Gericke, Christian A.; Wismar, Matthias; Busse, Reinhard

Working Paper

Cost-sharing in the German health care system

Diskussionspapiere // Technische Universität Berlin, Fakultät Wirtschaft und Management, No. 2004/4

Provided in cooperation with:
Technische Universität Berlin

Suggested citation: Gericke, Christian A.; Wismar, Matthias; Busse, Reinhard (2004) : Cost-sharing in the German health care system, Diskussionspapiere // Technische Universität Berlin, Fakultät Wirtschaft und Management, No. 2004/4, http://hdl.handle.net/10419/36425

Cost-sharing in the German Health Care System

Christian A. Gericke, M.D., M.Sc., D.T.M.H.
Dept of Health Care Management, Berlin University of Technology

Matthias Wismar, Ph.D.
European Centre for Health Policy, WHO Regional Office for Europe, Brussels

Reinhard Busse, M.D., M.P.H., FFPH
Dept of Health Care Management, Berlin University of Technology and European Observatory on Health Care Systems

Address for correspondence:

Dr Christian Gericke
Department of Health Care Management
Technische Universität Berlin
EB2 - Strasse des 17. Juni 145
D-10623 Berlin
Germany
E-Mail: christian.gericke@tu-berlin.de

Stand September 2003

Abstract

In Germany, cost-sharing for health care has been used as a financing mechanism since 1923. In this article, the historical development of user charges in Germany since the 1980s is presented in more detail by type of private expenditure, including direct payments, cost-sharing measures, and voluntary health insurance. This is followed by a mapping of current cost-sharing measures including a discussion of protection mechanisms and responsibility for decision-making on cost-sharing measures and a summary of national policy debates. In the final section, the results of a systematic review of the literature on the impact of cost-sharing on equity, efficiency and health outcomes in Germany are presented.

Zusammenfassung

Die Selbstbeteiligung des Patienten an den Gesundheitsversorgungskosten hat in Deutschland eine lange Tradition und geht auf das Jahr 1923 zurück. In dieser Arbeit wird die historische Entwicklung und Bedeutung von Kostenselbstbeteiligung im Gesundheitswesen seit 1980 detailliert nach Art der Gesundheitsausgaben dargestellt. Dies beinhaltet direkte Zahlungen, Kostenbeteiligung, und private Krankenversicherung. Darauf folgt eine Darstellung der derzeitigen Regelungen zur Selbstbeteiligung mit Berücksichtigung der verschiedenen Mechanismen zum Schutz vor katastrophalen Gesundheitsausgaben und der Zuständigkeit für politische und administrative Entscheidungsfindungen zur Selbstbeteiligung. Im letzten Abschnitt werden die Ergebnisse einer systematischen Literatursuche zu den Auswirkungen von Kostenbeteiligungen auf Effizienz, Gerechtigkeit und Gesundheitsstatus in Deutschland dargestellt.

Contents

1. Levels of private expenditure on health care

Cost-sharing has a long tradition within the German health care system. In 1923 the first cost-sharing measure in the form of a 10-20% co-insurance for pharmaceuticals and medical appliances was introduced during a period of economic recession into the social health insurance (SHI) system, and an exemption mechanism for the unemployed was already put in place (Reichelt 1994a). In 1930 this co-insurance was replaced by a flat fee co-payment per prescription and an additional co-payment for ambulatory care consultations was introduced (Reichsministerium des Innern 1930). These changes were part of a number of emergency regulations passed to counteract substantial reductions in sickness fund revenues and increases in claims for unemployment benefits during the financial crisis at the end of the Weimar republic (Alber 1992).

Since Bismarck's original legislation from 1883 which already defined a minimum benefits catalogue (Bärnighausen & Sauerborn 2002), benefits were gradually expanded, in particular during the era of economic growth of the 1950s and 1960s, to become very comprehensive in the first half of the 1970s. This is reflected by the rapid growth of health care expenditure in the period 1965 to 1975 and a falling ratio between monetary and service/product benefits during the same time (Busse 2000). Cost-sharing measures were almost inexistent during this period, being limited to a co-payment of DM 1 per prescription for pharmaceuticals (Alber 1992). The era of rapid expansion of health care expenditure and benefits ended with the global oil crisis. The Health Insurance Cost-Containment Act of 1977 started a long series of legislation with the primary aim of containing costs (Busse 2000).

Since 1980 private expenditure in the form of out-of-pocket payments and voluntary health insurance (VHI) as a percentage of total health expenditure has steadily increased from 15.5% in 1980 to 18.7% in 1998, with most of the increase attributable to out-of-pocket payments. The share of the latter increased by 36% during this period, whereas the share of VHI only increased by 4% (Table 1).

Table 1: Main sources of finance (percentage of total expenditure on health care), 1980-1998

Source of finance	1980	1990	1992	1994	1996	1998
Public						
Statutory insurance	66.2	-	64.4	63.7	65.2	67.4
Taxes	10.9	-	13.1	12.7	11.1	8.4
Private						
Out-of-pocket	8.1	-	9.0	9.7	10.3	11.0
Private insurance	7.4	-	7.2	7.6	7.1	7.7

Sources: New health account data, Federal Statistical Office 2001 (Presseexemplar zur Einführung der neuen Gesundheitsausgabenrechnung)
Notes: 1. Data in all tables and figures up to and including 1990 is for the Federal Republic of Germany only, from 1991 onwards data is for the unified Germany including the *Länder* of the former GDR unless otherwise stated. 2. Figures do not add up to 100% due to obmission of "other" sources (mainly employers). 3. "Statutory insurance" includes health, pension, accident and long-term care (the latter from 1996).

Within the last 25 years successive governments have intervened twelve times to regulate user charges and major changes in cost-sharing arrangements are again planned for the next health sector reform in 2004 (table 2).

The period covered by table 2 can be summarised by five characteristics:

- User charges started very moderately from a low level;
- Subsequently, more and more areas were covered, most importantly the inpatient sector comprising hospital care, rehabilitative treatment and preventive spa-treatment from 1983 on;
- Various forms of user charges got more differentiated and sophisticated over the years (price-related and later package-size-related co-payments for pharmaceuticals; different levels of user charges for crown and denture treatment in relation to take-up of preventive annual check-ups);
- Reference prices became part of the co-payment regulations in 1989;
- In 1998 nominal amounts for user charges payable peaked and the trend of expanding them was reversed.

The proposals for the health system modernisation act planned to come into force on 1 January 2004 contain plans for a complete re-structuring of cost-sharing arrangements (Deutscher Bundestag 2003). If adopted, these will again result in substantial increases in private expenditure.

Table 2:Co-payment/ co-insurance levels in Germany (Western part of the country), 1977–2004 (€)

	1977-1981	1982	1983-1988	1989-1990	1991-1992	1993	1994-1996	1st half 1997	2nd half 1997	1998	1999	2000-2001	2002-2003	2004 - (planned)
Ambulatory medical treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	10[1]
Pharmaceuticals (€)	0.5	0.8	1											
- without reference price [2]				1.5	1.5									5-10 (10%)
- with reference price (RP)				100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	100% above RP	5-10 (10% of price up to RP) [2] *plus* 100% above RP
						plus	*plus*	*plus*	*plus*	*plus*	*plus*	*plus*	*plus*	
- up to € 15 in price [2]						1.5								
- >30 up to € 25 in price						2.6								
- over € 25 in price						3.6								
- small pack [2]							1.5	2.0	4.6	4.6	4.1	4.1	4.0	
- medium pack [2]							2.6	3.1	5.6	5.6	4.6	4.6	4.5	
- large pack [2]							3.6	4.1	6.6	6.6	5.1	5.1	5.0	
Conservative dental treatment	0	0	0	0	0	0	0	0	0	0	0	0	0	10[1]
Crowns and dentures	20% or more	40%[3] or more	40%[3] or more	50% 40%[4] 35%[5]	50% 40%[4] 35%[5]	50%[6] 40%[4 6] 35%[5 6]	50%[6] 40%[4 6] 35%[5 6]				50%[6] 40%[4 6] 35%[5 6]	50%[6] 40%[4 6] 35%[5 6]	50%[6] 40%[4 6] 35%[5 6]	100% above fixed sum
- for persons born before 1979								50%[6] 40%[4 6] 35%[5 6]	55%[6] 45%[4 6] 40%[5 6]	100% above fixed sum				
- for persons born after 1978								100%	100%	100%				
Orthodontic treatment	20% or less	20% or less	20% or less	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]	0-20%[8]
- if eating, speaking or breathing is severely limited [7]														
Transportation to and from medical facility (€ per trip)	1.8	2.6	2.6											
- inpatient treatment or emergencies				10.2	10.2	10.2	10.2	10.2	12.8	12.8	12.8	12.8	13	5-10 (10%)
- ambulatory treatment				100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Non-physician care (e.g. home nursing, physiotherapy) (€ per prescription or % of costs)	0.5	2	2	10%	10%	10%	10%	10%	15%	15%	15%	15%	15%	10 plus 10%[9]
Hospital stay and inpatient rehabilitation after a hospital stay (€ per day) [10]	0	0	2.6	2.6	5.1	5.6	6.1	6.1	8.7	8.7	8.7	8.7	9	10
Preventive spa or inpatient rehabilitation unrelated to hospital stay (€ per day)	0	0	5.1	5.1	5.1	5.6	6.1	12.8	12.8	12.8	12.8	8.7	9	10

