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**Health Care Reform in Germany:
Patchwork Change within Established
Governance Structures**

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Abstract Under the pressure of health care reform in the 1990s, interactions among the state, sickness funds, and providers in Germany are said to have entered a new era. We examine this new era by assessing both long-term developments connected to German statutory health insurance and related short-term developments of the 1990s. Highly institutionalized rules and practices provide little opportunity for abandoning the historical path of two primary factors: the self-governance of SHI and a strong tradition of a semisovereign state. Some opportunities exist for introducing new ideas, rearranging priorities, softening rules, and adding new complex rules and procedures in a fairly fragmented policy-making system, perhaps even because of fragmentation. Yet reforms that depart from the status quo are severely limited by strong legal and administrative traditions and established rules of the game. These restrictions tend to reinforce state intervention, prevent the emergence of consistent and coherent visions of future health policy, and stifle policy innovation and implementation. In sum, reform measures tend to remain well within the priorities established within state and corporatist governance structures.

During the 1990s, health care reform was squarely on the German political agenda, with various reform legislation and regulatory interventions addressing different aspects of German statutory health insurance (SHI).

The conservative Kohl government introduced the first phase of reform measures in 1989 with the Health Care Reform Act, followed by the Health Care Structure Act in 1993. When the Schroeder Social Democratic (SPD)-Green coalition came to power in 1998, it quickly adopted

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the Act to Strengthen Solidarity in SHI later that year. In December 1999, the coalition enacted the SHI Reform Act of 2000, a slimmed-down version of the original legislation proposed a month earlier. All these reform packages, and those that have followed, deal with cost containment, the restructuring of medical financing, and the restructuring of SHI.

Yet observers now point to the reemergence of the Ministry of Health as a key player during this decade of frenzied reforms: the ministry is visible not only vis-a-vis the German parliament but also in relation to sickness funds and providers. Thus, questions can be raised about the scope of the reforms of the 1990s. Do these changes outline a dramatic departure from the 120-year history of SHI, which is part of a well-known state tradition in Germany? Or do they simply amount to tinkering on the edges? The argument presented here is that path dependency, institutional continuities, and a semisovereign state policy-making model (Katzenstein 1987) characterized by a strong division between civil society and the state, have combined to inhibit radical reform and instead have contributed to reforms without vision. Within these constraints, opportunities for change exist in three areas: normative beliefs and ideas, procedures, and institutional arrangements (Giaino and Manow 1997; Dohler and Manow-Borgwardt 1991, 1992; Dohler 1990).

This analysis looks at the SHI, and the state governance structures in which it is embedded, through the lens of path dependency (Pierson 2000) or, put more simply, through a historical-comparative perspective (Pierson and Skocpol 2002). In history and political science, path dependency is not deterministic; nor does a path predetermine policy outcomes. This approach calls for separating long-term from short-term developments when assessing reforms. Any argument about path dependent SHI developments needs to be anchored within a larger context.

There are several manifestations of path dependency in health care in Germany. The first is the continued influence of strong legal and administrative traditions on the perceptions and actions of policy actors and policy processes (in both formulation and implementation). These structural forces greatly affect the interaction of state governance and self-governance (Knill 2002). The second is the literature that groups Germany among the democracies with a strong state-centered, rather than society-centered, governance system. Yet this variant of state centrism in Germany is distinct from state centrism in, for example, Britain and France. Peter Katzenstein's (1987) "semi-sovereign state" involves a strong legal separation of the state from self-regulating or self-governing societal groups as well as a strong (negotiation-based) interdepen-

dency between the two structures. Their interaction is clearly corporatist (Dohler 1990; Bandelow 1994, 1998; Dohler and Manow 1995; Blanke 1994; Manow 1994). Corporatist self-governance by association in health care entails substantial state regulation and even emergency decree power by the state (Streeck and Schmitter 1985). State offices are dominant, if not always highly visible; a command-and-control logic tends to prevail in both offices of the state and corporatist self-governance.

Past research on German health policy has paid much attention to politics and economics but very little attention to the role of public and social law and the role of administration through state offices and offices of the self-governing bodies. These offices serve the values and the purpose for which they were created. The leadership of the self-governing bodies is operating under the umbrella of a restrictive legal SHI framework, which allows for accommodations rather than departure from the SHI umbrella. Negotiated agreements between the leadership of the two sides are binding not only on the regional self-governing bodies but also on the state offices and, last but not least, on individual members of SHI and individual providers.

Rulings of the German administrative social courts tend to reinforce rather than open up the basic parameters for the operation of SHI. Despite numerous legislative changes over recent years, the power of SHI-related law and regulations has not been eroded. Moreover, the legislative changes have not diminished the principle of solidarity or weakened the force of law as interpreted by the administrative social courts.

When Bismarck established SHI in the 1880s, he wanted to subject it to a central imperial office. Control instead went to labor and business, but the imperial state, and later the democratic state, retained strong supervisory powers over social policy and industrial relations. Supervisory powers over SHI rested with the Reich Interior Office from the 1880s until 1918, when this power was handed over to the Reich Labor Ministry. After 1949, the Gesundheitsabteilung (Health Department) of the Federal Ministry of Labor and Social Affairs supervised SHI. In the early 1990s, SHI was taken out of the industrial relations nexus and transferred to the Federal Ministry of Health (Manow 1997).¹ a young ministry created in 1961 (Gartner 1964: 19). However, this change in ministry does not indicate a reduced influence of bureaucratic politics and strong state regulators.

