM1.95583.

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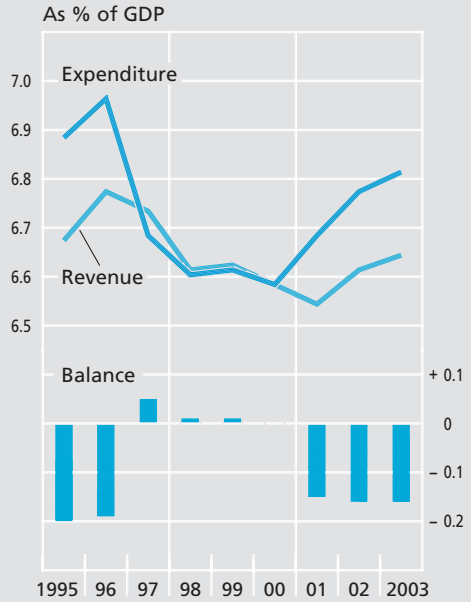
Underlying pattern of financial development since 1995

Deficits resulted in indebtedness

Since the mid-1990s the finances of the statutory health insurance scheme have been subject to considerable fluctuations (see adjacent chart).[5] Following deficits of around €3½ billion in 1995 and 1996, there were small surpluses in the four years that followed. Since 2001, however, there have been further deficits amounting to between €3 billion and €3½ billion. Since, following the deficits in the mid-1990s, the reserves barely fulfilled the statutory minimum requirement of one-quarter of a month's expenditure, the new financial shortfalls could frequently only be bridged through borrowing; this resulted in (net) indebtedness of €6 billion at the end of 2003.[6]

Finances of the statutory health insurance scheme



Source: Federal Ministry of Health and Social Security, KJ1 statistics and Bundesbank calculations.

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Salient feature is weak revenue

The overall negative financial development since the mid-1990s is primarily attributable to the sluggish growth of income subject to compulsory contributions (basic wages). Since 1995 this has grown by only 1.1% per year. Its share in GDP consequently fell from 48.7% to 44.8%. Only an increase in the contribution rates from 13.2% to 14.4% in western Germany and from 12.8% to 14.1% in eastern Germany enabled the ratio of revenue to GDP to be maintained at around 6.7%.

Between 1996 and 1998, health insurance institutions in eastern Germany had already started to resort to borrowing, which was not provided for by law. The Act Reinforcing the Financial Basis of the Statutory Health Insurance Scheme of 1998 then extended the risk structure compensation scheme to the whole of Germany – initially only for the period from 1999 to 2001. With the Act Reinforcing Solidarity in the Statutory Health Insurance Scheme, which entered into force at the beginning of 1999, the pan-German compensation scheme was continued indefinitely. The resultant transfers from western to eastern Germany were designed to enable the east German health insurance institutions to reduce their debt again (for more details on this and the risk structure compensation scheme in general, see the box on page 20).

5 For developments in previous years see Deutsche Bundesbank, Recent trends in the finances of the statutory health insurance institutions, *Monthly Report,* January 1991, pp 26-36.

6 In gross terms, ie disregarding the positive reserves of individual institutions, the level of indebtedness amounted to €8.3 billion at the end of 2003.

The risk structure compensation scheme of the statutory health insurance scheme

One of the aims of the Act regulating the structure of the health insurance system of 1992 was to foster keener competition among the health insurance institutions. Thus from 1996 the right to freely choose one's health insurance institution was extended to all members. Despite the fact that health insurance institutions are compelled to accept everyone who applies to join, a selection into good and bad risks was feared. In order to avoid this, a risk structure compensation scheme was introduced in 1994; this comprises the components income subject to compulsory contributions paid by members, age, gender and invalidity.

Until 1998 the risk structure compensation scheme was split into two separate accounts: East and West. The Act Reinforcing the Financial Basis of the Statutory Health Insurance Scheme of 1998 extended the financial compensation scheme to the whole of Germany. This was originally limited to the end of 2001 and primarily served to eliminate the accumulated debt of the east German institutions. Moreover, this solely involved compensating "financial strength" but not the "contribution requirement" between eastern and western Germany.

The contribution requirement of a health insurance institution is calculated as the sum of "standardised expenditure on benefits" per insured person. The standardised expenditure on benefits for each insured person varies depending on age, gender, sickness benefit entitlements and, where appropriate, receipt of a disability pension. The contribution requirement of institution i (BB_i) is calculated as the sum of standardised expenditure on benefits per risk category j (sLA_j) multiplied by the institution-specific absolute frequency (n^i_j).

$$BB_i = \sum_j sLA_j \cdot n^i_j$$

The financial strength of an institution is measured by multiplying the compensation requirement rate (*Ausgleichsbedarfssatz* (ABS)), formed as a "standardised contribution rate" as a quotient of the aggregated contribution requirement of all institutions and the total income subject to compulsory contributions of all members of the statutory health insurance scheme, by the total income subject to compulsory contributions of the relevant institution (bpE_i).

$$FK_i = bpE_i \cdot ABS, \text{ with } ABS = \frac{\sum_i BB_i}{\sum_i bpE_i}$$

The risk structure compensation scheme establishes a balance between the institution's contribution requirement and financial strength. Whether an institution is a net payer or a net receiver depends on whether its financial strength is larger or smaller than its contribution requirement.