Notes: [1] per physician or dentist consulted per quarter except referrals; [2] with price of drug as maximum; [3] from 1982-1988 limited to % of technical/laboratory costs; [4] if insured had regular annual check-ups for the last five years; [5] if the insured had regular annual check-ups for the last ten years; [6] 100% for major dental work (more than four replacement teeth per jaw or more than three per side of mouth, except multiple single bridges, which may exceed three); [7] and treatment is begun under age 18, otherwise 100%; [8] full cost is reimbursed retrospectively by the sickness fund if a predefined treatment plan is entirely completed; [9] for home nursing limited to 28 days per year; [10] 1983-2003 limited to a total of 14 days per year, from 2004 limited to 28 calendar days per year. Several rates in this table were lower in the Eastern part of Germany until 1999.

Source: Own compilation based on data from (Alber 1992;Busse 2000;Deutscher Bundestag 2003;Verband der Angestellten-Krankenkassen (VdAK) & Arbeiter-Ersatzkassen-Verband (AEV) 2003a)

In the following sections, the historical development of user charges in Germany since the 1980s is presented in more detail by type of private expenditure. Informal payments are not an issue in Germany.

1.1. Direct payments

Direct payments for goods or services which are not covered by any form of insurance in Germany consist in exclusions of specific services from the SHI benefits catalogue and in the form of non-reimbursement of over the counter (OTC) pharmaceuticals. In Germany, some OTC drugs are reimbursed by sickness funds if they are prescribed by a physician.

During the 1960s and 70s the benefits covered by SHI became very comprehensive, as legislation grants every insured person the right to medical care "necessary to diagnose, cure, prevent aggravation of disease or to alleviate symptoms" (§§ 2, 12 SGB V). All benefits covered by SHI are listed in the Uniform Value Scale, which represents the fee schedule for office-based physicians. The explicit exclusion of ambulatory care medical benefits from SHI coverage was not possible until 1997, when a new mandate to evaluate health technologies was introduced (Busse 2000). The decisions on which benefits to exclude are made by the Federal Committee of Physicians and Sickness Funds. So far the committee has excluded only a small number of technologies with limited medical benefit, e.g. osteodensitometry for asymptomatic patients. Nevertheless, the committee's decisions have raised massive protests from providers and the public.

Until 1997 exclusion of benefits was thus limited to other sectors. Consequently, certain dental services like gold or ceramic inlays, some medical aid devices, death pay for those insured after 1989, and pharmaceuticals for so-called "petty diseases" like the common cold and travel-related diseases and pharmaceuticals which are either cheap or of unproven medical benefit were incrementally excluded from the SHI benefits catalogue (Braun, Kühn, & Reiners 1998).

Between 1987 and 2001, OTC sales have continuously grown in real terms. In 1987 price terms, OTC sales have risen to 190 in 2001, whereas physician-prescribed OTC drug sales are

at the same level as in 19871(Bundesverband der Arzneimittel-Hersteller (BAH) 2002). In 2001, pharmacy sales for non-reimbursed OTC totalled 3.9 billion € and OTC worth 350 million € were sold outside pharmacies e.g. in drugstores (Bundesverband der Arzneimittel-Hersteller (BAH) 2002).

On the other hand, OTC spending has decreased both as a share of total pharmaceutical spending and in absolute terms between 1997 and 2001, from 18% to 14%, and from €4.6 to 4.27 billion, respectively. This was mainly caused by a fall in prices for OTC drugs during this period, whereas the number of OTC packages sold remained remarkably stable with about 680 million packages sold per year (Bundesfachverband der Arzneimittel-Hersteller (BAH) 1998a;Bundesverband der Arzneimittel-Hersteller (BAH) 2002). Physician-prescribed OTC sales have also decreased from 4 billion € in 1996 to 3 billion € in 2001 (Verband Forschender Arzneimittelhersteller e.V. 1998;Verband Forschender Arzneimittelhersteller e.V. 2002).

1.2. Cost-sharing

Depending on the type of expenditure, both flat rate co-payments and co-insurance are used in the German SHI. The evolution of cost-sharing measures per type of expenditure from 1980 to 1994 is presented in table 3.

[1] After transient increases to 120 in 1992 and 1996 (Bundesverband der Arzneimittel-Hersteller (BAH) 2002).

Table 3. Proportion and total amount of co-payments and co-insurance payments of SHI-insurees in Germany in 1980, 1992, and 1994

1.1.1 Area	**West Germany**		**Germany**			
	1980		**1992**		**1994**	
	2 million €	in % of SHI expenditure in given area	**3 million €**	in % of SHI expenditure in given area	**4 million €**	in % of SHI expenditure in given area
Total	1,289	3.1	3,734	3.6	4,708	4.2
Denture	939	20.0	2,385	32.8	2,459	40.6
Pharmaceuticals	329	4.9	673	3.9	1,464	8.9
Hospital	0	0	354	1.1	432	1.1
Non-physician treatment	20	2.4	207	9.4	225	9.2
Travel	1	0.3	75	5.5	79	4.3
Preventive spa and rehabilitation treatment	0	0	38	2.1	48	2.2

Source: Adapted from Federal Statistical Office data (Statistisches Bundesamt 1998b)

1.2.1. Pharmaceuticals

Cost-sharing for pharmaceuticals was first introduced in 1923 and has since been around without interruption. Between 1923 and 1929 a co-insurance of 10% (in special cases 20%) was in place, which was replaced in 1930 by a flat fee co-payment per prescription, independent of the number of items prescribed. With variation of the fixed amount this regulation was in place until 1969 (Reichelt 1994a). Between 1970 and 1977, the legislators opted again for a co-insurance of 20%, this time with a ceiling of DM 2.5 per prescription. In 1977, this was changed back to a co-payment of DM 1 per drug prescribed (Reichelt 1994a). Thereafter, nominal co-payments were increased by small increments until 1989, when reference prices were introduced. In Germany, reference prices mean that sickness funds only reimburse pharmacies up to a predefined ceiling for reference-priced drugs and the patient ending up paying the difference between the reference price and the market price. Currently 61.4% of SHI prescriptions and 36.8% of pharmaceutical sales fall under the reference price scheme (Nink & Schröder 2003). Between 1989 and 1992 for reference-priced drugs no fixed fee co-payment had to be paid on top of the price differential. Since 1993 flat-rate co-payments have to be paid on top of the price differential between the drug bought and the reference price. It is noteworthy that because of competition within the reference-price groups and the legal obligation for physicians to inform patients on the fact that they are liable for the price difference for a reference-priced drug, very few drugs now exceed the reference-price.

The co-payment system for pharmaceuticals was again completely restructured in 1993, when the co-payment amount was first linked to the price of the drug sold. From 1994 on it was linked to package size (see table 2). This system combining reference pricing plus package-size-related co-payments still remains in place today. The graded scheme is meant to provide an incentive to physicians for prescribing larger package sizes (Ess, Schneeweiss, & Szucs 2003) with lower average costs per dose resulting in overall cost-savings per patient treated. The new co-payment levels also meant that more than 20% of prescribed drugs had to be paid entirely by patients (Busse 2000).

Patients' aggregate expenditure on co-payments for pharmaceuticals have continuously increased from € 0.6 billion in 1987 to an all-time high of € 2.7 billion in 1998. The then newly elected Social Democratic Party (SPD)/Green coalition government lowered nominal

co-payment rates immediately after the elections. As a consequence, aggregate co-payments for pharmaceuticals decreased to € 2 billion the following year and remained stable at € 1.8 billion in 2000 and 2001 (Nink & Schröder 2003).

1.2.2. Ambulatory medical care

Although a co-payment for consultations with ambulatory care physicians was one of the earliest cost-sharing measures introduced in 1930, cost-sharing for ambulatory medical care has completely vanished from the German health policy arena since 1945 (Reichelt 1994a). Only in the latest proposals for the 2004 reform, a co-payment of € 10 per consulted physician per quarter is again proposed (Bundesministerium für Gesundheit und Soziales (BMGS) 2003).

1.2.3. Hospital care

Cost-sharing for hospital care was introduced in 1983 in the form of a co-payment of € 2.6 per day as an inpatient in a hospital or a rehabilitation facility after a hospital stay. A ceiling of a maximum payment for 14 days per year was introduced. Since then, nominal amounts have been steadily increased over time to € 9 per day in 2003, but the ceiling definition has remained unchanged.