A final but significant constant in this state tradition is a separation of

1. Since late 2002, after assuming responsibilities for pensions, this ministry is now the Federal Ministry of Health and Social Security.

Table 1 Sources and Methods of Funding Health Care

Source of Finance	Method of Raising Funds	Costa	1971
Public budgets	Taxes (direct and indirect: not earmarked)	17.2	7.9
Statutory health insurance	Wage-related contributions (50% each employer and employee)	124.4	56.9
Statutory long-term care insurance	Wage-related contributions (50% each employer and employee)	15.6	7.2
Statutory retirement insurance	Wage-related contributions (50% each employer and employee)	3.9	1.8
Statutory accident insurance	Risk-related contributions (employer only)	3.8	1.7
Out-of-pocket and private organizations (e.g., the Red Cross, foundations)		26.6	12.2
Private health insurance	Risk-related premiums	17.9	8.2
Employers	Direct expenditure (excluding sick pay)	9.1	4.1
TOTAL		218.5	100

Source: Statistisches Bundesamt 2002.
In billions Euro.

financing. Since the inception of the German welfare state, the funds that support the individual social insurance programs, including SHI, have been kept separate from those that sustain social programs in public budgets, whether federal, regional, or municipal (Henke 2001). However, the balance of power between the various players, along with control over the organization of each program, has varied over time, and cost-shifting from public budgets to insurance-based budgets has occasionally occurred (see table 1).

Given the different origins, timing, and attributes of state-centered governance and SHI, one might think that after transitions to democracy in 1918 and again after 1945, the role of state offices would have declined in favor of civil society and non-state-based actors. On the face of it, this is what seemingly happened. But in reality, the two structural forces have coexisted, having been mediated through democratic-electoral politics and the persistence of legal and administrative traditions. Despite the legal autonomy of SHI, it has been interdependent with the state office of the respective ministry, even across the discontinuities of the political system.

The state has acted as regulator, facilitator, and enabler to the parties in

corporatist self-governance; that is, the providers and payers. State offices have been more visible at some times than at others but have never disappeared from this triangular relationship. Pressures and influences have flown both ways from the state-Division V (Abteilung V) of the Federal Ministry of Labor and Social Affairs until the early 1990s and Division II (Abteilung II) of the Federal Ministry of Health-to the parties of self-governance and back.² The bureaucracy, with the backing of the respective minister, has kept a tight grip over SHI, only relaxing when politically necessary. Since the 1990s, the grip has been tightening again; the Ministry of Health has become more forceful vis-a-vis providers and payers.

The detailed story of SHI, including the new role of the Advisory Council on Concerted Action in Health Care, is well enough known to not require repetition here (Busse 2000a; Altenstetter 2002). Still, we will provide a brief historical-political explanation of German SHI by defining the (somewhat blurry) demarcation lines between historical continuity and change in German national health policy.³ Next, the political and policy environment will be discussed. Finally, the SHI Reform Act 2000 will be examined from a short-term perspective, raising the question of whether innovations are possible in embedded structures.

Historical-Political Development of SHI in Germany: A Recap

The institutional development of German health care policy has followed a unique historical path. During a long process of growth and social experimentation, Germany has combined a vigorous, highly competitive capitalist economy with a social welfare system that, with some exceptions, provides generous benefits and services. These benefits are so extensive that by 2000, annual total health care spending reached €18 billion or 10.7 percent of gross domestic product (*Statistisches Bundesamt* 2002). However, Germany does not provide health care through a centralized state-

2. An interesting study yet to be undertaken would identify the leading figures-elected and politically nominated officials and top-ranking civil servants-in the post-1949 era in Abteilung V and, after 1992, Abteilung II. Such a study could examine the career path of each group and its influence on health-policy making, as well as observe a new phenomenon: the recent lateral moves of some from the public to the private sector.

3. Although national health care policy is usually preoccupied with SHI, it should be noted that Germany has the largest private health insurance sector in Europe, with about 9 percent of the population insured privately and not covered by SHI. Also, the interrelationship between national health policy and SHI does not exclude elements of privatization. For example, the market share of private for-profit hospitals contracted by sickness funds doubled during the 1990s.

run system, but via a complex network of federal agencies and numerous independent regional and local entities, whether public, quasi-public, or private. Many of these structures date from the nineteenth century and even earlier.

Today no citizen, resident, or foreign worker is without coverage (92 percent through SHI and the rest through private health insurance). The basis of this system was legislation passed in 1883 by imperial Germany's parliament, the Reichstag, to help German workers meet life's vicissitudes, thereby making them less susceptible to socialism. The principles that have mainly guided the development of German health care policy were set at that time: membership in the SHI program is mandated by law for those earning up to a certain threshold; administration of health insurance is delegated to nonstate bodies that include representatives of the insured and employers; contributions and, though in a limited and diminishing way, benefits are related to earnings (in the case of sick pay); and finance is secured through wage-based contributions levied on employers and employees.

There is abundant evidence for the validity of a path dependent interpretation of the 120-year history of German SHI. The program survived the shift from imperial Germany to the Weimar Republic in 1918 and then to the Nazi regime in 1933. The formation of two Germanys in 1949 resulted in two different political and health care systems. In East Germany, a centralized state-run system was put in place, and most physicians became state employees; but in the West, the prewar system was reestablished, supervised by the government but not state-run. Not only did SHI survive the collapse of each regime, but so did the civil service bureaucracy.