The Act Reinforcing the Financial Basis of the Statutory Health Insurance Scheme merely envisaged a uniform compensation requirement rate for the whole of Germany and not a harmonisation of the standardised expenditure on benefits. Although absolute per capita expenditure in eastern Germany is below the west German level, the ratio of expenditure to income subject to compulsory contributions is less favourable in eastern Germany; for this reason the compensation requirement rate for the whole of Germany is lower than the figure for eastern Germany alone but higher than the value for western Germany. Consequently, western Germany is allocated higher and eastern Germany lower financial strength. The financial strength of the east German institutions calculated in this way is therefore effectively below their contribution requirement calculated in isolation. The financial strength compensation offsets the differences in the average sum of income subject to compulsory contributions between the east and west German states.

The Act Reinforcing Solidarity in the Statutory Health Insurance Scheme of 1998 saw the 2001 limit lifted and the Act creating legal equality in the statutory health insurance scheme of 1999 provided for the gradual transition to a pan-German risk structure compensation scheme by 2007. This also introduced the offsetting of contribution requirements between eastern and western Germany. The pan-German standardised expenditure on benefits is likely to be lower than in western Germany and higher than in eastern Germany. Therefore, the contribution requirement will be raised in eastern Germany and lowered in western Germany; this will result in additional transfers from western to eastern Germany.

The gradual transition to a complete risk compensation structure for Germany as a whole will result in a harmonisation of the "standardised contribution rates". Since, however, not all expenditure categories (for example administrative costs, state-financed spa treatments) are included in the compensation scheme, institutions retain full freedom of competition in these areas. The risk structure compensation scheme leads to an (intended) disinterest of institutions in good or bad risks when selecting their insured persons. There is, however, still an incentive to deal with the risks arising as cost-effectively as possible.

The Act Reforming the Risk Structure Compensation Scheme of 2001 extended the risk structure compensation scheme by creating a risk pool. If the annual expenditure of an insured person on certain benefits exceeds a defined threshold, the 60% of the excess amount is borne by all institutions. In addition, institutions receive a grant if they set up disease management programmes for certain chronic illnesses. Furthermore, from 2007 onwards the morbidity rate of a community of insured persons will no longer be determined indirectly by proxies such as gender or age, but instead will be determined directly using statistical recording of morbidity differences.

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Decoupling the contribution base from the overall wage trend

The weak revenue trend was the outcome, firstly, of the relatively small rise in overall gross wages and salaries. This was compounded, however, by the fact that the revenue of members subject to compulsory contributions grew 0.4 percentage point more slowly on average than overall gross wages and salaries (see adjacent chart). This was caused in part by the high-earning members switching to private health insurance institutions.[7] Other contributory factors were the cuts in health insurance contributions for recipients of unemployment assistance as well as the option introduced in 2002 permitting employees to contribute to company pension schemes with direct payments which are not subject to social security contributions.

Comparison of GDP, gross wages and salaries, and basic wage total

1 Income subject to compulsory contributions of persons insured under the statutory health insurance scheme.

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Expenditure ratio relatively stable

With an annual average increase of 2.0%, expenditure has not risen more steeply than nominal GDP since 1995; this means that the ratio has remained virtually unchanged at 6.8%. However, this pattern fluctuated in individual years, with legislative changes playing a significant role (see the box on pages 24 and 25). Whereas expenditure on healthcare services grew by 1.9%, administrative costs (which accounted for 5.7% of total spending in 2003) went up by 3.7% on an annual average.

