EZA739/12May06: Germany – Health Care Reform

German health care reform – small step towards funding

- The health care system is at the top of the reform agenda for the grand coalition government.
- Although the current negotiations among health care experts of both coalition parties are held in a secretive atmosphere, a reform compromise seems likely on the lines of the model presented by CDU floor leader 12 April.
- In a move away from the current system based on wage-related health care contributions transferred to the health insurers; contributions are to be channelled through a funded pool, through which an equal amount of €170 per month will be distributed.
- Although likely to increase transparency and cost control, it is unlikely to reach key objectives such as securing sustainable funding or fostering of growth and job creation.

Asset Conclusions: Slow health care reform preserves monopoly profits for, in particular, healthcare service sector, hence positive for German pharmaceutical companies. Impact on economy mixed: negative impact from extending inefficiencies but longer term positive because of gradual progress towards greater competition.

Health care reform – secret negotiations to find practical solutions

The reform of the German health care system has moved to the top of the priority list for the grand coalition government and the 1st May government meeting heated up efforts to agree on a concept for this reform. A timeframe appears to have been agreed: by the end of June party heads will lay the foundations for a reform act in a staged approach, starting with the scope for reforms, then defining basic features, leading to a draft proposal to be moulded into law by September.

Health care spending by country in % of GDP (2003)

Source: OECD
The current negotiations have started in an almost secretive atmosphere. However, secrecy seems the only way to secure a pragmatic approach towards reform, which in the past has been regarded as an ideological battleground rather than an opportunity for economic progress.

Superficially the current reform debate is about two conflicting concepts for funding the public health care system, the SPD sponsored citizens insurance and the CDU concept of a flat health tax – plus income-related employers’ contributions.

These two concepts are based on fundamental differences between the two parties’ views on how to engineer a general overhaul of the German social security system as well as the economy. For the SPD reforming the expanding sector of public health care is seen as an opportunity to put its own vision of big government and tight regulation into practice. By contrast the CDU during the last four years has made a remarkable policy shift in moving away from the current regulated system towards a more market driven and less regulated approach. The thrust of the reformers within the CDU, who mainly consist of medical practitioners and social experts like Bert Rürup (the head of the council of economic advisors, and an SPD member) lies in fostering growth and securing medical/technological progress.

However the CDU hasn’t moved all the way towards this model, partly because the CSU rejects profound changes to the current system. Instead the CSU, driven by its ambitions to combine conservative and social values, under its health care expert Horst Seehofer accepts only piecemeal changes - along the lines of the 2004 (mini) reform geared towards cost control - and remains in many respects closer to policies of the SPD. Even its commitment to the CDU-sponsored health premium (in a joint declaration in Oct 04) appears at best half-hearted.

**History of health care reforms**

<table>
<thead>
<tr>
<th>Prior health care reforms</th>
<th>Year of taking effect</th>
<th>Reform target</th>
<th>Social tax at time (%)</th>
</tr>
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<tbody>
<tr>
<td>Updating act of public health care</td>
<td>2004</td>
<td>Full health tax for pensioners, flat contribution for doctors appointments, patients’ cost contribution of 10% per medicine, min. 5 €; patients’ hospital contribution 10 €/day</td>
<td>14.4%</td>
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<tr>
<td>Strengthening solidarity act</td>
<td>1999</td>
<td>Reduced patients’ contribution to medicine, reimbursement for dental care</td>
<td>13%</td>
</tr>
<tr>
<td>1st/2nd revision of public health care</td>
<td>1997</td>
<td>Hike of patients’ flat contribution to medicine by package size, hike of contribution to hospital care to 17 DM/day</td>
<td>13%</td>
</tr>
<tr>
<td>Health care system act</td>
<td>1993</td>
<td>Patients’ cost contribution to medicine in % of selling price; constraining reimbursement for dental surgery</td>
<td>13%</td>
</tr>
<tr>
<td>1st health care reform</td>
<td>1989</td>
<td>Defining lists for reimbursable medicine, constraining cost reimbursement to standard medicine, flat cost contribution of patients / unit of medicine, glasses, hospital treatment</td>
<td>12.9%</td>
</tr>
<tr>
<td>Cost curbing act</td>
<td>1977</td>
<td>Curbing reimbursement for medicine; setting minimum price for reimbursement</td>
<td>11.3% (1970: 8.4%)</td>
</tr>
</tbody>
</table>
Health care reforms in the past were focused on curbing the – politically sensitive – health tax at 13% to 14% of gross incomes, and covering standard health provision. Reforms were mainly geared towards making the current system of health care more efficient while leaving intact the basic principles of health care – patient equality and protecting existing health care providers. By contrast the current debate has broadened to take in the revenue side as well as costs. Instead of focusing on the interests of health care insiders the debate has become more politicised around the conflicting ideological backgrounds of the CDU and the SPD – with the CSU caught in the middle.