SHI has survived other incidences of turmoil and chaos. After the unification of Germany, a wholesale transfer of institutions, rules, and procedures from West to East occurred. SHI and West German hospital laws were superimposed on East Germany from 1991, with civil servants playing a leading role in working out the details. Proposals to allow the East to continue its health care system were rejected. To everyone's surprise, East German physicians made the transition to the fee-for-service medicine of West Germany more rapidly than expected and abandoned their employed status (Wasem 1997).

This historical record challenges the conventional wisdom that crises trigger dramatic change, however defined. It is not clear whether decision makers at these critical junctures rationally calculated or instinctively felt that the political, administrative, and legal costs for changing the developmental path were too high or whether in such crisis situations they were

simply relieved to find a functioning institution amid the chaos. Still, it is clear that decision makers erred on the side of preserving rather than dismantling SHI.

Time-honored normative (solidarity) and operational (self-governance) principles survived the dramatic regime changes in Germany as well. According to Germany's constitution-the Basic Law of 1949-the federal government sets broad policy for SHI, especially concerning benefits, eligibility, compulsory membership (though today one may change funds), covered risks, income maintenance during temporary illness, and employer-employee contributions. Still, except for the financing of hospitals, the responsibility for administration and service provision is delegated to nonstate entities, including federal and regional provider associations, Land hospital associations, nonprofit sickness funds, private insurance companies, and voluntary organizations.

Any change in institutional arrangements and financing has been largely incremental, and new elements have conformed to previously existing patterns. The German case shows that each successive regime change produced "path-dependent, self-reinforcing historical sequences" (Pierson and Skocpol 1999: 30-31) of prior decisions on health care policy. Do the still-evolving changes implemented during the past decade qualify as nonreinforcing sequences'? Admittedly, in-depth analysis is needed to measure these recent policies against the claims of path dependency and incrementalism. However, given the continuity of the key factors discussed below, it is doubtful.

With the perceived escalation of health care costs since the mid-1970s, the need to macro-manage health care financing and micromanage provider reimbursement has accelerated tremendously, especially during the past decade. The 1993 Health Care Structure Act, while reproducing the organizational and regulatory status quo, also launched substantial restructuring, including setting regional budgets for ambulatory medical services-administered by the twenty-three physicians' associations (Schwartz and Busse 1996)-and hospital services, the reorganization of sickness funds, and reform of the hospital sector (Busse and Howarth 1999).⁴

4. Among the many elements of reorganizing the sickness funds, two measures stand out. Sickness fund membership no longer depends on occupational and professional status, which has been the norm since 1883. Rather, the insured can choose a sickness fund of his or her choice. Pooling risks of illness across all sickness funds, regardless of a particular type, and sharing the financial burden among all sickness funds was a second innovation. Evidence of hospital reform ranges from the introduction of negotiated target budgets in each hospital (operative between 1989 and 1992), legally set fixed budgets between 1993 and 1996, and

The best way to explain the unusual interpretation of German health policy and politics is to go back to the essence of path dependency and the role and significance of public law in the continental tradition. Path dependency argues that once a particular path has been chosen, in this case the delegation of state authority to sickness fund and provider organizations, it is difficult to leave that path. However, path dependency also suggests that timing and historical sequences may be crucial to any political process. Accordingly, there may be turning points allowing for a change in direction and the power balance among the three central players: the state, sickness funds, and provider organizations. Although accounts of German health policy and politics have emphasized the corporatist nature of the German health care system and the importance of the self-governing sickness fund and provider organizations, these accounts are valid for the 1960s, 1970s, and 1980s.

The 1993 Health Care Structure Act mirrors a critical juncture in German health policy development and has shifted the balance of power between the three central players. The extraordinary political circumstances surrounding the passage of this reform became a strong turning point allowing for a change in direction among the key players privileging the state and the Ministry of Health over the sickness funds and provider organizations. The key to understanding why the political process leading up to the 1993 reform was an important turning point for the power relations between these three central groups rests on three tactical moves that had never occurred in the political process of health care reform before. First, consensus among the federal and regional coalitions and a majority of the national opposition at the time was achieved prior to the involvement of the provider organizations and others who could act as veto player. In the past, the process was reversed and the political leadership simply endorsed the consensus reached by the sickness funds and provider organizations. Second, while the political consensus was vaguely formulated, it left sufficient leverage for the Ministry of Health to strike deals and bargains with the veto players should they oppose the provisions of the law. And third, the debate about reform was largely controlled by an exclusive decision-making network composed of the minister of health, his advisors, and supporters of the reform. The notorious veto

a return to negotiated target budgets between 1997 and 1998. In 1999, hospital budgets were capped. The method of financing health care through a diagnosis-related group (DRG) system introduced in 2003 is a path-breaking reform measure, yet the governance structure to work out the specifics at the federal and regional level is not.

players were practically all outside the network (Bandelow 1994; Dohler and Manow 1995).

In sum, the 1993 law is as important for understanding why the power balance among the three players changed as it is to understanding major changes in the health care system since then. The successive pieces of legislation over the past ten years do reflect the rise of power by the elected governmental leadership and, by extension, the minister of health over sickness funds and provider organizations, although these remain important stakeholders.

