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Institutional change or political stalemate?

Health care financing reform in Germany

Kai Mosebach

Summary: After its inauguration in Autumn 2005, the second Grand Coalition in German post-war-history announced a major reform of health care financing. The public and the media were curious to see how the governing CDU/CSU and SPD coalition would overcome their differences on health care financing. To date, the parties have not fully agreed on the final institutional design of the future system. However, the Grand Coalition will introduce some institutional innovations that nonetheless will alter the overall structure of health care financing in the country.

Key words: Germany, health care financing, health policy, regulated competition, health insurance

On 24 October 2006, the German government agreed a proposal that would alter the structure of both statutory (SHI) and private (PHI) health insurance, if approved by the the lower (*Bundestag*) and upper house (*Bundesrat*) of parliament in 2007. The parties representing the Grand Coalition between the Christian Democrats (*Christlich Demokratische Union* – CDU), their sister party the Bavarian Christian Social Unionist (*Christlich-Soziale Union in Bayern* – CSU), and the Social Democrats (*Sozialdemokratische Partei* – SPD) struggled to get their diverse factions to support this proposal. Moreover, these reforms have been faced by nearly unanimous opposition from the sickness funds, physicians, pharmacists and hospital managers, as well as the media and public.

As a result of lengthy rounds of negotiations, the original draft proposal, the SHI-Competition-Strengthening Act (*GKV-Wettbewerbsstaerkungsgesetz, SHICS-Act*) has been revised, thus making it extremely difficult to assess what the final outcome will be prior to the conclusion of parliamentary deliberations in March 2007.[1] However, this overwhelming level of dissent and ongoing debate obscures the fact that an evolutionary process of health system change is already under way; the most recent health care reform proposals are a further step in that direction.

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'Back to the future': regulated competition and managed care in Germany

Since the early 1990s, German health care policy has been changing course. In 1992, the governing CDU/CSU and the Free Democrats (*Freie Demokratische Partei* – FDP) agreed, in consensus with the opposition SPD, the Health Care Structure Act (HCS-Act). In hindsight, the most important structural change that the HCS-Act introduced was the implementation of regulated competition between, what by then had become, regionally and/or branch-organised sickness funds. Following the implementation of a risk-adjustment mechanism, from 1997, insurees could choose between most sickness funds. One consequence of this new policy of 'choice' was that the young, male, healthy and wealthy insured in particular, changed sickness funds, leading to rising levels of redistribution between funds.[2]

The notion of regulated competition meant that sickness funds could offer different packages of service provision. Initial steps in this direction were taken under the two Statutory Health Insurance Restructuring Acts (SHIR-Acts) by the CDU/CSU and FDP government in 1997. These Acts enabled sickness funds and health care providers to contract selectively for the first time. However, due to the political links between doctors and the FDP, as well as factions of the CDU/CSU, selective contracting still depended on the approval of regional physicians' associations.

This obstacle was overcome by the SHI Modernisation Act (SHIM Act), enacted by the first red-green SPD/Green government with support from the opposition CDU/CSU in 2003. From 2004, sickness funds could contract selectively with individual or groups of individual health care providers without requiring the formal approval of a physicians' association. Furthermore, to overcome financial constraints on selective contracting, the SHIM-Act decided to fund integrated health care at the expense of collective reimbursement schemes for physicians and hospitals. Ever since, the number of new forms of health care provision making use of selective contracting has risen constantly. These new 'networks of care' range from gate-keeping models and disease management programmes to integrated care – the German model of preferred provision, integrating providers from different health care sectors.

All these developments have meant that a new regulatory model has been emerging since the 1990s; one that, in line with international trends, focuses on regulating incentives instead of relying on cost-containment alone.[3] The new shape of the health care system has been labelled 'competitive corporatism'. This combines competition between sickness funds and among health care providers with the preservation of a common regulatory framework through corporatist bargaining procedures.[4] However, the political dynamics of competitive corporatism are both contradictory and conflict-driven. In essence, a dual structure has emerged, placing selective contracting into an environment where traditionally block contracts have been the norm.