Surge in spending on pharmaceuticals

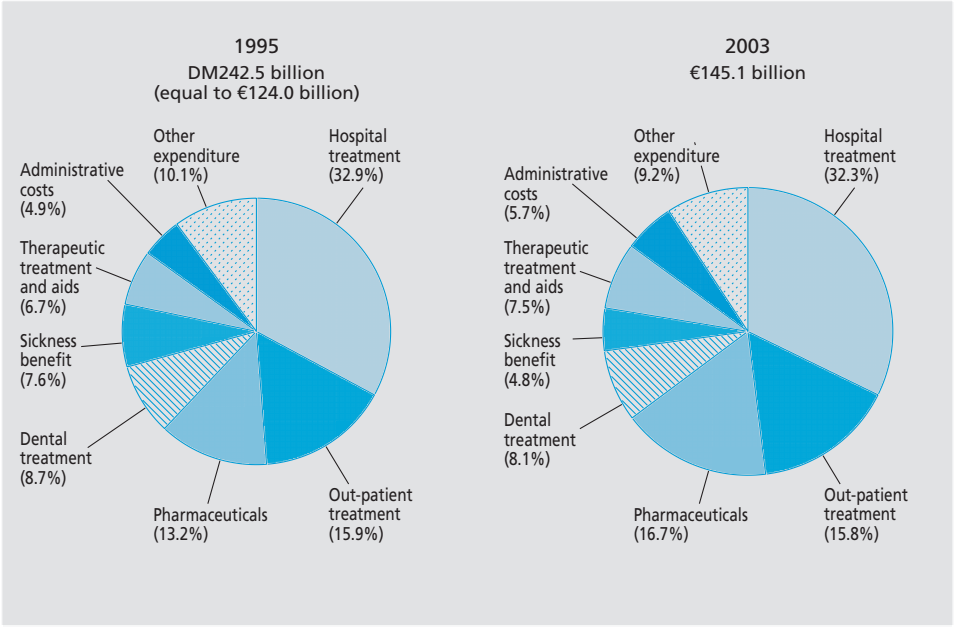
Among the main expenditure categories, spending on pharmaceuticals has shown the steepest rise by far since the mid-1990s (by 5.0% per annum), even though a string of short-term cost-cutting measures were taken to offset this (higher co-payments by patients, additional discounts from manufacturers, wholesalers and pharmacists, expansion of the list of pharmaceuticals that are subject to price regulation, direct payments from the pharmaceutical industry). The sharp growth was partly due to the increasing number of prescriptions for more expensive medicines, which, owing to their patent protection, are not subject to price regulation. Expenditure on therapeutic treatment and aids – albeit less significant – also recorded an above-average increase of 3.4% per year.

Much smaller increase or decline in other main expenditure categories

The other major expenditure items grew considerably more slowly. Spending on outpatient treatment, for example, rose by 1.9% per year. Although, with a view to stabilising

7 Whereas the number of members of the statutory health insurance scheme barely changed between 1995 (50.7 million) and 2003 (50.8 million), the number of persons privately insured rose from 6.9 million to 8.1 million over the same period.

Expenditure structure of the statutory health insurance scheme



Source: Federal Ministry of Health and Social Security, KJ1 statistics.

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contribution rates, budgeting in this area is fundamentally geared to the growth of basic wages, this expenditure item increased faster over the entire period. Spending on hospital in-patient treatment went up by 1.7% per year. Besides budget measures, these costs were held down primarily by a significant reduction in the duration of hospital stays. Despite an overall rise in the number of cases, the total number of days spent in hospital declined. Expenditure on dental treatment (including dentures) has developed very moderately since 1995, increasing by an annual average of 1.1% between 1995 and 2003. Unlike the other expenditure categories, spending on sickness benefit actually declined at an annual average rate of 3.7% between 1995 and 2003. The main reason for this was the lowering of sickness benefit from 80% to 70% of gross wages as from 1997 and also the noticeable decline in the sickness ratio from 5.1% to 3.6%.[8]

Administrative costs

Administrative costs of health insurance institutions rose much more steeply (by 3.7% per annum) than expenditure on benefits. This is partly due to the fact that fewer and fewer employers are willing to directly bear the administrative costs of their company health insurance institution. But even if the administrative costs per member of the company health insurance institutions had not increased more sharply than at other institutions, administrative costs would still have grown by an annual average of 2.7%, which

8 Compulsorily insured persons who have been certified unfit for work as a percentage of the total number of compulsorily insured persons excluding pensioners.

is considerably faster than expenditure on healthcare services. One of the probable reasons for this is that health insurance institutions which lost members to other institutions were unable to adjust their administrative capacity rapidly enough.

However, the varying trends in individual health service categories makes it almost impossible to draw any clear-cut conclusions about misdirected developments. For example, health services are in part substitutive. Thus if in-patient treatment is replaced by out-patient care, the respective expenditure shares are bound to change accordingly (for details of the expenditure structure see the chart on page 22).

Health service reform of 2004

Volume of financial relief

With the introduction of the latest health service reform (Act modernising the statutory health insurance scheme), a renewed attempt has been made to counter the unfavourable financial development and the pressure of increasing contribution rates (for details of the measures see the box on pages 24 and 25). The draft legislation envisaged financial relief of almost €10 billion – or 1 percentage point in contribution rates – for the public health insurance institutions for this year alone. With the additional outsourcing of denture services and the first increment in the new Federal grant, the volume of relief is set to rise to just over €15 billion in 2005. In 2006 the Federal grant will be raised by a further €1.7 billion. Moreover, starting in 2006 a special contribution of 0.5% will be introduced for members; this will bring about a redistribution of the contribution burden between employers and employees.

Potential to lower contribution rates

It was envisaged that the legislative measures will enable the average contribution rate to be lowered in 2004 from 14.3% to 13.6%. However, as things stand today, this figure will nowhere near be reached. The deficit of €3.4 billion in 2003 shows that even the contribution rate of 14.3% was not sufficient to cover expenditure. In the absence of reforms a rate of more than 15½% would have been required this year in order to completely eliminate the accumulated debt and to top up the reserves to their statutory minimum. Although the expected relief from the Act modernising the statutory health insurance scheme, together with the spreading of the debt reduction over four years which was also stipulated in that law, will reduce the contribution requirement by 1½%, an annual average contribution rate of under 14% seems barely attainable in 2004. This does not, however, rule out the possibility that it may be lowered to under 14% by the end of the year.