During long periods of time, i.e. between 1983 and 1990 and again between 1997 and 1999 co-payments for preventive spa and rehabilitation treatments unrelated to a hospital stay were markedly higher than the co-payments for hospital stays – by factor 1.5 to 2.

1.2.4. Dental care

Dental care was and still is the sector where SHI patients pay the largest share of out-of-pocket expenditure with € 2.46 billion user charges just for dentures in 1994 (see Table 4). Dentures were the last benefit to be included in the SHI benefits catalogue in 1975 and in 1977 the first to be subjected to cost-sharing in the form of a 20% co-insurance (Alber 1992). Dental care also became an area to test market-oriented cost-containment instruments (Busse 2000). In the 1989 Health Care Reform Act, cost-sharing was not only advocated to raise

revenue, but also to reward “responsible behaviour” by rewarding good preventive practice with lower co-insurance rates (Busse 2000). Thus, co-insurance for crowns and dentures was graded depending on the uptake of annual preventive check-ups. If an insured person had regular annual dental check-ups for the last 10 years he or she would pay 35% co-insurance, 40% for 5 years of check-ups, and 50% in case of less regular or no check-ups (see Table 2). In 1997, crowns and dentures were removed from the benefits catalogue for everyone born after 1978, although the affected insured population was required to pay the same level of contributions as everyone else. For people born before 1979 another innovation was introduced. For the first time a medical treatment was subjected to direct contracts between SHI patients and providers, and patients only received a fixed sum as a reimbursement from the sickness fund retrospectively, whereas for the rest of medical care in Germany physicians are reimbursed via their corporate bodies by the sickness funds. Despite legal limits for extra billing being in place, the Federal Ministry of Health estimated that at least one third of dentists overcharged and the regulation was abolished in 1998 accordingly to be replaced by the former co-insurance regulation (Busse 2000).

1.2.5. Other areas: transport and non-physician care

Sickness funds covered costs for transport to and from medical facilities until 1989. This included physicians’ offices. In 1977 a flat-rate co-payment of € 1.8 per trip was introduced and increased to € 2.6 in 1982. In 1989, more drastic changes were made. Transport to ambulatory care physicians was excluded from reimbursement and co-payments for transport to other facilities was increased by factor 4 to € 10.2 per trip. This regulation has since remained in place with incremental increases in co-payments to reach € 13 per trip in 2003 (see Table 2).

Non-physician care which has to be prescribed by a SHI-contracted physician to be reimbursable was subjected to moderate co-payments between 1977 and 1988. In 1989, a co-insurance of 10% was introduced which was increased to 15% in 1997 and is still in place.

1.3. Voluntary health insurance

Voluntary health insurance (VHI) has two facets in Germany: to fully cover a portion of the population and to offer supplementary insurance for SHI insured persons (Busse 2000). Between 1975 and 2002, the number of people having full-cover VHI has risen from 4.2 million to 7.7 million, representing 6.9% and 9.3% of the population respectively (Thomson, Busse, & Mossialos 2002b;Verband der Privaten Krankenversicherung (PKV) 2003). The VHI insured consist of three main groups: high-earning employees2, the self-employed, and civil servants (Thomson, Busse, & Mossialos 2002a). The benefits covered are usually equal or better than those offered by SHI, but depend on the package chosen (Busse 2000). Policies with high deductibles and/or excluding certain benefits like dental care are mainly bought by the self-employed, as for all employees the employers contribute 50% to VHI premiums up to a ceiling of € 241.50 per month for the employer contribution in 2003. For civil servants the government reimburses 50% to 80% of health care costs directly, and many take out a special VHI plan to cover the remainder. Students in higher education and junior physicians3 are also allowed to opt out of SHI and buy substitutive VHI, even if their income does not exceed the usual threshold (Verband der Privaten Krankenversicherung (PKV) 2003).

The second market for VHI is supplementary insurance to cover extra amenities like one-bed-rooms in hospitals, treatment by the head-of-department or to cover benefits like crowns and dentures with high user charges in the SHI. In 2002, 7.6 million people took out a supplementary VHI (Verband der Privaten Krankenversicherung (PKV) 2003). Between 1989 to 2001 total contributions to VHI increased from € 8.7 billion to € 21.7 billion (Verband der Angestellten-Krankenkassen (VdAK) & Arbeiter-Ersatzkassen-Verband (AEV) 2003a).

A survey conducted by the Federal Statistical Office from 1993 clearly showed that VHI insured households spend substantially more on out-of-pocket payments than households covered by SHI. Whereas SHI-insured households spent € 153, VHI-insured households spent € 394 per capita per year. This was also true for OOP as a percentage of income with on average 1.4% of annual net income spent on OOP in SHI-insured households compared to 2.5% in VHI -insured households (Statistisches Bundesamt 1998b).

[2] i.e. those employees with a gross pay exceeding € 3825 per month (Verband der Privaten Krankenversicherung (PKV) 2003).
[3] Ärztinnen/Ärzte im Praktikum

2. Current cost sharing arrangements: a mapping exercise

2.1. Goods or services for which cost sharing is required

The goods and services for which cost-sharing is currently required in Germany are listed in detail in Table 4. With the exception of ambulatory visits to general practitioners or specialists, conservative dental care and psychotherapy, almost all areas covered by the SHI are currently subject to user charges. Patients in the 'New Länder' in the Eastern part of Germany paid lower levels for selected user charges until 1999.

2.2. Cost-sharing methods currently applied

The dominant forms of user charges, according to the definitions provided by Kutzin (Kutzin 1999), are co-payment and co-insurance. Co-payments for pharmaceuticals, dressings and various aids (hearing aids, eyeglasses, orthopaedic aids) are combined with reference prices or fixed contractual price ceilings. The latter vary between the different Bundesländer.

Deductibles, although a common form of user charges in the private insurance sector, have never played a significant role in the SHI. Legislation to introduce deductibles came into effect on 1 July 1997. Sickness funds were allowed to offer deductibles to their insurees in exchange for lower contributions rates (Sing 1997). This legal provision was swiftly withdrawn by 1 January 1999 after the 1998 Social-democratic Party/Greens general election victory. Since 1 January 2003 however, one sickness fund is allowed to test a similar arrangement in a pilot project with a € 300 deductible per year in exchange for a € 240 bonus, i.e. an offer through which participants may gain up to € 240 and loose up to € 60 per year (Techniker Krankenkasse 2003).

Extra-billing is no longer employed within the SHI scheme. However, if a SHI-insured patient chooses to be treated by a head-of-department in hospital or chooses expensive ceramic or gold inlays not covered by the SHI benefits catalogue, the SHI will still pay the basic SHI

treatment and the patient will receive an extra bill for the services not covered by SHI from the physician or dentist on the basis of a private contract (§§ 28, 30 SGB V).

2.3. Fixed and variable components of the different forms of user charges

According to Table 4, user charges in Germany are overwhelmingly implemented in the form of co-payments with a fixed component. This is the case for pharmaceuticals, travel to and from medical facilities, hospital and inpatient rehabilitative treatment and inpatient preventive spa treatment. In terms of expenditure, the variable cost sharing methods like co-insurance are more important due to the high cost for denture and the high level of user charges (table 3). For pharmaceuticals, a mixture of fixed and variable components is used combining flat-rate co-payments with variable price differentials for reference-priced medication.

2.4. Proportion of the costs of particular services covered by user charges and the total amounts of revenue raised by them

Due to a conceptual change in health expenditure accounting (Statistisches Bundesamt 1999) no reliable data for the most recent years is available. Data on expenditure reported quarterly by the sickness funds to the Ministry of Health does not comprise user charges. Moreover, the complicated settings and various forms of exemption make an assessment of the cumulative and sectoral effects of user charges more difficult (Schneider et al. 1998). The data presented in table 4 presents the amount of user charges for three years calculated according to the new health accounts model.

Preliminary, unpublished estimates by the Federal Statistical Office for the total amount of user charges in the SHI for 2001 are in the order of € 9.9 billion, i.e. around 8% of expenditure (Gerlinger 2003).