The SHI Reform Act 2000 added still more elements to both macro- and micromanagement of medical services (Busse 3000b) and culminated in a radical shift from retrospective cost-covering to prospective case-based flat reimbursement of hospitals. This change is to be phased in over a seven-year period: however, it is already behind schedule, with new conflicts erupting among the major stakeholders.

Given the demographic, epidemiological, and technological transformations that are occurring in all advanced societies, are health care financing and medical progress sustainable and compatible in Germany? Specifically, can Germany continue to finance health care services under the conditions Germans have taken for granted for the past fifty years? Is solidarity-based financing of medical care merely an obsolete standard, an *Auslaufmodell* that can no longer be implemented? Currently, there are no clear answers to these questions.

Political Institutions and Federal Policy Making

State centrism or semisovereignty, and the concomitant political institutions of federalism, coalition governments in federal and regional power-sharing arrangements, a strong culture of legalism, civil bureaucracy, and self-governance (Dyson 1992), all limit radical policy change. These forces play an important role in federal policy making, ultimately building on prior institutional developments rather than dismantling them. They also have implications for the interactions between elected and bureaucratic policy makers, as well as those between state and non-state-based groups.

The Bundesrat, the upper house, representing the sixteen regional states, has considerable powers. A majority federal government may face an opposition majority in the Bundesrat resulting from sixteen regional Land elections. Even though the SPD-Greens won the elections in September 2002, the coalition faced an upper house controlled by the national

opposition. The left-leaning SPD-FDP (Free Democratic Party) coalition under Chancellors Brandt and Schmidt from 1969 to 1982 did not command a majority in the Bundesrat and could not pass reform legislation. Several elections from 1983 onward placed the conservative CDU/CSU-FDP (Christian Democratic Union/Christian Social Union) in the federal driving seat, but reversed this coalition's previous control over regional governments. After September 1998, the SPD-Green majority could initially rely on its party allies in the Lander, but regional elections a year later did not allow any of the large parties to form a majority in the Bundesrat.

The views of the regional governments—and the top echelon of their civil service bureaucracies—are known from the very beginning of the federal legislative process. According to parliamentary procedures, a federal draft bill must first be introduced by the federal government in the upper house before the lower house gets the chance to debate it. So-called *zustimmungspflichtige Gesetze* (agreement laws) can be adopted only with the approval of the Bundesrat and in the past it has used its veto powers extensively. If the Bundesrat does not approve, a conference committee with equal membership from the Bundestag (the lower house) and the sixteen Lander becomes the major political stage. If arbitration fails, elected officials resort to political maneuvers by redrafting legislation or federal ordinances in ways that no longer require the approval of the Bundesrat.

Federal ministries have no frontline offices; instead, they rely on regional public administration and local offices and on self-governance entities for implementation. Regional ministries monitor regional self-governance structures, providers, and sickness funds. Given the division of power within the federal system, veto points are widely distributed among stakeholders and state regulators. It is not clear that any regional office or self-governing body has ever lost credibility with the electorate or the public because of delayed or imperfect implementation. A recurrent stumbling block is that those with decision-making powers are not always responsible for implementation, and those responsible for implementation are not always held accountable.

Germany is known for solving problems (or not) through an increasing number of federal and regional laws, regulations, and ordinances that, taken together, stifle policy innovation. Since 1949, the German parliament has enacted at least fifty laws and 7,000 specific regulatory provisions in the area of health care and continues to add hundreds if not thousands of pages each year. When long-term care and mental health are added, the numbers rise further. Brown and Amelung's suggestion of *manacled*

competition (1999), codified legalism (rather than the adversarial legalism of the United States), and Max Weber's rational-legal authority all describe the same phenomenon. The Social Code Book (SGB) V, along with administrative law, is utilized to make reforms stick; its legal rules have served as a reference for all stakeholders and have secured predictability, enforceability, reliability, and certainty, expectations arising from rational-legal authority. The interpenetration of all parts of the health care system by the rules of the SGB V, administrative law, and rules on medical practice in offices or hospitals is extensive. At the same time, the SGB framework has greatly influenced and limited policy choices.

Party politics and coalition governments, which are prevalent at the federal and regional levels, result from the prevailing party system. Only four out of a total of twenty-six cabinets from 1949 to 1998 were majority led (i.e., no junior coalition partner was necessary). When either Conservatives or Social Democrats found themselves in this position, neither touched SHI. Of course, any democratic government, majority or coalition, controls executive-legislative relations: coalition discipline works as a rule (Saalfeld 2000). Yet the senior partner in German coalitions has never delegated supervision over SHI to the junior partner, with one exception in 1998-2001. SHI was simply too important.

Another feature of state-centric governance in a parliamentary regime is executive dominance and control over legislative-executive relations. Federal bills and ordinances are initiated in the executive branch and drafted by civil servants, whose influence comes to bear three times: first, in drafting new legislation; second, in planning new executive rules; and third, in monitoring compliance. Executive dominance is justified by the need for greater flexibility and the capacity to respond quickly to new developments and technological progress. However, it has been used to bypass political opposition. De facto, by reserving command, control, and authority to act, executive departments are able to protect turf, keep special relations with preferred clientele groups, and operate behind the scenes while keeping a low profile as the people's neutral servant.