Financial development in the first quarter of 2004 ...

In the first quarter of 2004, the public health insurance institutions achieved a surplus of €1.1 billion,[9] compared with a deficit of €0.6 billion in the same period of 2003. Overall revenue went up by 1.5%. Revenue from contributions increased somewhat more

9 This balance also takes account of the estimated revenue from contributions for "mini jobs" amounting to €0.4 billion (based on the figures from the risk structure compensation scheme). In the financial statistics of the statutory health insurance scheme these contributions are not booked as "contributions" but as revenue under the risk structure compensation scheme.

Major legislation concerning the financing of the statutory health insurance scheme since 1995

Contribution Relief Act (*Beitragsentlastungsgesetz*) (1996)

Contribution rate fixed until the end of 1996 and lowered by 0.4 percentage point as of 1 January 1997.

Patient co-payments for pharmaceuticals increased.

Cuts in health spa treatments (generally only three – rather than four – weeks, at intervals of four – rather than three – years).

Sickness benefit lowered from 80% to 70% of previous gross wage (maximum 90% of previous net wage).

No subsidy for dentures for persons born after 1978.

First and Second Act Restructuring the Health Insurance Scheme (*1. und 2. GKV-Neuordnungsgesetz*) (1997)

Higher patient co-payments and extraordinary right to give notice in the event of contribution rate increases.

More generous arrangements for the chronically ill in cases of hardship, lowering of the maximum burden from 2% to 1% of their gross income.

General increase in patient co-payments.

Switch from percentage-based subsidies to fixed subsidies for dentures.

Option of cost reimbursement extended to compulsorily insured persons.

"Special donation for hospitals" amounting to DM20 per member for the period 1997 to 1999.

Relaxation of budgeting in the hospital sector as well as for medical and dental treatment.

Act Reinforcing the Financial Basis of the Statutory Health Insurance Scheme (*GKV-Finanzstärkungsgesetz*) (1998)

Retrospective legalisation of borrowing by east German health insurance institutions for a temporary period up to the end of 1998.

Risk structure compensation scheme (limited to the compensation of financial strength) extended to Germany as a whole for the period 1999 to 2001 to facilitate debt relief for east German health insurance institutions.

Act Reinforcing Solidarity in the Statutory Health Insurance Scheme (*GKV-Solidaritätsstärkungsgesetz*) (1998)

Abolition of the coupling mechanism between higher contribution rates and higher patient co-payments.

Cut in patient co-payments.

Denture costs reimbursed also for persons born after 1978, reversal from fixed subsidies to percentage-based subsidies.

Cost reimbursement option now only for voluntarily insured persons.

Abolition of "special donation for hospitals".

Stricter budgeting for hospitals as well as for medical and dental treatment.

Lifting of the time limit on the pan-German risk structure compensation scheme.

Act creating legal equality in the statutory health insurance scheme (*Gesetz zur Rechtsangleichung in der GKV*) (1999)

Phased transition to a complete pan-German risk structure compensation scheme (compensation of financial strength and contribution requirement) by gradual alignment of standardised expenditure on benefits in eastern Germany with the west German level.

Harmonisation of the income ceiling for contributions in western and eastern Germany as from 2001.

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Health Insurance Reform Act (*GKV-Gesundheitsreformgesetz*) 2000 (1999)

Agreements on remuneration for services should generally be geared to the change in the income subject to compulsory contributions.

Limitation of the possibilities for privately insured persons to opt back into the statutory health insurance scheme.

Act revising the arrangements for low-paid part-time workers (*Gesetz zur Neuregelung geringfügiger Beschäftigungsverhältnisse*) (1999)

Introduction of pension insurance contributions (12%) and health insurance contributions (10%) for persons working in low-paid part-time jobs.

Act revising the arrangements for one-off payments (*Einmalzahlungs-Neuregelungsgesetz*) (2000)

Lowering of the contribution base for recipients of unemployment assistance from 80% of their previous gross wage to 58% from 1 January 2001.

Pharmaceuticals budget settlement act (*Arzneimittelbudget-Ablösungsgesetz*) (2001)

Abolition of collective recourse to doctors in the event of budget overshooting. Penalisation remains a matter of self-regulation.

Fixed amount adjustment act (*Festbetrags-Anpassungsgesetz*) (2001)

Federal Ministry of Health temporarily empowered to determine the fixed amounts (maximum prices) for pharmaceuticals (until 2003).

Act revising the right to choose a health insurance institution (*Gesetz zur Neuregelung der Kassenwahlrechte*) (2001)

Voluntarily and compulsorily insured persons' right to choose a health insurance institution harmonised as from 1 January 2002. All insured persons are able to change from one institution to another at the end of the next-but-one calendar month and are bound to their new health insurance institution for 18 months. Extraordinary right to give notice in the event of contribution rate increases remains in force.

Act reforming the risk structure compensation scheme (*Gesetz zur Reform des Risikostrukturausgleichs*) (2001)

Promotion of disease management programmes for selected chronic illnesses as part of the risk structure compensation scheme (from 2002).