Debating health care financing reform: red-green agenda and beyond

One motivation behind the introduction of regulated competition has been the desire for efficiency gains, which consequently would imply lower social insurance contributions. This would help support the international competitiveness of the German economy. This policy has been accompanied by higher levels of co-payment first introduced through the SHIR-Acts at the end of the CDU/CSU and FDP government in 1996. This was the only significant change in health care financing after the introduction of open enrolment in the 1990s.

Eventually, the red-green coalition put health care financing reform onto its political agenda in summer 2003. It established an expert Commission on Social Insurance Financing, which laid the conceptual groundwork for the ongoing political debate seen today. While focussing on several pillars of the German welfare state, the Commission's recommendations regarding health care financing rested on two commonly shared premises.[4] First, that the financial foundations of the income-related health care insurance had been eroding because of economic globalisation, European integration and rising unemployment. Second, in order to preserve the international competitiveness of the German economy, health care insurance contributions must not rise excessively. However, due to a lack of consensus, the Commission's reform proposals ended up consisting of two competing models of health care financing: a nation-wide citizen's health insurance (ending the co-existence of SHI and substitutive PHI by integrating the latter into the former), or alternatively a flat-rate health insurance limited to the SHI.

From a political perspective, the SPD and Greens favoured the citizen's insurance, while the CDU/CSU (the latter by no means unanimous) preferred a flat-rate insurance. This citizen's insurance would subject all individuals and all forms of income to health insurance contributions. By preserving the income component of the SHI, the citizen's insurance would lead to a significant increase in funds for health care. Additionally, it would make redistribution within the health care system more progressive.

However, the federal SPD/Green government had to contend with a CDU/CSU-led majority of state governments in the *Bundesrat*. Their conservative model of health care financing would imply a capital-funded health care insurance shifting the mechanism of income redistribution out of health insurance and towards tax based subsidies. As a consequence of this political stalemate, health care financing reforms were postponed, leaving only a new system of co-payments in place.[5]

After the end of the red-green government in early autumn 2005, the newly established Grand Coalition, under Chancellor Angela Merkel (CDU), agreed to bring in health care financing reforms. The proposed *SHICS-Act* will strengthen the role of the federal state in regulating the health care system at the expense of the traditional (corporatist) regulatory system. With regard to health care financing, this means on the one hand the introduction of a federal fund to pool financial flows, and on the other, a change in the relationship between SHI and the (substitutive) PHI system.

'Bringing the state in': federal fund, sickness funds and competition

Currently, sickness funds compete through different health insurance contribution rates paid by employers and employees. From 2009, the federal government will set (on an annual basis) income-related and uniform (for all sickness funds) health insurance contribution rates through legal regulation. The resulting revenues will be pooled centrally into a new federal fund on health care financing, managed by the Federal Insurance Office (*Bundesversicherungs-amt*). This federal fund will also receive tax subsidies which should rise from €1.5 billion (2008) to €3.0 billion in 2009. However, due to political pressure from the Federal Ministry of Finance the current (2006) tax subsidy of €4.3 billion will be reduced by €1.8 billion to €2.5 billion in 2007.

The proposals to channel funds from the PHI into the SHI and to construct a standardised reimbursement scheme for SHI and PHI were debated, but eventually abandoned. The SPD (especially its left wing) favoured both measures, but the CDU and CSU blocked these proposals, thereby reflecting their close links with PHI-companies and physicians that have the option of billing their services for private insurees at rates several times higher than those for statutorily insured patients. Furthermore, the implementation of the already concluded (SHIM-Act) morbidity-based and standardised reimbursement system for SHI physicians has been postponed to 2011.

After pooling the revenues, an amount of money consisting of a per capita amount, plus a risk-adjusted extra payment which balances the different risk structures of sickness funds, will be directed to the individual sickness funds. In contrast to the current risk-adjustment mechanism, in the future the total sum of health and administrative expenses of one sickness fund should be balanced with all others. In addition, the new system will redistribute health care expenditures according to the sickness fund's relative burden of morbidity.

At the start of the new health care financing system in 2009, sickness funds will be relieved of (recently accumulated) debt. If revenues are not sufficient to pay their health care expenditures, an individual sickness fund will be obliged to charge an additional levy on their members (but not their employers) – either through income-related or flat-rate payments. These charges should help incentivise funds to make further efficiency savings through the expansion of selective contracting. The reforms also aim to support selective contracting through strengthened outpatient and integrated care.