Table 4. Current cost sharing arrangements in Germany (2003)

Good or service	Type of cost sharing	Value in € / %	Protection mechanisms
Prescription drugs	Co-payment (per prescribed item)	€4 (small pack) €4.5 (medium pack) €5 (large pack) with price of drug as maximum for all package sizes plus 100% above reference price for reference-priced drugs	▪ Exemptions for children and adolescents ▪ Exemptions for social reasons ▪ General ceilings to prevent undue burden
Dressings	Co-payment (per prescribed item)	€4	▪ Exemptions for children and adolescents ▪ Exemptions for social reasons ▪ General ceilings to prevent undue burden
Inpatient hospital stay	Co-payment (per day)	€9	▪ Exemptions for children and adolescents only ▪ Ceiling of 14 hospital days/year = €126/year per person
Inpatient stay in rehabilitation facility or preventive spa	Co-payment (per day)	€9	▪ Exemptions for children and adolescents ▪ Exemptions for social reasons ▪ Only for rehabilitation treatment after a hospital stay: ▪ Ceiling of 14 inpatient days in rehab facility/year = €126/year per person
Transportation	Co-payment (per trip)	Inpatient or emergency care: €13	▪ Exemptions for social reasons ▪ General ceilings to prevent undue burden
Transportation	Co-insurance	Ambulatory care: 100%	No exemptions or ceilings
Dental care	Co-insurance (rates vary by type of treatment and dependent on regular preventive care)	▪ Orthodontic treatment: 20% if eating, speaking or breathing is severely impaired, otherwise 100%. Co-insurance is reimbursed to the patient if a predefined treatment plan is entirely completed as certified by the dentist ▪ Crowns and dentures: - 35% if the insured had annual check ups for the last 10 years - 40% if the insured had annual check ups for the last 5 years - 50% default rate - 100% for major dental work defined as replacement of >4 teeth per jaw or >3 per side of mouth, except multiple single bridges which may exceed 3 teeth	▪ Exemptions for social reasons ▪ General ceilings to prevent undue burden ▪ For orthodontic treatment in families with more than one child in need of treatment at the same time, the co-insurance rate is reduced to 10% for subsequent children (§ 29, SGB V).
Non-physician care	Co-insurance (per medical prescription)	15%	▪ Exemptions for children and adolescents ▪ Exemptions for social reasons ▪ General ceilings to prevent undue burden
Appliances (e.g. elasticated hosiery)	Co-insurance (per item)	20%	▪ Exemptions for children and adolescents ▪ Exemptions for social reasons
Prescription drugs	Reference pricing (per item prescribed)	100% above reference price plus flat-rate co-payments (s. above)	
Hearing aids and eyeglasses	Reference pricing	100% above reference prices, which vary between Bundesländer	SHI reimburses full cost of a hearing aid priced above the reference price if it leads to a documented improvement of >10% in sensory function compared to two reference-priced aids tested on the patient (Hepp 2003)
Ambulatory physician care	Out-of-pocket maximum	Optional contract offered by one sickness fund: a bonus of €240 per year is offered in case of no-consultation during that year in exchange for accepting an out-of-pocket maximum of €300 per year per person insured(Techniker Krankenkasse 2003)	Optional contracts between individual patients and sickness fund
Ambulatory physician care	Coverage exclusions	A specified number of medical services called 'individual health services' (IGeL) may be offered by SHI-contracted ambulatory care physicians, which are not covered by SHI. They consist in services not considered to be medically necessary by the SHI. Examples include annual comprehensive 'health check-ups', travel vaccinations, alternative and complementary medicine, and refractive corneal surgery to treat myopia.	Optional contracts between patients and physicians

2.5. Protection mechanisms

Exemption from user charges in Germany is either granted for patients of specific population sub-groups or for reasons of equity.

Population sub-groups which are in principle exempt from user charges are:

- Children and adolescents up to the age of 18 years. The exemption does not apply to crowns and dentures, transportation costs, and to orthodontic treatment. For orthodontic treatment the law specifies a reduction of the co-insurance of 20% to 10% in households with more than one child in need of orthodontic care. The reduced rate only applies to subsequent children (§ 29 SGB V).
- Women with pregnancy-related complaints (§ 36b BSG).

- Patients eligible for exemption for reasons of equity fall into three sub-groups:

- General exemption from user charges is granted to all insurees receiving state benefits (income support, war-victim benefits, unemployment support, student grants under the statutory grant scheme) or to insurees on low incomes4. The exemption does not apply to price differentials for reference-priced pharmaceuticals or co-payments for hospital treatment (Sozialklausel §61 SGB V).

- Partial exemption is granted if the cumulative user charges for pharmaceuticals, dressings, non-physician care and travel costs exceed 2% of the patient's household gross annual income5. The patient is then entitled to a reimbursement by the sickness fund of all excess user charges occurred during that year (2% regulation, Überforderungsklausel § 62 SGB V) (Verband der Angestellten-Krankenkassen (VdAK) & Arbeiter-Ersatzkassen-Verband (AEV) 2003b).

- For patients with chronic diseases, i.e. of at least one year duration, the threshold is reduced to 1% of gross annual income and exemption from further user charges is granted

[4] defined as income per month up to €952/one person, €1309/two persons dependent on the insured person's income, and €238 for each additional dependent.
[5] If more than one person is dependent on this income, the threshold is lowered by €4284 for the second person, and by €2856 for each additional dependent.

for as long as the disease persists. In contrast to the 2% regulation, this exemption only applies to the respective person individually and does not include user charges incurred by dependents (1% regulation, Überforderungsklausel §62 SGB V).

In 2001, 47% of prescriptions were exempted from co-payments (Nink & Schröder 2003). Exemptions on the basis of the legislation to avoid undue financial burdens (Überforderungsklausel) have risen by factor 5 between 1997 and 2000 from around 330.000 to 1.82 million insured persons (Nink & Schröder 2003). All exemption mechanisms taken together, more than one third of the SHI-insured population is now exempt from co-payments for pharmaceuticals (Nink & Schröder 2003). Between 1993 and 1998, the proportion of SHI-insured population completely exempted from user charges (Sozialklausel) increased from 10.2% to 13.7% (excluding children). The number partially exempted from user charges (Überforderungsklausel) increased from 0.2% to 0.6% in the same time (Eller, Baumann, & Mielck 2002). If private expenditure on health care, e.g. out-of-pocket payments for supplementary private medical care, exceed a threshold of € 600 per year and exceed a certain percentage of the annual household income, income tax relief is granted for the costs above the threshold.

Complementary VHI in Germany is not usually taken out to protect against co-payments and co-insurance as e.g. in France, but is rather seen as a luxury choice for SHI-insured persons to get the benefits of private medical care. Recently however, a small number of private health insurance companies started to offer special insurance packages to cover SHI co-payments. Data on actual sales of these insurance packages are not available.

2.6. Responsibility for decision-making on cost-sharing measures

Decisions on cost-sharing methods and initial levels are made through the national parliamentary process. Usually, the federal government under the leadership of the Minister of Health and Social Security develops a proposal for a change in legislation, which is formally presented to parliament, which decides on the adaptation in a majority vote. The change in legislation has then to be approved by the Federal Council, representing the Bundesländer. Some laws grant power to the Federal Minister of Health to extend the new legislation by decrees, which do not require renewed parliamentary approval. For instance the

Health Care Reform Act of 1989 empowered the Minister of Health to extend the negative list for pharmaceuticals by decree (§ 34 SGB V).

The SHI benefits catalogue is only defined in broad terms in federal legislation (§§ 2,12 SGB V) and decisions on which benefits to exclude are left to the self-administration of sickness funds and physicians associations at federal level in form of a joint committee – the Federal Committee of Physicians and Sickness Funds.

The decision process for reference prices for pharmaceuticals has two steps. In the first step, the Federal Committee of Physicians and Sickness Funds decides which groups of pharmaceuticals will be included in the reference-price scheme. Experts from academia, physicians' organisations or pharmaceutical industry have a right to be heard by the Committee. The second step is the fixing of price ceilings, which is done by a committee of high-level representatives of all sickness funds at federal level (Spitzenverbände der Krankenkassen). The reference price scheme for sensory and orthopaedic aids differs from the scheme for pharmaceuticals. Groups of aids subject to reference-pricing are decided by the high-level representatives of all sickness funds at federal level and price ceilings are fixed in a second step at Bundesland level by committees representing the regional sickness funds. This leads to regional variation in reference prices for aids, except for the two most important categories of hearing aids and eyeglasses which are uniform throughout the country. Individual sickness funds thus have no decision making power in setting user charges. Voluntary health insurers on the contrary have considerable discretion in defining cost-sharing arrangements in insurance policies offered, resulting in a very intransparent market with myriads of different benefit packages at different premiums to choose from.

Physicians are explicitly prohibited to raise user charges other than those foreseen by law, i.e. for massages, medicinal baths or physiotherapy provided in a physician's office (§ 18 BMV-Ä, § 21 EKV-Ä). The legal case of a physician who lost her SHI contract because she offered homeopathic treatment to SHI patients on a private co-payment basis has been published (Gollrad 2003). The provision of benefits not covered by SHI to SHI-insured patients, so-called individual health services (individuelle Gesundheitsleistungen – IgEL) is tightly regulated by the regional physicians' associations and billing has to be conform to the regulations for VHI-insured patients, which include a written contract between the patient and physician before treatment and a nationwide uniform fee-schedule (Kassenärztliche Vereinigung Niedersachsen 2003).