The Political Environment

On September 22, 2002, the Social Democrats and Greens won a razor-thin victory over the conservative opposition of the CDU-CSU, maintaining only a four-seat majority in the Bundestag. Despite the Greens' stronger-than-expected showing, the dominance of the SPD-led health program over the Greens (Worz and Wismar 2001: 864) should continue

providing the Ministry of Health with the muscle it needs to pressure self-governing bodies to get their house in order or else face more state intervention. Historically, threats of intervention and decision making by administrative fiat have been part of the political repertoire and practice in the relations between the state and self-governance. During the past few years, these threats have significantly increased. When the 1998 federal elections resulted in a change of government from Kohl to Schroder, the Social Democrat-Greens adopted the Act to Strengthen Solidarity in SHI and reversed decisions that increased patient co-payments under Kohl. The 1998 law reduced patient cost-sharing burdens and reintroduced sectoral budgets in the outpatient and inpatient care sectors.

The political process presents two lessons, which were considered during the deliberations surrounding the SHI Reform Act 2000. First, it is difficult to win elections on the strength of health reform when the public continues to be fully supportive of solidarity-based health care and feels that the proposed reforms compromise the system (Ullrich 2002; Busse 1999). During the sixteen-year reign of conservative chancellor Kohl, the general public did not support reform, particularly reforms enacted under the leadership of Seehofer, the last minister of health before Kohl's electoral defeat. Seehofer imposed cost-sharing and co-payments, thus attempting to influence the demand side while previous reforms targeted the supply side. The elimination of dental coverage for young Germans and increases in co-payments hit a sensitive nerve, helping to oust Kohl in 1998.

The second lesson is that federal politicians may be able to implement reform against physician opposition, but they have not been able to push through measures that are opposed by regional governments. Even Social Democratic-led regional governments helped curtail the more ambitious plans to control expenditures on drugs, dressings, and physician salaries introduced in the Act to Strengthen Solidarity in SHI in late 1998. These plans, expanded in the proposed SHI Reform Act 2000, were abandoned when the upper house flexed its muscle and vetoed the original bill in November 1999.

The SHI Reform Act 2000-Changing Health Policies and Patient Access?

Over the past decade, German health care reform has focused on several issues: cost containment, quality and patient satisfaction, health technology assessment (HTA), and clinical practice guidelines. Sustainable health care financing, access to medical innovations through sectoral budgets

	Ambulatory Care	Hospitals	Pharmaceuticals
1989-1992	Negotiated regional fixed budgets	Negotiated target budgets at hospital level	No ouaget or spending cap
1993	Legally set regional fixed budgets	Legally set fixed budgets at hospital level	Legally set national spending cap
1994			Negotiated regional spending caps
1995			
1996	Negotiated regional fixed budgets	Negotiated target budgets at hospital level	Negotiated target volumes for individual practices
1997	(Target volumes for individual practical		
1998	Negotiated regional fixed budgets with legally set limit	Negotiated target At budgets hospital level legally set limit	Legally set regional spending caps
1999			Negotiated regional spending caps
2000			Negotiated target volumes for individual practices
2001			
2002			
2003 and following	Introduction of DIRG system		

Figure 1 Cost Containment through Budgets and Spending Caps, 1989-2003. Source: Busse 2000a. Updated by the author. Note: The larger the text size, the more strictly regulated the sector, except for shaded areas, which indicate that the importance of regulation is unclear at this time.

(hospital, ambulatory, and, prescription drugs, until 2000), and the flatrate pricing of hospital services present major challenges for stakeholders and patients alike. State-centered and corporatist approaches have both contributed to these reforms, with important consequences both for health and for state governance. Recent reform measures may have equalized cost containment conditions for physicians and hospitals, but they may also have jeopardized sustainable patient access to the best therapeutic treatments and diagnostic tests. Although these reforms have maintained corporatist governance, the roles of state and sectoral actors have not remained unchanged (see figure 1).

The SHI Reform Act 2000 seemingly introduced several policy and organizational innovations; yet upon closer examination, it simply copied the traditional committee structure prevalent in corporatist self-Governance. It set up two new federal committees with broad-ranging responsibilities: the committee for hospital care and the coordinating committee. The latter is charged with developing binding evidence-based guidelines for ten indications each year and makes recommendations for the work of the hospital committee and the existing Federal Committee of Physicians and

Sickness Funds, which-based on the recommendations of its Working Committee on Medical Treatment-decides upon coverage of diagnostic and therapeutic procedures in the ambulatory sector.'

The SHI Reform Act also renewed global budgets for each sector under stricter conditions than those that existed previously. Based on the change in contributory income in the previous year, the federal Ministry of Health now fixes the annual growth rate for SHI-reimbursed health care. In September 2001, the rate for 2002 was announced at 1.85 percent. In reality, income rose by only 1.6 percent whereas expenditures rose by 3.7 percent. The rather steep increase in expenditure was almost entirely due to pharmaceuticals.