Creation of a risk pool for the partial coverage of exceptionally high spending by individual health insurance institutions on certain insured parties (from 2002).

Changeover to a morbidity-oriented risk structure compensation scheme by 2007.

Act introducing the residence principle in negotiations on fees for doctors and dentists (*Gesetz zur Einführung des Wohnortprinzips bei Honorarverhandlungen für Ärzte und Zahnärzte*) (2001)

Changeover to standard place of residence principle, ie the health insurance institutions reach agreements on overall remuneration with the medical service associations in whose catchment area the members live.

Act limiting spending on pharmaceuticals (*Arzneimittelausgaben-Begrenzungsgesetz*) (2002)

Aut idem rule, ie pharmacists are obliged to dispense a cheaper medicine with the same active ingredients unless the doctor has expressly prescribed a specific product.

The originally envisaged temporary lowering of pharmaceutical prices dropped in favour of a lump-sum payment by the pharmaceutical industry.

Pharmacy discount raised from 5% to 6%.

Act on diagnosis-related groups (*Fallpauschalengesetz*) (2002)

Diagnosis-related groups to be incorporated into the financing of hospitals for a transitional period up to 2006. Hospitals have been able to account on the basis of diagnosis-related groups since 2003. From 2004, this remuneration system is binding on all hospitals.

Act safeguarding the contribution rate (*Beitragssatzsicherungsgesetz*) (2002)

Additional discounts by pharmacists, wholesalers and the pharmaceutical industry to the health insurance institutions.

Raising of the income ceiling for being able to opt out of the statutory health insurance scheme.

Halving of death benefit.

Payment freeze imposed in 2003 for hospital treatment as well as for medical and dental treatment. Exception: hospitals which account using diagnosis-related groups.

Prices of technical dental services cut by 5%.

Fixing of contribution rates for 2003.

12th Act amending the Fifth Book of the Social Security Code (*12. SGB V-Änderungsgesetz)* (2002)

General inclusion of patented pharmaceuticals in the regulation of prices.

Administrative costs in 2003 capped at the 2002 level.

First Act Promoting Modern Labour Market Services (*Erstes Gesetz für moderne Dienstleistungen am Arbeitsmarkt*) (2002)

Contribution base for recipients of unemployment assistance lowered from 58% of their previous gross pay to the level of unemployment assistance paid as from 1 January 2003.

Second Act Promoting Modern Labour Market Services (*Zweites Gesetz für moderne Dienstleistungen am Arbeitsmarkt*) (2002)

New arrangements for low-paid part-time jobs ("mini-jobs") and the related compulsory contributions to the statutory health insurance scheme (11%).

Act modernising the statutory health insurance scheme (*GKV-Modernisierungsgesetz*) (2003)

Exclusion of certain benefits

- Complete abolition of death benefit and maternity benefit.
- Generally, no reimbursement of non-prescription medicines.
- Generally, no longer any assumption of costs for spectacles etc.
- Cutbacks in the case of IVF.
- Generally, costs of sterilisation to be paid for by the insured person.
- Generally, no longer any assumption of travel costs for out-patient treatment.

Patient co-payments increased

- Generally, 10% co-payment for all services up to €10 per service with a minimum co-payment of €5.
- Surgery visit charge of €10 per quarter for visiting the doctor or dentist.
- Patient co-payment for hospital treatment and follow-up treatment of €10 per day for a maximum of 28 days in a given year.

From 2004, the full contribution amount (rather than 50%) is to be paid, especially on company pensions. Lump-sum pension payments are subject to compulsory contributions spread over ten years.

Increase from 6% to 16% (limited to 2004) in manufacturer's discount for prescription pharmaceuticals that are not subject to the fixed-amount regulation.

Inclusion of patented pharmaceuticals without additional therapeutic benefits in the list of pharmaceuticals subject to fixed prices.

Rise in administrative costs per insured person generally limited to the change in revenue from compulsory contributions (basic wage total) until 2007.

Exclusion of dentures: From 2005, payments for dentures will be excluded from the services provided by the statutory health insurance institutions. The institutions must offer a supplementary insurance policy with contributions which are not coupled to income and which are to be paid solely by the members. The supplementary insurance policy may also be concluded with a private health insurance institution.

From 2006, a special contribution of 0.5% will be raised, which is to be paid solely by the members.

Federal grant for flat-rate reimbursement of non-insurance-related benefits amounting to €1 billion in 2004, €2.5 billion in 2005 and €4.2 billion from 2006.

New arrangements for doctors' remuneration: from 2007, budgeting for medical services is to be replaced by doctor-specific standard service volumes. Within these standard service volumes, a fixed point value will be paid. If this is exceeded, a downward graduation will be applied.

New arrangements applying to pharmacists

- Restructuring of the pharmaceuticals pricing regulation. In future, pharmacists will receive a smaller percentage mark-up and a higher absolute amount per pack instead.
- Authorisation of mail-order trading in pharmaceuticals.
- Partial easing of the ban on owning more than one pharmacy (maximum of three branches).