3. The impact of cost sharing on equity, efficiency and health outcomes: a review of the literature

There is little clear-cut evidence for the long term effect of user charges in Germany. This is caused by various reasons:

- User charges remain marginal in many areas.

- Legislation on user charges changes quickly, making changes in demand difficult to attribute. For example in the case of psychotherapy, legislation on user charges was amended by a successive law but then abolished altogether by a third law before the original legislation was coming into force.

- The problem of confounding with other regulatory interventions does not allow to clearly attribute effects to changes in user charges. For example the more than 100% rise in user charges for inpatient preventive spa treatment in 1997 was accompanied by legislation reducing the length of treatment episodes and extending the time between two treatment episodes before patients were eligible to the service again (Schwartz & Wismar 1998).

In contrast, short term effects of changes in user charge legislation have been sometimes rather dramatic. A well known example is the notorious „Blüm-belly-effect“6. In 1988 a rise in user charges for dentures was announced for the following year. Patients hurried to get their teeth fixed before the new legislation came into force. This resulted in an increased SHI expenditure for 1988 and a subsequent drop in the following year – making the reform look successful (Wismar 1996).

In 1998 the expenditure for dentures collapsed by –30.6% for Germany (-28.8% old Länder, -39.6% new Länder) compared with the previous year. This was caused not only by introducing extra billing. The dentists' associations had been at loggerheads with the Ministry over the question of who pays for the treatment plan and various other issues, creating an atmosphere of uncertainty. Patients consequently refrained from consulting a dentist. In 1999, expenditure for dentures increased again by 9.2% (8.5% old Länder, 13.2% new Länder)7. This also demonstrated that demand was more price elastic in the new Länder, which might

[6] an expenditure curve which resembles the physical appearance of a former Minister in charge of the SHI, Norbert Blüm.
[7] Own calculations based on expenditure data 1976-2001 provided by the Federal Association of Dentists (Kassenzahnärztliche Bundesvereinigung (KZBV) 2003).

reflect the difference in income structure between the two parts of the country, which is particularly pronounced in older age groups. The results of a systematic literature review on cost-sharing arrangements in Germany are summarised in Table 5.

3.1. Impact on efficiency

The reference price scheme for pharmaceuticals proved to be an effective measure for cost-containment. Because of the patient's intention to circumvene co-payment, demand for pharmaceuticals below the reference price ceiling has increased. This, in turn, has led to an increased competition among the pharmaceutical industry. As a consequence the sickness funds were able to make substantial savings in the reference price segments of prescribed drugs, without raising co-payment for patients (Statistisches Bundesamt 1998a). The annual savings for sickness funds from the reference-price scheme gradually increased from € 1.2 billion in 1996 to €2.1 billion in 2002 (Verband Forschender Arzneimittelhersteller e.V. 2002).

But user charges do not necessarily increase efficiency. In some cases they may contribute to rising costs and inefficiencies. The exclusion of trivial pharmaceuticals from SHI coverage in 1983 which resulted in a user charge of 100% did not lead to a reduction in SHI expenditure. Instead there is evidence that these pharmaceuticals were substituted by more effective but also more expensive pharmaceuticals. Neither a decrease in prescriptions nor an increase in the consumption of cheaper pharmaceuticals was observed (Reichelt 1994b).

From an administrative point of view it has been argued that some forms of user charge may not generate the expected revenue. Deductibles will incur high administrative costs for the sickness funds (Sing 1997). Exemption schemes are expensive to administer in general and how much of the additional revenues raised through user charges is spent on administration to run the schemes is largely unknown. This particularly applies to the complicated system of exemption regulation in Germany. However, data on how much administrative costs are caused by the German schemes are not available.

Table 5. Review on the literature on cost sharing in Germany.

Author + date	Study period	Study population + data source	Outcomes	Price variation	Type of study / design	Results
von der Schulenburg 1987 (Graf von der Schulenburg 1987)		76 private health insurance contracts			Observational	Price elasticity of demand between -0.078 to 0.389
Von der Schulenburg and Uber 1993 (Graf von der Schulenburg & Uber 1993)		Ambulatory patients	Demand for phlebotropic drugs	Higher co-payments	Willingness-to-pay study Survey	Low percentage of patients show price responsiveness: 5% would stop buying phlebotropic drugs, 22% would reduce consumption if they had to pay cost themselves
Reichelt 1994 (Reichelt 1994b)		SHI insurance	Pharmaceutical spending	Exclusion of pharmaceuticals through negative list	Observational	Substitution of pharmaceuticals excluded from SHI reimbursement by more effective and more expensive prescription medications
Bundesfachverband der Arzneimittel-Hersteller 1998 (Bundesfachverband der Arzneimittel-Hersteller (BAH) 1998b)	January-March 1998	Citizens	Ambulatory medical care utilisation	Planned increase in co-payments for pharmaceuticals	Survey	70% of interviewees indicated that they would not consult their ambulatory care physician to get a prescription for OTC available drugs in case of higher co-payments
Lauterbach et al 2000 (Lauterbach, Gandjour, & Schnell 2000)	Oct-Dec 1998	Users of pharmacies aged over 18 and not-exempted from user charges, 10,000 questionnaires, 695 responses	Reported change in behaviour after increases in user charges in July 1997	Higher co-payments (+90%)	Survey Questionnaire	4.5% reduction in ambulatory medical care utilisation; 0.06% reduction in pharmaceutical consumption. Demand in chronically ill was less elastic. Demand in low income group was more elastic (no statistical analysis for subgroups because of small numbers)
Eller et al 2002 (Eller, Baumann, & Mielck 2002)	May-Sept 2000	18,238 persons insured with one regional sickness fund (AOK Augsburg), 6244 responders (34%), 1,002 telephone interviews	- Knowledge about exemption regulation - Application for exemption	Not applicable	Survey Questionnaire and telephone interviews in random sample	62% of SHI insurees are not aware of partial exemption regulation, 28% are not aware of general exemption regulation. Proportions are in similar range for eligible population sub-groups. In those aware of regulation, the main reason for not applying for exemption is lack of knowledge about income ceilings to determine eligibility.
Uhlich 2002 (Uhlich 2002)	June 1997-June 1998	1889 responding patients in 9 GP practices in Hesse, number of questionnaires distributed not given	User satisfaction with ambulatory medical care	Introduction of drug budget and higher copayments starting at start of survey (+90% to +200% depending on package size)	Survey Questionnaire	No significant impact of policy changes on user satisfaction within the time period surveyed
Verband Forschender Arzneimittelhersteller 2002 (Verband Forschender Arzneimittelhersteller e.V. 2002)	1996-2002	Company-based sickness fund (BKK) data	Cost-savings for SHI from reference-price scheme	Reference-price scheme	Observational	Cost-savings for SHI from pharmaceuticals reference-price scheme (billion €): 1996 (1.2), 1997 (1.4), 1998 (1.6), 1999 (1.7), 2000 (1.7), 2001 (1.8), 2002 (2.1)

3.2. Impact on equity

There is evidence that in Germany expenditure for co-payments for pharmaceuticals grow with age (Table 6). Assuming that elderly people are more in need and that pensions are substantially lower than income, user charges introduce a risk-related financial burden which is incompatible with solidarity in SHI. However, many elderly people are exempt from co-payments for social reasons (2% regulation, Überforderungsklausel § 62 SGB V).

Table 6: Co-payments for pharmaceuticals grow with age, 1996-2002.

Age (years)	<20		21-40		41-60		>60		
	male	female	male	female	male	female	male	female	average
1996 (€)	1.3	1.7	7.7	12.1	19.2	28.2	52.7	58.3	22.7
1997 (€)	1.7	1.4	11.3	17.7	27.8	39.7	75.9	80.8	31.8
2002 (€)	0.45	1.11	10.5	16.8	24.3	34.0	50.4	55.6	24.1

Source: GKV-Arzneimittelindex im Wissenschaftlichen Institut der AOK (WIDO) (personal communication)

Equity implications of exemption mechanisms from user charges constitute another problem. There is some evidence that many eligible patients do not claim exemption. A recent study showed that 28% of surveyed sickness fund members did not know about the general exemption mechanism (Sozialklausel) and 62% did not know about the possibility of partial exemption (Überforderungsklausel) (Eller, Baumann, & Mielck 2002). These rates were not markedly different in those with potential eligibility for exemption based on questionnaire data. Although this study only covered a population of about 18,000 people insured with one particular regional sickness fund, it can be assumed that many insured who are eligible for exemption do not claim reimbursement of user charges. Most of the patients who were aware of the possibility of exemption and eligible but did not apply stated that they thought their income was too high (Eller, Baumann, & Mielck 2002). This is an effect of a lack in flow of information from sickness funds to eligible patients and of the complexity of the exemption regulation.