Federal legislation also established HTA of medical procedures and technologies. With a delay of several years when compared to its European neighbors, payers and health policy makers in Germany have thus joined the international health care community in endorsing HTA, evidence-based medicine (EBM), clinical practice guidelines, expert consensus, and so forth as a basis for domestic decision making (Perleth, Busse, and Schwartz 1999; Perleth et al. 1999). Medical guidelines and standards in hospital care became a political priority only under the first Schroder government. Quality assurance programs have been run by the regional associations of SHI-accredited physicians (KVs; Weisner 1995) on a voluntary

5. In late 2000, the three parties to the hospital care committee submitted a contract for approval by themselves and the Ministry of Health. The parties intended to split the financial cost of maintaining a hospital committee office (50 percent from sickness funds and 25 percent each from the hospital association and the doctors' chamber). The sickness funds seek a large agency with as many as fifty full-time employees, whereas the medical profession wants to restrain the scope of the committee for fear that too many guidelines will affect clinical freedom. After this article was written, the formerly separate sectoral and coordinating committees were merged into one Common Federal Committee of physicians, dentists, hospitals, sickness funds, and-without voting rights-patient representatives (as of January 1, 2004).

6. After a few days in office, the new minister of health, Ulla Schmidt, declared in January 2001 that she would abolish physicians' requirement to pay back part of their income in favor of practice-specific targets to reduce pharmaceutical costs. This announcement was warmly welcomed by the Federal Association of SHI Physicians. The sickness funds, on the other hand, pointed out that practice-specific targets are not welcomed by all physicians, as they limit their freedom. The announcement of the physicians' association should therefore be viewed skeptically, especially as no physician association has yet used the instrument to review the actual prescription behavior of its members. Although the new minister was initially very positive that pharmaceutical expenditure could be contained without a spending cap, she later became less sure. In late May, she said that the 9.7 percent increase in pharmaceutical expenditure in the first quarter of 2001 constituted a "severe danger for the financial stability of the statutory health insurance" and warned that the contribution rates might have to be raised, a danger the sickness funds had already pointed out. In June, the first major sickness fund increased its rate by a full percentage point (Busse 2001). By the end of 2001, pharmaceutical expenditure had risen by 11.2 percent and the sickness funds increased their contribution rates by an average of 13.5 to 14 percent.

and nonbinding basis. Additionally, regional KVs have organized quality circles, consensus conferences, interlaboratory comparisons in laboratory medicine, guidelines for pharmacotherapy, and special training programs for diabetes patients. Still, the SHI Reform Act now provides a legal basis for the creation of a formal HTA process that is bound to affect clinicians, hospital management, and ambulatory care providers.

The legislation also introduced a total overhaul of hospital financing, from retrospective cost-based reimbursement (Pfaff and Wassemer 2000) to payments based on DRGs. The type of DRG model to adopt was left to the federal associations of sickness funds and the German Hospital Association, who submitted their proposal to the Ministry of Health in June 2000. Otherwise, the Ministry of Health could have determined the DRG type by administrative fiat (Busse 2000c).

Corporatist decision makers chose the Australian-refined DRG system (AR-DRG), which came into force on a voluntary basis on January 1, 2003, and on a mandatory basis on January 1, 2004. During 2003 and 2004, AR-DRGs were intended to be used alongside hospital budgets to ensure a smooth transition. In 2005 and 2006, hospitals will be partly compensated for differences between current budgets and the DRG fees, but the latter will be the only method of reimbursement from 2007. A long transition period is considered necessary because current hospital budgets are based on greatly varying per diems, which are negotiated between individual hospitals with all sickness funds jointly.

Finally, the SHI Reform Act widened options for providers and sickness funds to enter into contracts directly without having to go through their respective corporatist associations. These new agreements will come in the form of model contracts requiring scientific evaluation or in the form of integrated care requiring an agreement between ambulatory physicians and a hospital to contract jointly. In theory, variations of these options have existed since 1989 when the Health Care Reform Act was initially adopted. Although the political mandate to the respective Land associations of sickness funds, physicians, and hospitals to negotiate new public contracts was clear, implementation gaps existed. Because interfacing the two care sectors required coordinated investment decisions controlled by the regional governments, progress within the Lander was slow.

As a result, the 1993 Health Care Structure Act required the regional

7. The Health Care Reform Act can be considered a sequence of legislation that began in 1989 and that followed in an interval of almost every other year (see figure 1). This frenzy applies to all three major care sectors: ambulatory care, hospitals, and pharmaceuticals.

bargaining and negotiating associations of doctors, hospitals, and sickness funds and the responsible Land agencies to do what they had failed to do voluntarily. Yet regional variations in complying with the original intent of the 1989 legislation have continued. When implementation calls for cooperation across the ambulatory and hospital sectors or across payers and providers, chronic implementation gaps are the rule rather than the exception (Altenstetter 1985, 1997, 1999). Although some model contracts have been signed, they remain rare.

Similar gaps in implementation are likely to delay the operation of the new hospital reimbursement system. Three major hurdles exist. First, many agreements on definitions and criteria need to be reached within tightly set deadlines. A second hurdle is the strengthening of the gatekeeper role of general practitioners (GPs), as separate budgets for GPs and specialists remain. The third hurdle is the operation of a new accounting system. The German hospital association estimated an initial cost of €50 million, plus €10 million annually to maintain the DRGs.

In 2002, the implementation of DRGs already created problems. The line between proponents and opponents of rapid implementation cuts through hospitals, sickness funds, and politicians. Private hospitals with shorter than average lengths of stay want to switch quickly, whereas university hospitals are afraid of losses. The AOK (general regional) sickness funds, whose members typically face a relatively high risk of experiencing ill health and tend to have relatively long hospital stays, hope to gain from the DRGs, whereas funds with a relatively healthy membership and especially private health insurers are afraid of rising costs. Therefore, no consensus was reached at the level of self-governance. Therefore, the Ministry of Health plans to issue a federal ordinance. This tactic is quite rare but has been used before, at times when the national opposition blocks initiatives in the upper house (Rosewitz and Webber 1990). Such ordinances are permissible provided the legislative branch authorizes the executive branch to draft them.