**Health care – pre-empting burgeoning deficit or insufficient market forces?**

Although the effect of the divergence of costs and revenues in public health care has, in contrast to the general government budget or the public pension system, appeared latent it has had significant economic repercussions. Through its link to wages, health care contributions work as a flat tax, impeding job creation, while administered spending curbs work as a brake to technical progress, innovation and job creation in this sector.

Proposals on the revenue side for rebalancing health care funding focus on pre-empting the dwindling revenue base of the current “pay as you go” health care system, which has resulted from rising unemployment, and low wage (and pension) increases. Medical experts, eg from the council of economic advisors warn that the health tax would have to rise to around 20% of gross wages to secure appropriate funding levels.

While growing funding needs seem widely accepted, there is a debate on how to combine enhanced funding with re-regulation in order to tackle wastefulness on the part of patients and oversupply and inefficiencies on the part of health care providers.

**Reform options – funded or unfunded, flat contribution or defined entitlement**

In theory there are three options for a future health care system, distinguished by the funding method and the link between contribution and entitlement.

- **An unfunded system with defined (equal) entitlement** - the basis of the current public health care system. While contributions are defined as a percentage share of gross wage income - a kind of health tax of 13.8%, of which 6.5% is borne by the employer, 7.3% by the employee (up to € 3562.50 monthly salary) - entitlement is not related to contributions. This implies a significant redistribution of health costs from higher lower incomes – apart from the obvious redistribution from the healthy to the less healthy and singles to families. *Citizens Insurance* - the key reform proposal put forward by the SPD and the Greens is based on this option. As presented by the health scientist Karl Lauterbach, health care contributions will be related to all income sources (such as capital income and corporate profits) in order to lower wage-related contributions. Another feature of this option would be the extension of coverage to the self-employed, high income earners and civil servants, who are currently exempt from public insurance. But constitutional considerations have made the SPD, for the meantime, refrain from their demand to include those groups.

- **An unfunded system with equal contributions** – a so called flat health premium – of €170 per month, per capita, with equal entitlement. This option, promoted by the CDU (but diluted by the CSU – which insisted on income-related employers’ contribution of 6.5% plus a flat health premium of € 110) would leave the current mixed system of public and private insurers intact. In a separate version a top-up of € 30, designed to help fund medical-technical progress would at least allow partial funding.
A funded system with personalised fees, defined by the situation of the insured, i.e., their age and the risk profile, with entitlement linked directly to the amount paid. This has been standard for those who are privately insured (covering 11% of the population). Private health insurers currently build reserves for each individual, allowing them to over-fund, when the insured are young and to draw them down for the old insured. In fact this only works as a buffer to cost increases, rather than prevent fee increases in general. Apart from the lack of political support – the liberal FDP is the only party committed to such a system – the portability of old age reserves remains a big impediment to a general application of this option in practice.