3.3. Evidence of administrative and other effects

Higher levels of co-payments for pharmaceuticals since July 1997 resulted in 20% of all prescriptions and 4% of pharmaceutical sales volume in the SHI market being below the co-payment ceiling – which in effect constitutes a 100% co-payment. Although prescriptions are legal documents owned by the sickness funds, it has been argued that pharmacists do not pass these prescriptions on to the pharmacy-computing service as they have already perceived the total amount due in the form of the co-payment. As a consequence, these prescriptions are not taken into account in the statistics. This results in a distortion of the overall statistics of SHI expenditure and limits the possibility of efficiency benchmarking (Schwabe 1997)

4. Political feasibility: a discussion of policy debates concerning cost sharing

Although user charges have played a minor role in the German SHI in terms of generating revenue, they have always been a major issue of political controversy.

Since the creation of the Federal Republic two health care reform proposals failed in 1960 and in 1964. Both of them contained provisions for user charges which exceeded by far the extent of user charges introduced during the cost-containment period (Bandelow 1998). In 1960 a co-payment of DM 1.50 was planned for each item on the medical fee schedule delivered by physicians in the ambulatory sector. The co-payment would have been limited to 6 weeks for every disease episode. At the same time a differentiated co-payment for pharmaceuticals up to DM 3 per prescription was suggested. Highly relevant was the co-insurance for hospital-, preventive spa treatment and rehabilitation of 0.5% of the monthly income up to DM 3.30 per day (in 1960 the assessable income limit was DM 630). The second reform proposal in 1964 planned user charges of a total of 25% of all outpatient medical and dental services (Müller 1980). Both reforms failed in the political process. While the physician associations welcomed user charges as a further source of revenue, they opposed other parts of the reform. The trade unions and the Social Democratic Party (SPD) forcefully opposed the reform proposal on the grounds that it implied general moral hazard by patients. The minister in charge could not rely on the support of his own party - large parts of the governing Christian

Democratic Party (CDU), in particular the committees for social affairs, opposed the proposals. Only the employers' association and the association of private health insurers were in favour of the proposal (Müller 1980). Due to a coming general election, Chancellor Adenauer intervened into health policy and withdrew his support for the reform proposal. The failed reform attempts led to the resignation of the Minister of Health in charge and in turn constituted a reform-trauma which contributed to the myth of the reform resistance of the SHI.

As a prelude to the era of cost-containment, the political debate was dominated by the issue of the so-called „cost-explosion". Expenditure had, intentionally, risen rapidly until the mid 70s. In 1977 the first explicit cost-containment law was introduced extending user charges substantially. But user charges remained an awkward political issue under the SPD/Free Democratic Party (FDP) government. The SPD could not convincingly reconcile user charges with social justice and equity which was very important for the party's identity. Expectations of their traditional blue collar electorate were disappointed. For the successive CDU/FDP coalition government – which took over in 1982 - user charges fitted better into the party programme. Since the major criticism of the welfare state by the CDU was an alleged imbalance between individual rights and solidarity, the concept of subsidiarity became a guiding principle. Originating from catholic social theory, subsidiarity conceptualises the relation between the individual and the state. The state is conceived of as a supporter in the last instance (Wismar 1996). Only if the individual is unable to take care of himself and his family, friends, neighbourhoods or the church or trade unions fail to give support, the state steps in (Biedenkopf 1985;Blüm 1983;Späth 1985). Although it is debatable whether this approach has much in common with social reality in Germany, it remained the main focus of political debate on the welfare state and health policy. User charges were conceived of as the perfect instrument in this respect. But bearing in mind the experiences of the failed reform attempts in the 1960s the government was eager not to increase the amount of user charges excessively. Furthermore there was little need to extend user charges because until reunification the share of SHI expenditure as a percentage of GDP and contribution rates remained fairly stable.

After two major healthcare reforms which came into force in 1989 and 1994 there was again a growing awareness of the need to generally overhaul the whole system. An unprecedented reform debate on the roll-back of social insurance in health care and the privatisation of health

care took place (Stegmüller 1996). Although no drastic measures were taken, the political debate shifted. SHI was considered not only a burden in terms of expenditure but at the same time as an industry and potential job market of the future (Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 1996;Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 1998). In order not to strangle this industry by strict cost-containment policies the new strategy of the government was to channel more money into the system without raising the employers' contribution. The major instrument of this policy was to expand user charges drastically (Busse & Wismar 1997). Today, this move in health policy is conceived of as having substantially contributed to the defeat of the CDU/FDP coalition government in the general elections of 1998. In the federal election campaigns of 1998 user charges – especially with regard to dentures - became an important political issue. After a clear-cut victory, the newly elected SPD/Greens coalition government set immediately pace to introduce legislation reducing the level of user charges and lowering the thresholds for exemption.

Over the decades provider attitudes towards user charges have remained rather stable. A survey among 4,500 German physicians in November 1996 showed that the majority of doctors are still in favour of user charges. Asked whether the current level of user charges was reasonable, 90% responded positively. 67% were in favour of an increase in user charges while 31% were against an increase (Beske, Hallauer, & Kern 1997).

5. Plans for the development of cost-sharing arrangements

In a speech to parliament, Chancellor Gerhard Schröder has stated in March 2003 that the reform of the SHI is the most important aspect of political renewal in Germany (Bundesregierung 2003). He explicitly announced cuts in benefits and a raise in user charges in order to sustain a system of high-quality health care which is accessible for everyone, independent of age or income.

To avoid blocking of this health care reform by the Federal Council8 the SPD/Greens coalition government has elaborated the new legislation together with the opposition parties and representatives of the Bundesländer. This is an exceptional procedure and only happened

[8] The opposition parties have the majority in the Federal Council.

once before in 1992, at the time with inverted roles for government and opposition. The ensuing Health Care Structure Act of 1993 was considered a political success as it cooled down the health policy debate for three years (Becker 2003), although it was not successful in stabilising SHI expenditure. The final bill from 8 September 2003 for the Statutory Health Insurance Modernisation Act (Deutscher Bundestag 2003) thus contains a mixture of red-green and conservative political demands. This partly explains the increase in cost-sharing and other more pro-market reform orientated measures, e.g. legalising pharmaceutical sales by internet pharmacies, compared to health policy decisions so far made by the ruling government.

The stated objectives of the reform are to improve efficiency and quality of health care, in particular for frequent chronic diseases, and to stabilise SHI contribution rates in order to avoid disincentives for employers to invest in job-creating activities without rationing services (Deutscher Bundestag 2003).

The changes in cost-sharing arrangements anticipated to come into force on 1 January 2004 are detailed in Table 2. Based on Federal Ministry of Health calculations these will result in substantial cost-savings for SHI rising from € 9.8 billion in 2004 to € 23 billion in 2007 (Deutscher Bundestag 2003). The € 23 billion savings in 2007 are mainly achieved through cost-shifting from employers (€ 11.5 billion) and healthy employees (€ 3 billion) to patients, pensioners, smokers, and to a lesser extent to providers and industry (figure 1).

The anticipated changes in financing affecting users and insurees are composed of the following measures (Deutscher Bundestag 2003):

- exclusion of benefits (€ 2.5 billion[9]);
- higher co-payments (€ 3.2 billion);
- a separate insurance for dentures (€ 3.5 billion) which will be regressive because a flat premium will applied;
- financing of some benefits which are not considered to be core SHI benefits through increases in tobacco taxes rising from € 1 billion in 2004 to € 4.2 billion in 2007;
- extension of SHI contributions to income from additional, non-statutory pensions which have been hitherto exempted raising € 1.6 billion in revenues for SHI;

[9] Savings from exclusion of benefits in cash and kind are further broken down. The major savings accrue from exclusion of OTC medication from reimbursement (€ 1 billion), exclusion of ambulatory travel costs (€ 0.5 billion), and cash benefits to families in case of death (€ 0,4 billion) (Deutscher Bundestag 2003).

- a “special” contribution (Sonderbeitrag) by all SHI insurees (but not by employers) raising € 5 billion per year.

This reform will end the parity in SHI contributions by employers and employees which was established in 1949 (Alber 1992) and is still in place in 2003. If the law comes into force as planned, employees will contribute 53.3% and employers 46.7% to formal SHI in 2007 (Retzlaff 2003). If the new obligatory insurance for dentures which is no longer part of the SHI is taken into account, the distribution is even more unequal with 53.7% contribution by employees compared to 46.3% by employers (Fig. 1).

The general exemption regulation currently in force (§ 61 SGB V) is completely abolished10. The exemption of children and adolescents under age 18 remains in place. Partial exemption – now called ceiling on financial burden (Belastungsobergrenze) - as defined in § 62 SGB V now generally applies (Deutscher Bundestag 2003).