In the path dependent development of the hospital sector in Germany, the shift in reimbursement is a major event, although flat-rate payments were introduced in 1995 (albeit within a system of budgets). The latest reform touches on coverage decisions for pharmaceuticals and the reintroduction of a positive list of reimbursable drugs, which has been bitterly opposed by the pharmaceutical industry in the past. It introduces, for the first time, a positive list of medical and surgical procedures in hospitals, which might mean the delisting—whether explicit or de facto—of some procedures from the benefit catalog (Worz et al. 2002).

Clearly, the utilization of medical technologies, evidence-based medi

care, and patient access to the latest therapeutic treatments are no longer under the legal monopoly of corporatist-organized actors, but are on the legislative and executive agenda. Politically, these are highly sensitive issues sparking passionate debates among the major stakeholders: clinicians, the pharmaceutical and the medical device industries, the payers of medical and hospital care, and politicians and bureaucrats in Berlin and the capitals of the Land governments. The pharmaceutical industry has been a powerful force in all these debates for quite some time. In contrast, the medical device industry, with its high potential for medical innovation, is only now becoming visible (Altenstetter 2003).

The debate over the SHI Reform Act 2000 clearly shows the historical persistence of the arguments of each stakeholder group. For decades now there has been a certain cognitive dissonance between organized medicine, the medical device and pharmaceutical industries, payers, and politicians about how to improve health care services. The medical profession especially wants to exclusively control evaluation. From the patient's perspective, access to certain treatments and devices is limited indeed.

This issue also became obvious in the debate on disease management programs. The SHI Reform Act 2000 legally introduced the concept of integrated care, that is, care delivered under contracts between sickness funds and providers from several sectors. But due to long and complicated procedures within self-governance, concerns over how this would affect sectoral budgets, and the lack of will to implement contracts, such care has not yet materialized. Legislation in late 2001 that reformed the criteria for risk-structure compensation among sickness funds tried to strengthen the incentives for sickness funds to introduce such care and provided higher per-capita compensations. Yet the federal association of SHI-affiliated physicians decided to block such contracts until after the 2002 elections, so the first programs could only have been implemented in the spring of 2003 (Busse 2004).

Finally, regardless of how one views the methodology employed in the World Health Organization's *World Health Report 2000*, Germany's position on the world list—twenty-fifth, as compared to France (first) and the United Kingdom (eighteenth)—raises concerns about German health care's performance, its cost-effectiveness, and its underemphasis on health promotion and disease prevention. Change will be difficult without a new alliance of stakeholders with the political will to redefine the allocation of financial burdens, establish a new balance in the relationship between SHI and private health insurance, and secure patient access to medical innovations for all Germans.

Conclusion

Statutory health insurance policy making, even in the 1990s, displays a history of muddling through and incremental change within a stable normative and institutional framework. Meaningful institution building that would have changed or broken the SHI path has not materialized, as change remains at the margins. Normative ideas may include competitive elements, but are mediated by the influence of the three S's—solidarity, self-governance, and subsidiarity (i.e., leaving decisions to the smallest capable unit). Legislative and regulatory changes are largely process driven and procedural, whereas new institutions in the hospital sector have been copied from the prototypical committee structures within self-governance. In contrast, the introduction of DRGs in the hospital sector is a dramatic change, yet DRGs will take a long time to show their effects.

The main flaw in Germany's health policy, regardless of whether state initiatives or self-governance bodies advance proposals, is that it involves legislating and regulating without actually reforming and implementing. Spending continues without resetting priorities from curative medicine to prevention and promotion of public health. By continuing the frenzy of legislated and regulated intervention into the health care system without a broad vision for the future of health care, federal legislators and regulators jeopardize the undisputed achievements of SHI. One can simply sum up: health care reform is a mess.

Regional politics and bureaucratic structures within the federation play a key role. Cost-containment policies and demands for HTA and EBM over the past decade have combined to further tilt the balance of power in favor of payers and regulators to the detriment of the medical profession. Medical power over economic issues (i.e., in deciding the monetary value paid for medical services) has been declining over the years, beginning in the mid-1980s and accelerating over the 1990s. However, the influence and authority of medical professionals as knowledge bearers and technological craftsmen have not declined, although physicians are subject to increasingly restrictive conditions. Neither has the medical profession lost the ability to police itself according to the rules, codes, and norms developed by corporatist medicine.

The road ahead is not entirely clear. Five types of uncertainties and restraints loom—one unavoidable, the others unpredictable. The unavoidable concern arises from the increase in the absolute numbers of elderly, especially those over seventy-five years of age, and chronically ill needing medical care. A second restraint is the future role of innovative medical

technologies, regardless of whether they have cost-cutting potential. There are also uncertainties surrounding the decision-making behavior of payers and regulators in an atmosphere of tight health care budgets and increasing macro- and micromanagement. In this atmosphere, the demands for EBM and HTA are unlikely to go away.