### Health care: reform options in perspective

<table>
<thead>
<tr>
<th>Reform option 1</th>
<th>Reform option 2</th>
<th>Reform option 3</th>
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</thead>
<tbody>
<tr>
<td>Public health insurance (&quot;citizen insurance&quot;)</td>
<td>Combined public-private health care with flat health tax</td>
<td>Obligatory private health insurance</td>
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<tr>
<td><strong>Key features</strong></td>
<td><strong>Key features</strong></td>
<td><strong>Key features</strong></td>
</tr>
<tr>
<td>Similar to public hc in current system</td>
<td>Private hc: similar to current system</td>
<td>Similar to private hc in current system</td>
</tr>
<tr>
<td>Funding: all income sources, wages, capital income</td>
<td>Public hc: Funding: flat health tax</td>
<td></td>
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<tr>
<td></td>
<td>Family coverage: only adults, children covered through tax surch.</td>
<td>Extension: as current system</td>
</tr>
<tr>
<td></td>
<td>Payment, capital stock: as in current system</td>
<td>Variations</td>
</tr>
<tr>
<td></td>
<td>Extension: as current system</td>
<td>Child insurance reimbursed by government (through tax surcharge)</td>
</tr>
<tr>
<td><strong>Variations</strong></td>
<td><strong>Variations</strong></td>
<td><strong>Variations</strong></td>
</tr>
<tr>
<td>Maintaining private hc., subsidizing &quot;citizen insurance&quot; by private hc., varying income sources</td>
<td>Funding through flat health tax for employee, income-related as regards employers contribution</td>
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<tr>
<td></td>
<td>Capital stock built through top-up</td>
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<td></td>
<td><strong>Potential compromise:</strong></td>
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<td></td>
<td>Combined public-private health care</td>
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<td>Private hc: as current system</td>
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</tr>
<tr>
<td></td>
<td>Public hc: Funding as current system</td>
<td></td>
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<tr>
<td></td>
<td>Payment: 4 stages: insured person – insurance pool – insurer receives flat pay per capita – hc provider</td>
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<tr>
<td></td>
<td>Family coverage: through a tax-funded pool</td>
<td></td>
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<tr>
<td></td>
<td>Capital stock: partly funded capital</td>
<td></td>
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<tr>
<td></td>
<td>Extension: as current system</td>
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</tbody>
</table>

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A key issue for defining the scope for a health care compromise will be to square the key demands from both parties,

- SPD: quest for “solidarity”, access to health care irrespective of the income level;
- CDU: the decoupling of wages and health costs, thus lowering non-wage costs, which are seen as a key obstacle to job creation;
- Both parties: the objective to set funding on a long term sustainable path, where the SPD focuses on the funding side, the CDU on cost control.

In a nutshell: the SPD would define progress in health care reform by the enhancement of the principle of solidarity through extending current public insurance, while the CDU would define progress in terms of narrowing the scope of public insurance. Hence a key thrust of the CDU sponsored reform will fund health care for children (and spouses) through taxes.

**A potential reform compromise – contributions to a health care pool**

Although the current system is regarded as unsatisfactory by both parties, any deviation of the status quo will be regarded in particular by party ideologues with great suspicion. A potential compromise has been indicated by a model, presented by CDU floor leader Volker Kauder 12 April. His presentation, although officially endorsed could be seen as testing the waters for reform. Key features:

- the current practice of income-related health contributions will continue, although the level might be lowered;
- the main innovation will be the establishment of an insurance pool, through which health contributions of the insured will be channelled to the health insurers;
- all public health insurers will receive a flat per capita amount – of € 150 to € 170 – instead of an amount related to the actual income of their members; thus reducing any incentive to attract only those with higher incomes;
- child health insurance will be covered by a separate pool, funded by a income tax supplement (talk has been of 3%)
- some reserve building for old age might be included in the contributions.

Economically this proposal is seen as having advantages when compared to the current system; increasing transparency and the pressure to control cost by the insurance companies. The two main shortcomings of this model are (1) its failure to sever the link between wages and health care costs and (2) its failure to provide compensation for extra costs for intensive or chronic medicare.

More important will be the political battle within the SPD around Andrea Nahles criticism of the reform in principle (a position supported by the public health insurers). But key SPD members, including health care minister Ulla Schmidt seem supportive of the model, which they might see as an exit strategy from their commitment to the citizen insurance.