Option of cost reimbursement extended to compulsorily insured persons.

In future, all recipients of social assistance will be treated like persons insured with the statutory health insurance scheme. The institutions will assume the costs of treatment. The bodies responsible for paying social assistance will reimburse the institutions for the costs plus a 5% flat-rate charge for administrative costs.

Indebted institutions must reduce their liabilities by at least one-quarter a year between 2004 and 2007.

Fourth Act Promoting Modern Labour Market Services (*Viertes Gesetz für moderne Dienstleistungen am Arbeitsmarkt*) (2003)

Contribution base defined for recipients of "unemployment benefit II" from 2005 (36.2% of their monthly benefit).

sharply (by 2.0%); the main reason for this was probably the extension of compulsory contributions for company pensions. Expenditure fell by 3.6% compared with the first three months of last year. Spending on pharmaceuticals, therapeutic treatment and aids, sickness benefit and travel expenses declined particularly sharply. Moreover, death benefit has been completely abolished as from this year. By contrast, higher expenditure was recorded for out-patient treatment, dentures and hospital treatment.

... and in 2004 as a whole

These results already indicate that the health service reform will achieve considerable relief. However, the improvement in the first quarter of 2004 was overstated by a surge in demand for pharmaceuticals and therapeutic treatment and aids, in particular, at the end of 2003 prior to the introduction of the new measures. On the other hand, during the remainder of 2004 additional Federal resources of €1.0 billion will accrue to the health insurance institutions. Overall, a surplus is expected for 2004.

Challenges and reform options

Further steps required

The Act modernising the statutory health insurance scheme initiated important steps towards strengthening the individual responsibility of insured persons. The attempt to stabilise contribution rates relies not just on rationing services and fixing prices but also notably on attaching a greater weight to patient co-payments so as to raise cost consciousness and thus encourage a more efficient utilisation of healthcare resources through a closer linkage of costs and benefits. The pegging of contributions to labour income has, however, been largely retained. Similarly, competition among health insurance institutions as well as among health service providers has been stepped up only slightly. Problems are also looming in connection with the foreseeable demographic changes.

Cost-curbing measures insufficient in the long term

Past health service reforms were aimed primarily at limiting the rise in contribution rates. This aim clashes, however, with the growing demand for healthcare services, as a natural consequence of our affluent and also ageing society, and with rising costs owing to advances in medical technology. Cost-curbing measures – once available rationalisation reserves have been exhausted – therefore imply reductions in the benefits provided by the public health insurance institutions. At the macroeconomic level this raises the question, above all, of how tasks assigned to the statutory health insurance scheme can be organised and financed so as to avoid distortions of allocation while maintaining desired redistribution aspects.

Distortions on the labour market

The high wage-related contributions and the lack of equivalence between contributions and benefits in the statutory health insurance scheme lead to considerable distortions on the labour market. For example, incentives for taking up employment in areas subject to compulsory insurance are dampened. At the same time, employers' willingness to offer such employment declines – if the social security burdens cannot be directly and fully passed on to employees. If domestic labour

becomes more expensive, this triggers substitution effects in favour of the production factor capital (in the form of rationalisation) or foreign labour (by shifting production abroad). In addition, this leads to distortions on the domestic labour market in favour of jobs which are not subject to compulsory social security contributions.

Act modernising the statutory health insurance scheme reduces negative employment incentives

The health service reform of 2004 will place the financing of the statutory health insurance scheme on a somewhat more employment-friendly footing. In future, for example, insurance for dentures will be financed separately by non-income related premiums. The shift away from the current system of equal financing by employer and employee by levying a special contribution from employees as from 2006 may likewise promote employment if the reaction of the labour supply to the increase in employees' share of contributions is not as strong as that of the labour demand to the decrease in employers' share – and as long as this shift in the balance is not neutralised in the coming pay rounds. The tax-financed Federal grant will also reduce the contribution burden. However, taxes have to be raised in other areas in order to finance it. Specifically, tobacco tax rates have been raised substantially for this purpose, although this will not yield the originally expected additional revenue.

Proposals for further-going reform approaches

Further-going proposals for reorganising the financing of the statutory health insurance scheme range from widening the income base subject to compulsory contributions, by including additional types of income and additional social groups, to switching to a system of non-income related insurance premiums coupled with financing the desired redistribution components out of general tax revenue.

Raising the maximum level of income subject to contributions

Raising the maximum level of income subject to contributions from the current monthly amount of €3,487.50 to, for example, the same level as for the statutory pension insurance scheme (€5,150) would yield additional revenue of around €4 billion per year, thus enabling the contribution rate to be lowered by 0.4 percentage point. However, this general relief would create noticeable additional costs of up to €230 per month (including the employer's contribution) for higher-income earners. By contrast, the burden on lower-income earners would be eased. With regard to possible employment effects, it should be remembered that pensioners, who constitute a large social group but are not part of the labour market, would also benefit.