The federal government will also determine (by legal regulation) the overall distribution rate of funding from health insurance contributions, as well as the level of additional funding to be raised by individual sickness funds. In 2009, the share of funds from the income-related health insurance contribution will be 100%. However, the scale of additional charges could rise to as much as 5% of the overall

health care costs in the SHI, possibly reducing the share from health insurance contributions to 95%. Consequently, the level of additional charge should act as a signal of the efficiency of the sickness funds' operations.

However, due to a proposed hardship clause, sickness funds with an unfavourable risk structure (for example, many chronic ill and low-income insurees) may face funding problems. Under the terms of the hardship clause additional charges are individually limited to a maximum of 1% of the income of the member. The charge will in fact be collected without respective income testing up to an amount of €8, meaning that poor and low-income households (i.e. the working poor) will suffer the most if this additional charge is applied by their sickness funds.

Funds with a high concentration of low income households may face the additional problem of having to charge their more affluent members at a much higher level than low income members because of the restrictions on charges set by the hardship clause. One scenario where this might be the case would be if the government decides to raise the scale of any additional charges to more than 5% of total health care costs. Therefore many, but by no means all sickness funds, fear that if financial pressure on the SHI persist, in future the hardship clause might lead to a loss of competitiveness in some funds in comparison to those with a more favourable 'risk structure'. Eventually, many funds may face bankruptcy and/or have to merge with their competitors; the latter is in fact a political goal of the current reform proposals.

Regulating the boundaries between voluntary SHI and PHI

In Germany, the structure of health care financing currently consists of both SHI and (substitutive) PHI. High income earners above a specific income ceiling can choose between SHI and (substitutive) PHI. In fact, competition exists (albeit limited) between SHI and PHI for high income earners. Since the early 1990s, the number of privately insured individuals has continuously risen. There are however increasing restrictions for solidarity related reasons. These for example, prevent high income earners who are privately insured from insuring their children without any cost through the SHI contributions of their low paid spouses, thereby pulling insurance contributions out of the SHI-system and shifting the health care costs of children onto the solidarity based system of SHI. Moving from SHI to Moving from SHI to PHI will now also be more difficult than in the past.

Consequently, while the regulation of the boundaries of SHI and PHI has been the subject of contention, there has nevertheless been some covergence, leading first to the introduction of a standardised health insurance scheme within the PHI, covering mainly low income older people (*Standardtarif*) in 2000. In addition, some PHI-measures were implemented into SHI, for example deductibles and no-claim refund schemes if insurees did not make use of health insurance benefits within a given period. The *SHICS-Act* will also expand the scope of PHI-type regulations in the SHI by enabling all SHI-insurees to choose (reduced) health insurance schemes with deductibles and to opt for reimbursement schemes instead of benefits-in-kind.

Although the 'Great Coalition' did not agree to integrate the PHI into the SHI as proposed by the Social Democrats, the *SHICS-Act* will change the rules of the game for (substitutive) PHI. In order to establish a more competitive framework, the *SHICS-Act* will introduce new regulations. First, the federal government will oblige PHI to offer a (revised) standardised insurance scheme, similar to SHI, which is prohibited from applying individual health risk-adjusted premiums (*Basistarif*). The original draft regulation which required PHI funds to accept every insured person from SHI and PHI schemes to this standardised insurance scheme (as favoured by the Social Democrats) was however abandoned during consensus negotiations in early January 2007. This was due to pressure from PHI companies channelled through the CDU/CSU.

Now SHI-insured individuals can switch to PHI (probably to the *Basistarif*) if they have an income in excess of a specified income ceiling for at least three years. The window of opportunity for those already PHI-insured individuals to change to the new standardised insurance scheme (*Basistarif*) will now been limited to a six month period in 2009.

The government will also make old age reserves in the PHI transferable in order to establish a higher level of competition within PHI. At the moment, capital funded old age reserves are not transferable even if the privately insured would like to change their PHI provider. Competition between PHI companies has thus been severely limited for this group until now.