In comparison, the anticipated cost-savings from measures targeting health care providers and pharmaceutical industry are minimal, totalling € 1.5 billion in 2004 rising progressively to € 3 billion in 2007. This imbalance is even more pronounced if one considers that users of health services, insurees and citizens have little possibility to reduce utilisation or avoid paying taxes or SHI contributions whereas experience in Germany and other countries has shown that providers and industry are often able to compensate for financial cuts by raising additional revenue through other channels. A notorious example in Germany was the rise in private health insurance expenditure in areas where SHI cost-containment measures was most successful, e.g. for dental care and pharmaceuticals (Busse 2000). In contrast to current legislation, prices for OTC drugs which are not reimbursable by sickness funds will no longer fall under price regulation (Deutscher Bundestag 2003), i.e. pricing for OTC drugs will be left to free market competition. Whether this will lead to an increase or decrease of aggregate consumer expenditure for OTC drugs remains to be seen. As the current regulation’s aim is cost-containment and the pharmacists’ monopoly to sell drugs will remain largely unaltered, an increase in prices and higher costs for patients are the more likely scenario.

[10] Interestingly the former § 61 SGB V regulating the exemption of the most deprived groups in the population now details the new cost-sharing measures.

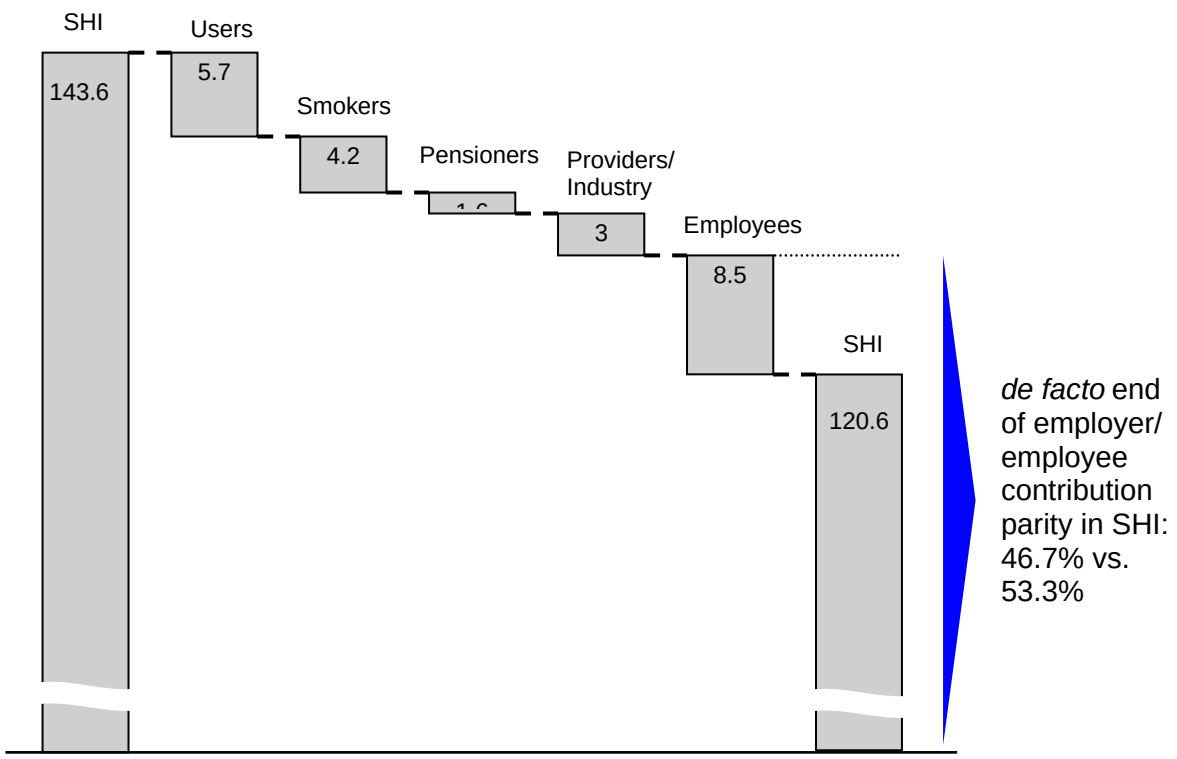

Figure 1. Anticipated cost-shifting from employers and healthy employees to users of health care, smokers, pensioners, providers and industry, and the *de facto* end of contribution parity in SHI. Source: Own calculations based on SHI health care spending in 2002 (Bundesministerium für Gesundheit und Soziale Sicherung 2003) and data from the original proposals for the Statutory Health Insurance Modernisation Act 2003 (Deutscher Bundestag 2003).

The public is not unaware of these developments. In a recent survey 64% of users thought the new reform proposals were unfair and represented a major cost-shifting to patients and insurees. Only 28% of users declared that they would plan their utilisation of medical care more carefully because of the new co-payment for outpatient consultations (Anonymous 2003). This can be interpreted as yet another indicator that user charges are not an efficient means to steer utilisation behaviour, an often repeated claim also made by the Chancellor to justify the current proposals for a change in legislation (Bundesregierung 2003). In reality, in Germany user charges primarily serve to raise additional revenue without getting into conflict with powerful lobbying groups representing health care providers and industry.

References

Alber, J. 1992, "Grundzüge des deutschen Gesundheitswesens," in *Das Gesundheitswesen der Bundesrepublik Deutschland. Entwicklung, Struktur und Funktionsweise*, Campus Verlag, Frankfurt/Main, pp. 17-62.

Anonymous 2003, "Gesundheitsreform. Bürger sind skeptisch", *G+G Gesundheit und Gesellschaft*, vol. 6, no. 9, p. 13.

Bandelow, N. C. 1998, *Gesundheitspolitik: Der Staat in der Hand einzelner Interessengruppen?* Leske + Budrich, Opladen.

Bärnighausen, T. & Sauerborn, R. 2002, "One hundred and eighteen years of the German health insurance system: are there any lessons for middle- and low-income countries?", *Soc.Sci.Med.*, vol. 54, no. 10, pp. 1559-1587.

Becker, J. 2003, "Konsens statt Konflikt", *G+G Gesundheit und Gesellschaft*, vol. Sonderausgabe August 2003, pp. 4-5.

Beske, F., Hallauer, J. F., & Kern, A. O. 1997, "Reform des Gesundheitswesens: Die Meinung der Ärzte. Ergebnisse einer Leserumfrage (II); Themen heute: "Leistungskatalog, Selbstbeteiligung, Rationalisierung"", *Deutsches Ärzteblatt*, vol. 94, no. 38, pp. A-2400-2402.

Biedenkopf, K. H. 1985, *Die neue Sicht der Dinge* Piper Verlag, München.

Blüm, N. 1983, "Solidarität und Subsidiarität in der Sozialpolitik", *Medizin, Mensch, Gesellschaft*, vol. 8, pp. 1-2.

Braun, B., Kühn, H., & Reiners, H. 1998, *Das Märchen von der Kostenexplosion - Populäre Irrtümer zur Gesundheitspolitik* Fischer, Frankfurt/Main.

Bundesfachverband der Arzneimittel-Hersteller (BAH) 1998a, *Der Selbstmedikationsmarkt in der Bundesrepublik Deutschland in Zahlen 1997*, BAH, Bonn.

Bundesfachverband der Arzneimittel-Hersteller (BAH) 1998b, *Geschäftsbericht 1997/1998*, BAH, Bonn.

Bundesministerium für Gesundheit und Soziale Sicherung 2003, *Vorläufiges Rechnungsergebnis 1. bis 4. Quartal 2002*.

Bundesministerium für Gesundheit und Soziales (BMGS) 2003, *Eckpunkte der Konsensverhandlungen zur Gesundheitsreform*, BMGS, Berlin.

Bundesregierung. Regierungserklärung von Bundeskanzler Schröder am 14. März 2003 vor dem Deutschen Bundestag. http://www.bundesregierung.de/servlet/init.cms.layout.LayoutServlet?global.naviknoten=8674&link=bpa_notiz_druck&global.printview=2&link.docs=472179 (accessed 15 September 2003) . 2003.

Bundesverband der Arzneimittel-Hersteller (BAH) 2002, *Der Arzneimittelmarkt in Deutschland in Zahlen 2001 - Unter besonderer Berücksichtigung der Selbstmedikation*, BAH, Bonn.

Busse, R. 2000, *Health care systems in transition - Germany* European Observatory on Health Care Systems, Copenhagen.

Busse, R. & Wismar, M. 1997, "Health care reform in Germany: the end of cost containment ?", *eurohealth*, vol. 3, no. 2, pp. 32-33.

Deutscher Bundestag 2003, *Gesetzentwurf der Fraktionen SPD, CDU/CSU und Bündnis 90/Die Grünen. Entwurf eines Gesetzes zur Modernisierung der Gesetzlichen Krankenversicherung (GKV-Modernisierungsgesetz - GMG)*, BT-Drucksache 15/1525, Berlin.