Inclusion of other types of income in compulsory contributions

The inclusion of other types of income in compulsory contributions is targeted first and foremost at capital and rental income. In this case, too, there are income redistribution effects. To the extent that the contribution base can actually be widened, this would create potential for lowering the contribution rate. However, this would simultaneously dampen incentives to make private pension provision, which is necessary in view of the demographic development and which, moreover, is being subsidised by considerable public funds, for example in the "Riester pension plan". Furthermore, it would weaken the efforts that are being made in the context of the tax amnesty to repatriate capital that has so far evaded the tax authorities. In addition,

given the high mobility of capital, its additional taxation is likely to enjoy only limited success. This would also necessitate considerable administrative costs associated with the additional recording of this income in the statutory health insurance scheme.

Inclusion of other social groups in compulsory contributions

Extending compulsory contributions to the statutory health insurance scheme to persons who are currently privately insured[10] would not only widen the contribution base but would also entail additional expenditure for this group of persons. Leeway to lower the contribution rate would arise only if this new group of members turned out to be net contributors to the statutory health insurance scheme. Owing to legal constraints, extending compulsory contributions to this new group might be applicable only for those just beginning their career, so that a noticeable lowering of contribution rates could be expected at most only in the distant future.

Effects of "citizens' insurance model" on contribution rates

The approaches to widening the contribution base are subsumed under the umbrella term "citizens' insurance model" (*Bürgerversicherung*). However, diverse alternatives are conceivable, which means that the term is by no means unambiguous. Calculations including all currently private insured persons indicate a potential to cut contribution rates within the framework of a "citizens' insurance model" (without raising the maximum level of income subject to contributions) of 1.3 percentage points in total.[11] The inclusion of higher earning employees, self-employed persons and civil servants would contribute 0.2 percentage point per group. An extension to other types of income would allow a contribution rate cut of 0.8 percentage point. By contrast, the additional costs that would be incurred by the inclusion of currently private insured pensioners would require an increase in the contribution rate of 0.1 percentage point. These effects have to be viewed in the context that this approach is not concerned with lowering the contribution burden but with redistributing it. Appreciable employment gains can hardly be expected from this – also given the fact that the task of easing the pensioners' burden would have to be financed by persons in work.

"Health premium" allows financing of statutory health insurance scheme to be decoupled from labour income

The concept of a flat-rate "health premium" represents a proposal to completely decouple contributions to the statutory health insurance scheme from labour income. Under this concept each insured person would have to pay a flat-rate monthly premium regardless of his/her individual income. The current employer's contribution would be paid out to employees as part of their pay. Most proposals advocating a health premium include non-contributory co-insurance for children; on the other hand, both spouses would have to pay the premium. A social compensation component is envisaged so as to avoid overburdening persons on lower incomes, for example by stipulating that the level of contributions to the statutory health insurance scheme does not exceed a certain percentage of their income. This social compensation

10 Employees with an income above the defined threshold of currently €3,862.50 per month, self-employed persons and public sector employees with civil servant status can join a private health insurance scheme.
11 See S Sehlen, W F Schräder and G Schiffhorst, Bürgerversicherung Gesundheit – Grünes Modell – Simulationsrechnungen zu Ausgestaltungsmöglichkeiten, *IGES Paper,* No 04-06, 10 May 2004.

component could largely be financed by taxing the share of contributions currently borne by the employer, which would place a greater burden on the higher income brackets. Nevertheless, additional financing resources would also be necessary. The social welfare and redistribution effects would then depend on the precise form of this financing. All in all, however, a regime of separate wage taxation – which is what the current system of financing the statutory health insurance scheme amounts to – would be replaced by a "health insurance price" which is free of distortions. The desired social compensation component would be financed more appropriately out of general tax revenue. Although this would in turn give rise to new distortions, the associated redistribution effect would be more transparent, could be more selectively targeted and would probably be more limited, with the result that the distortions would be smaller.

Current reform proposal

An expert opinion presented on 15 July 2004 contains proposals for a concrete changeover to a health premium model and discusses the financing alternatives for the inter-personal social compensation.[12] It assumes that the scope of services will be concentrated on the mandatory standard services and that sickness benefit insurance will be spun off. Given these assumptions, every adult person insured under the statutory health insurance scheme would be required to pay a health premium of €169 per month as an average across all health insurance institutions. This would be accompanied by a tax-financed payment per child of €78. This could be financed by the additional tax revenue resulting from the outpayment and taxation of the employer's contribution. The social compensation component envisages a contribution ceiling of 12.5% of an insured person's gross income. Additional tax resources amounting to €22.5 billion are necessary for financing the premium grants. To achieve this, for example, the solidarity surcharge would have to be increased by 11.9 percentage points (ie more than tripled) or the standard turnover tax rate would have to be raised by 2.5 percentage points. The option of financing within the health insurance system would require, besides the flat-rate premium, an additional income-related contribution of 2.9% to the statutory health insurance scheme. These reform proposals highlight the massive volume of income redistribution within the statutory health insurance scheme. Financing this solely out of tax resources would result in macroeconomic problems.