**German health care – a brief overview of parties and agents**

**The demand side – demographic trends prevailing**

The trend in total insured persons has been subject to demographic trends, notably the ageing of the German population. Currently about 89% of all Germans (70.2 million) are insured by public health insurance, the rest (8.26 million) are insured by private insurers. During the last 13 years about 1.8 million have changed from the public insurance system to the private system, reflecting the general trend towards higher incomes and ageing (indirectly):
In the public insurance system the principle of equality in entitlement with income-dependent contributions implies significant income redistribution. This makes private insurance the obvious choice for medium and higher income earners – but to contain this migration, taking out private insurance requires a minimum salary income of €3,937.50 per month, removing this option for more than 2/3 of citizens.

For those on higher incomes the public health insurance might still be advantageous, if they have a family, since public health insurance – in contrast to private health insurance – covers the whole family. In case of a double income couple, one of whom is privately insured, the children are excluded from public health care.

Among the publicly insured there has been a remarkable shift from general health insurance (AKV) to pensioners insurance (KVDR) during the last 13 years: while the “customer base” of the general health insurance shrank by 4 million, the pensioners insurance gained 2.3 million. Given the pending retirement of the baby boomers (born 1946 to 1964) this trend is likely to accelerate in coming years. Even worse for public health insurers: the relief they got in the past from shrinking family sizes – about 20 million (almost 30%) of those publicly insured are non-paying family members – will lessen in coming years, as the decline in birth rate is unlikely to continue.

German citizens by health care coverage (million)

![Graph showing the number of German citizens by health care coverage from 1993 to 2003.](https://example.com/graph.png)

Source: Federal Health Ministry BMGS

The supply side – providers driven by regulation

With the citizens at one end of the health insurance market, the providers of health care, i.e., the producers of goods and services are at the opposite end. As regards pharmaceutical goods, the production and distribution of medicine, the market is still highly regulated by restricted drug lists and obligatory pharmacy sales. A similar situation applies to the “market” of service providers, i.e., doctors (and dentist) practices, hospitals and walk in health care institutions (massage, health practitioners).

Public health insurance spending, which in 2004 accounted for 57% of total health spending, was driven by regulations rather than market forces. Overall spending had risen by a moderate 2.2% per year between 1993 and 2005, reflecting vigorous spending curbs and increased obligatory cost sharing by individuals as regards doctors’ visits and hospitals. But these curbs – mainly through restricted lists – did little to prevent mounting costs for pharmaceutical/drug spending, which rose by over 5% pa, as there were offsetting measures for producer protection such as restricting distribution channels which keep costs artificially high.
The mediators – insurance-providers duopoly protects insiders at the expense of patients

Finally both the level and trend of costs relate to the system for health care mediators, ie public and private health insurers and – as regards cost sharing – individuals. Health experts define German health care as an “obligatory duopoly” (with health insurance companies on one hand and hospitals and doctors associations on the other) rather than a market. Public health insurance comprises 250 companies, with the bulk of it consisting of 23 regional general public insurers, 155 company related health insurers and 7 substitute employee insurers. These companies, along with 50 private health insurance companies which (in contrast to the British and US system) provide full insurance coverage, negotiate costs with the health care providers (23 doctors associations and 2,100 hospitals). The market counterparties are both subject to and key drivers of health care legislation.

Trends in stationary medicine and doctors practices

![Graph showing trends in hospitals and doctors practices](image)

Source: Deutsche Krankenhausgesellschaft

This “market duopoly”, negotiates re-imbursement for medicine and services, either through (i) defining the cost share borne by the insurers or (ii) by curbing the total amount for medical treatment. This system, while helping contain increases in private health care spending to a cumulative 40% over the last ten years (to 2003), in fact led to growing inefficiencies, since only certain methods and practices are fully reimbursable. Innovative medicine and prevention, by contrast, mostly has to be borne by the patients. Offloading these costs to the patients allows private health insurers to follow this bad precedent, thus reducing market competition.

Medical oversupply and insufficient supply response in terms of downsizing of the hospital network, and a record high (and still growing) density of doctors well above the international average have been the obvious consequences of this health care system. An expert report presented by McKinsey estimated that the number of state-run hospitals would have to shrink at least by another third – as it did between 1991 and 2004 – to match international standards. The ongoing strike among clinic doctors regarding pay and working conditions indirectly highlights the inefficient conditions in the German health care system.

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