Eller, M., Baumann, F., & Mielck, A. 2002, "Bekanntheitsgrad der Härtefallregelungen in der gesetzlichen Krankenversicherung", *Gesundheitswesen*, vol. 64, pp. 565-571.

Ess, S. M., Schneeweiss, S., & Szucs, T. D. 2003, "European healthcare policies for controlling drug expenditure", *Pharmacoeconomics.*, vol. 21, no. 2, pp. 89-103.

Gerlinger, T. 2003, "Rot-grüne Gesundheitspolitik 1998-2003", *Aus Politik und Zeitgeschichte*, vol. B33-34, no. 11 August 2003, pp. 6-13.

Gollrad, W. 2003, "Entzug der Zulassung als Vertragsarzt wegen Verlangens privater Zuzahlungen bei homöopathischer Behandlung von Kassenpatienten", *MedR Schriftenreihe Medizinrecht*, vol. 4, pp. 242-243.

Graf von der Schulenburg, J. M. 1987, *Selbstbeteiligung: Theoretische und empirische Konzepte für die Analyse ihrer Allokations- und Verteilungswirkungen* J.B.C. Mohr, Tübingen.

Graf von der Schulenburg, J. M. & Uber, A. 1993, "Socio-economic aspects of veous insufficiency: a report on a survey conducted in the Federal Republic of Germany," in *Enjeux médico-sociaux et economiques d'une pathologie*, Université Libre de Bruxelles, Bruxelles.

Hepp, H. Empfehlungen für Versicherte zum Vorgehen bei der Hörgeräteversorgung. http://www.schwerhoerigkeit.de/RATGEBER/HOERGERAETE/empfehlg.htm (accessed 5 September 2003) . 2003.

Kassenärztliche Vereinigung Niedersachsen. Individuelle Gesundheitsleistungen (IGeL). http://kvns.arzt.de/Homepage/arwirind/IGeL/katalog.pdf (accessed 4 September 2003) . 2003.

Kassenzahnärztliche Bundesvereinigung (KZBV). GKV: Ausgaben für zahnärztliche Behandlung. http://www.kzbv.de/m33.htm (accessed 11 September 2003) . 2003.

Kutzin, J. 1999, "The appropriate role for patient cost sharing," in *Critical challanges for health care reform in Europe*, R. B. Saltman, J. Figueras, & C. Sakellarides, eds., Open University Press, Buckingham-Philadelphia, pp. 78-112.

Lauterbach, K. W., Gandjour, A., & Schnell, G. Zuzahlungen bei Arzneimitteln. http://www.medizin.uni-koeln.de/kai/igmg/stellungnahme/zuzahlungen/sld001.htm (accessed 18 September 2003) . 2000.

Müller, A. 1980, "Versuch einer Kostendämpfungspolitik unter Theodor Blank", *DOK*, vol. 62, no. 15, pp. 521-535.

Nink, K. & Schröder, H. 2003, "Der Arzneimittelmarkt in der Bundesrepublik Deutschland," in *Arzneiverordnungsreport 2002*, U. Schwabe & D. Paffrath, eds., Springer, Berlin, pp. 853-893.

Reichelt, H. 1994a, *Steuerungswirkungen der Selbstbeteiligung im Arzneimittelmarkt* Gustav Fischer Verlag, Stuttgart.

Reichelt, H. 1994b, *Steuerungswirkungen der Selbstbeteiligung im Arzneimittelmarkt: Analyse der Auswirkungen bisher praktizierter Reformgesetzgebung 1989 und 1993 auf die Versicherten* Campus, Frankfurt/Main.

Reichsministerium des Innern 1930, *Reichsgesetzblatt*, vol. I, p. 311.

Retzlaff, L. 2003, "Gesundheitsreform. Streit der Parteien vorerst beigelegt", *Marburger Bund Zeitung*, vol. 56, p. 1.

Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 1996, *Gesundheitswesen in Deutschland: Kostenfaktor und Zukunftsbranche. Band I: Demographie, Morbidität, Wirtschaftlichkeitsreserven und Beschäftigung; Sondergutachten 1996* Nomos Verlagsgesellschaft, Baden-Baden.

Sachverständigenrat für die Konzertierte Aktion im Gesundheitswesen 1998, *Gesundheitswesen in Deutschland Kostenfaktor und Zukunftsbranche. Band II Fortschritt Wachstumsmärkte Finanzierung und Vergütung. Sondergutachten 1997* Nomos Verlagsgesellschaft, Baden-Baden.

Schneider, M., Beckmann, M., Biene-Dietrich, P., Gabanyi, M., Hofmann, U., Köse, A., Mill, D., & Späth, B. 1998, *Gesundheitssysteme im internationalen Vergleich: Übersichten 1997* Basys, Augsburg.

Schwabe, U. 1997, "Der Arzneimittelmarkt in der Bundesrepublik Deutschland," in *Arzneiverordnungs-Report ´97: aktuelle Daten, Kosten, Trends und Kommentare*, U. Schwabe, ed., Gustav Fischer Verlag, Stuttgart-Jena-Lübeck-Ulm, pp. 586-625.

Schwartz, F. W. & Wismar, M. 1998, "Wie steuerbar ist das Gesundheitswesen," in *Wie steuerbar ist das Gesundheitswesen?*, O. Meggeneder & H. Noack, eds., Oberösterreichische Gebietskrankenkasse, Linz, pp. 31-47.

Sing, R. 1997, "Selbstbehalt - ein geeignetes Instrument zur Weiterentwicklung der GKV?", *DOK*, vol. 79, no. 6-7, pp. 181-184.

Späth, L. 1985, *Wende in die Zukunft: die Bundesrepublik auf dem Weg in die Informationsgesellschaft* Rowohlt, Reinbek bei Hamburg.

Statistisches Bundesamt 1998a, *Gesundheitsbericht für Deutschland: Gesundheitsberichterstattung des Bundes* Metzler-Poeschel, Stuttgart.

Statistisches Bundesamt 1998b, "Zuzahlung, direkte Käufe," in *Gesundheitsbericht für Deutschland*, Statistisches Bundesamt, ed., Metzler-Poeschel, Stuttgart, pp. 479-483.

Statistisches Bundesamt 1999, "Konzept einer Ausgaben- und Finanzierungsrechnung für die Gesundheitsberichterstattung des Bundes", *Wirtschaft und Statistik* no. 3, pp. 225-236.

Stegmüller, K. 1996, *Wettbewerb im Gesundheitswesen: Konzeptionen zur +dritten Reformstufe der Gesetzlichen Krankenversicherung* VAS, Frankfurt a. M.

Techniker Krankenkasse. Modellvorhaben Selbstbehalt. http://www.tk-online.de/centaurus/generator/tk-online.de/s01__aktuell/01__tk240/010__modellvorhaben__selbstbehalt.html (accessed 2 September 2003) . 2003.

Thomson, S., Busse, R., & Mossialos, E. 2002a, "Low demand for substitutive voluntary health insurance in Germany", *Croat.Med.J.*, vol. 43, no. 4, pp. 425-432.

Thomson, S., Busse, R., & Mossialos, E. 2002b, "Low demand for substitutive voluntary health insurance in Germany", *Croat.Med.J.*, vol. 43, no. 4, pp. 425-432.

Uhlich, C. 2002, *Auswirkungen von Praxisbudgets und Zuzahlungen auf Patientenzufriedenheit und Hausarztkontakte,* Dr. med. Doctoral thesis, Philipps-Universität Marburg.

Verband der Angestellten-Krankenkassen (VdAK) & Arbeiter-Ersatzkassen-Verband (AEV). Ausgewählte Basisdaten des Gesundheitswesens 2003. http://www.vdak-aev.de/b2003_kap_d.htm (accessed 11 September 2003) . 2003a.

Verband der Angestellten-Krankenkassen (VdAK) & Arbeiter-Ersatzkassen-Verband (AEV). Basisdaten - Befreiungsmöglichkeiten von der Zuzahlungspflicht. Härtefallregelungen 2003. http://www.vdak-aev.de/zahlen8_2003.htm (accessed 5 September 2003) . 2003b.

Verband der Privaten Krankenversicherung (PKV). Die Möglichkeiten. Die Sicherheit. Die Zukunft. http://www.pkv.de/default.asp (accessed 10 September 2003) . 2003.

Verband Forschender Arzneimittelhersteller e.V. 1998, *Statistics: die Arzneimittelindustrie in Deutschland '98* Verband Forschender Arzneimittelhersteller e.V., Bonn.

Verband Forschender Arzneimittelhersteller e.V. 2002, *Statistics: The Pharmaceutical Industry in Germany 2002* Verband Forschender Arzneimittelhersteller e.V. (VFA), Berlin.

Wismar, M. 1996, *Gesundheitswesen im Übergang zum Postfordismus: Die gesundheitspolitische Regulierung der Fordismuskrise in Großbritannien und der Bundesrepublik Deutschland* VAS, Frankfurt a. M.