Options for funded schemes

In view of the demographic changes that are occurring, a greater element of capital funding is often proposed for the statutory health insurance scheme. In this way the private health insurance institutions attempt to keep premiums stable in spite of the age-induced increase in individual expenditure requirements. In a pay-as-you-go social security system where the bulk of expenditure is on elderly people, a changeover to a funded system would, however, mean a double burden for the transitional generation; not only must they build up their own reserves but they also have to finance a large part of expenditure for those people who do not have sufficient

12 See B Rürup and E Wille, Finanzierungsreform in der Krankenversicherung, July 2004.

reserves of their own. This additional burden has to be compared with a possibly higher yield under a funded system.[13] An argument against a collective accumulation of reserves is that in the past reserves set up for particular purposes were often liquidated prematurely.

A funded system of healthcare provision can help to shift part of the additional financial burdens caused by demographic changes from the future to the present. However, such a funding system would not have to be located within the statutory health insurance scheme. One conceivable option, for example, could be additional private old-age provision in the form of a funded pension insurance scheme, which could be used to cover the higher insurance premiums of older insured persons in the future. In this way, the statutory health insurance scheme, too, would be better prepared for the demographic burdens.

Possible reform measures on the benefit side

Nevertheless, a fundamental reform of the statutory health insurance scheme cannot be limited to restructuring the financing system (which is the focus of this article). Concentrating efforts on the revenue side could reduce the pressure to maximise the efficiency potential. A reform on the revenue side must not lead to neglecting necessary measures on the benefits side.

There is a broad consensus that efficiency reserves are available on the benefits side which, once mobilised, could help dampen the increase in expenditure – especially by intensifying competition both among health insurance institutions and among health service providers. This also includes allowing the institutions greater discretion in connection with additional competition parameters, for example the extent of insurance protection which is offered. A further extension of patients' co-payments would be a suitable means of raising the cost consciousness of both service providers and patients. The present contractual relationship between institutions and service providers could be liberalised by, for example, granting institutions the right to conclude contracts with individual doctors or groups of doctors. Other important measures aimed at boosting competition and curbing costs include a more extensive use of remuneration systems based on diagnosis-related groups, greater provision of out-patient treatment by hospitals and the liberalisation of trading in pharmaceuticals. In addition, the transparency of service provision could be enhanced for insured persons by switching from the principle of receiving free benefits to the principle of cost refunding.

Conclusions

Demographic development will exacerbate financing problems

The latest health service reform is likely to stabilise the finances of the statutory health insurance scheme for a limited time. However, they have not yet been placed on a sustainable long-term footing. Under the status quo, the ageing of the population and the welcome but costly advances in medical technology will soon increase the pressure to raise

13 No clear gain in efficiency is apparent solely from changing the method of funding. See Deutsche Bundesbank, Prospects for, and obstacles to, a stronger reliance on funding in the statutory system of old-age provision in Germany, *Monthly Report,* December 1999, p 22.

contribution rates to the statutory health insurance scheme. On average, pensioners' contributions to the statutory health insurance scheme currently cover barely half of the expenditure for which they account. By contrast, members of working age contribute one-and-a-half times as much as the average costs which they cause. A shift in the relative ratio of working to retired persons will therefore require a higher contribution rate.

Basic issues of healthcare provision still unresolved

As is already the case with the current health service reform, future reforms will need to focus not just on exploiting available efficiency reserves – especially by fostering keener competition – but above all on deciding what services are to be provided by the statutory health insurance scheme and how the associated financial burdens are to be shared. The insufficient scope under the current insurance system to use the pricing mechanism to align healthcare supply more closely with demand as well as the problem faced by every insurance company of excessive claiming of the insured services point to the need to further strengthen individual responsibility via patients' co-payments. Another general option could be to concentrate the range of services provided on major risks.

Distribution of financial burden

The distribution of the financial burden has both interpersonal and intergenerational aspects. The interpersonal distribution effects inherent to the statutory health insurance scheme, which go beyond mere risk-sharing between healthy and sick people, concern not only distribution between higher and lower-income earners but also between single persons and families, men and women and, finally, between younger and older people. These distribution mechanisms embrace only the compulsorily insured members' income up to the contribution ceiling. The distribution effects are largely non-transparent. Transparency could be increased considerably if the insurance element were to be separated from the interpersonal redistribution aspect, thus allowing the social compensation component to be financed more appropriately – including from a social point of view.

The intergenerational redistribution problems of the pay-as-you-go statutory health insurance scheme stem primarily from the process of demographic change. This threatens considerable additional burdens for future generations. With the help of increased individual funding, higher contributions could be better accommodated in the future – albeit at the expense of present-day consumption.

Significance for the employment trend

The future of the statutory health insurance scheme, as well as that of the social security system as a whole, depends to a significant extent on the development of the overall economy in general and of the labour market in particular. The aim of reducing unemployment and increasing labour market participation could be bolstered by decoupling the financing of the statutory health insurance scheme as far as possible from wages. Otherwise, the foreseeable rise in contribution rates would directly increase non-wage labour costs further and make the deployment of the production factor labour even more difficult.