Finally, as a step towards counteracting the recently growing numbers of the non-insured, the government wanted to introduce a regulation stating that every (legal) resident will have the legal right to return to the system from whence he/she had been insured previously, before becoming ineligible for health care insurance (be it either SHI or PHI). Concerning this regulation, the Association of PHI Companies has highlighted the potential perverse incentive that privately insured persons could decide to opt-out of health insurance and return to the *Basistarif* if they were to become ill and need expensive health care (*Vorteil-shopping* – health-insurance-free-riding). To counter this would require additional funds within the PHI through comparatively higher insurance premiums, because it would be possible that especially high income earners would opt-out of PHI. In order to avoid such health-insurance-free-riding the Grand Coalition has decided to make health insurance compulsory for SHI and PHI.

Institutional change: health care financing at the crossroads

The *SHICS-Act* will introduce several innovations into the German health care system. Most prominently, will be the establishment of a federal fund, thus reducing the power of sickness funds. Furthermore, the boundaries between SHI and PHI will be both more closed and more open. While it will be more difficult to switch from SHI to PHI, the probable implementation of a standardised health insurance scheme (*Basistarif*) as well as the transferability of capital funded old age reserves will intensify competition within the PHI system and between (voluntary) SHI and PHI. However, both the original proposals and final agreed regulations underline the highly contested boundaries of SHI and PHI. In addition, most reform proposals within the *SHICS-Act* (concerning health care financing) are to be implemented only in 2009.

Furthermore, the basic problems of health care financing are still to be addressed. The proposed reform will not counteract the erosion of the financial foundations of health care insurance, nor will it prevent the social insurance contribution from rising steadily. Therefore, critics argue that in effect there has been no health care

financing reform at all, only the extension of a political stalemate.

Nevertheless, it is clear that some initial steps that will change the institutional foundations of health care financing have been taken. The introduction of the federal fund and the (however limited and contested) convergence between SHI and PHI point to an evolutionary change from competitive corporatism to the marketisation of health care (financing), accompanied by a changing role for state regulation. However, the *SHICS-Act* also represents a political stalemate in respect of the final design of health care financing (be it citizen's or flat-rate-insurance) in Germany. Health care financing reform, no doubt, will be a key issue in the electoral campaign of 2009.

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Pharmaceutical policy reform in Spain

Joan Costa-Font and David McDaid

Summary: There are many deficiencies in the operation of pharmaceutical policy in Spain. This article provides a brief overview of the way in which the market functions and highlights some structural problems. We describe and provide some insights on the main economic policy problems to be faced in the regulation of the Spanish market. Key measures introduced as part of new 2006 legislation intended to address some of these deficiencies are then discussed.

Keywords: Spain, pharmaceutical policy, generics, reference pricing, medicines, regulation

Spain has traditionally faced serious problems in containing pharmaceutical expenditure. Compared to other European Union countries, she has historically relied heavily on pharmaceutical treatments.[1] The pharmaceutical market has struggled with a number of deficiencies related to quality and performance including variability in clinical practice and limited use of clinical guidelines in prescribing. There are also inefficiencies at the provider level, including limited use of generics with few incentives to switch to generics, while at consumer level there is a high level of self medication and limited impact of co-payments.

Traditionally mark-ups to reimburse the pharmaceutical distribution chain have neither fostered cost-containment nor generic substitution; instead there have been subtle incentives including non-transparent discounts that benefit retailers and wholesalers but do little for the tax payer. The mechanism for distributing pharmaceuticals also heavily restricts competition between retail pharmacists, for instance by requiring the owner of the business to have a degree in pharmacy. Wholesalers are also linked to groups of pharmacies, rather than subject to wider competition. This system, compounded by strict price regulation based on unclear indexation and costs-plus formulae, leads to low average prices and explains why the country is involved in the parallel export of drugs.[2]

Physicians traditionally have had very few incentives to prescribe efficiently. Moreover generic prescriptions do not guarantee that the cheapest generic will be dispensed; economic incentives are not in place. There is also only a very limited role for cost-effectiveness analysis in guiding drug reimbursement and pricing.

While the responsibility for health generally has been decentralised to the 17 Autonomous Communities (ACs), pharmaceutical policy and regulation remains one the few areas much less affected by this process; although some steps have been taken to involve the ACs in quasi-federal decision making boards that look at pricing and coordinate some policies. Consequently, pharmaceuticals are a high priority for health policy reform.

There have been some recent attempts to break the cycle of stagnation in the pharmaceutical market through modest reforms that strive to accommodate all

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