A related concern is the future of the decision-making powers of self-governing actors, who have time after time failed to implement important pieces of reform legislation. Within the Social Democrats, an influential group is proposing a new balance between the state, the sickness funds, and the providers by increasing the role of the state—a fact that became very obvious in the discussions of the latest health care reform debated in 2003 and enforced in January 2004.⁸ Finally, there is the uncertainty regarding the role of the European Court of Justice, which has raised the questions of whether national fee and benefit schedules are a violation of free trade and whether German corporatist decision making is in conflict with European competition policy. Future research must pay close attention to these uncertainties.

References

- Altenstetter, C. 1985. *Krankenhausbedarfsplanung: Was brachte sie wirklich? (Hospital Need Planning: What Was Really Achieved?)*. Munich: Oldenbourg Verlag.
- . 1997. Health Policymaking in Germany: Stability and Dynamics. In *Health Policy Reform, National Variations, and Globalization*. ed. C. Altenstetter and J. W. Bjorkman, 136-160. New York: St. Martin's.
- . 1999. From Solidarity to Market Competition? Values, Structure, and Strategy in Germany Health Policy, 1993-1997. In *Health Care Systems in Transition*, ed. F. D. Powell and A. Wessen, 47-88. Thousand Oaks, CA: Sage.
- . 2002. *Health Care in Germany*. European Union Studies Center, Graduate Center, City University of New York Occasional Paper No. 49. web.Cc.cuny.edu/Eusc/activities/papechim, Prepared for distribution at the seminar series *Rekindling Reform: A Vision of Quality Health Care for All*, New York.

8. A visible sign was the government's proposal to introduce a state-run Institute for Quality and Efficiency in Health Care, modeled after the National Institute of Clinical Excellence in England. Another part of the original bill was to give sickness funds increased power vis-avis the physicians associations by abolishing collective contracts for specialists in ambulatory care. As the reform package needed the consensus of the Christian Democrats, it was changed considerably regarding these two points: the institute will be run by the self-governing actors and collective contracting is retained for specialists (Busse and Worz 2003; Riesberg and Busse 2003).

- . 2003. EU and Member State Medical Device Regulation. *International Journal of Technology Assessment in Health Care* 19: 228-248.
- Bandelow, N. C. 1994. *Korporatismus und Parteienkonkordanz: Die Durchsetzung von Strukturreformen im deutschen Gesundheitswesen durch den taktischen Wechsel der Arena (Corporatism and Party Concordance: Achieving Structural Reforms in the German Health Care System through a Tactical Change of the Arena)*. Forschungsstelle für Sozialwissenschaftliche Innovations- und Technologieforschung Working Paper No. SIT wp-I-94. Bochum: Ruhr-Universität.
- . 1998. *Gesundheitspolitik. Der Staat in der Hand einzelner Interessengruppen? Probleme. Erklärungen, Reformen (Health Policy. The State in the Hands of Interest Groups? Problems. Explanations, Reforms)*. Opladen: Leske & Budrich.
- Blanke, B., ed. 1994. *Krankheit und Gemeinwohl. Gesundheitspolitik zwischen Staat, Sozialversicherung und Medizin. (Illness and Public Interest: Health Policy among State, Social Insurance, and Medicine)*. Opladen: Leske & Budrich.
- Brown, L. D., and V. E. Amelung. 1999. "Manacled Competition": Market Reforms in German Health Care. *Health Affairs* 18: 76-91.
- Busse, R. 1999. Priority-Setting and Rationing in German Health Care. *Health Policy* 50: 71-90.
- . 2000a. *Health Care Systems in Transition: Germany*. Copenhagen: European Observatory on Health Care Systems.
- . 2000b. New German Health Reform Act Passes. *Euro Observer* 2: 3.
- . 2000c. Germany Optes for Australian Diagnosis-Related Groups. *Euro Observer* 2: 1-3.
- . 2001. Interesting Times in German Health Policy. *Eurohealth* 7: 7-8.
- . 2004. Disease Management Programs in Germany's Statutory Health Insurance System-A Gordian Solution to the Adverse Selection of Chronically Ill in Competitive Markets? *Health Affairs* 23: 56-67.
- Busse, R., and C. Howarth. 1999. Cost Containment in Germany: Twenty Years Experience. In *Health Care and Cost Containment in the European Union*, ed. E. Mossialos and J. LeGrand. 303-309. Aldershot, UK: Ashgate.
- Busse, R., and M. Worz. 2003. Germany Plans for "Health Care Modernisation." *Eurohealth* 9: 21-24.
- Dohler, M. 1990. *Gesundheitspolitik nach der "Wende." Politik, Netzwerke und ordnungspolitischer Strategiewechsel in Großbritannien, den USA und der Bundesrepublik Deutschland (Health Policy after a Change of Government: Policy Networks and Structural Change of Strategy in Great Britain, the USA, and the Federal Republic*

- . 1992. Gesundheitspolitische Steuerung zwischen Hierarchie und Verhandlung (Steering of Health Policy between Hierarchy and Negotiation). *Politische Vierteljahresschrift* 33: 571-596.
- Dyson, K. 1992. Theories of Regulation and the Case of Germany: A Model of Regulatory Change. In *The Politics of German Regulation*. ed. K. Dyson. Aldershot, UK: Dartmouth.
- Gartner, H. 1964. Einführung und Grundlagen (Introduction and Basics). In *Lehrbuch der Hygiene (Textbook on Hygiene)*, ed. V. H. Gartner and H. R. Stuttgart, 1-38. Frankfurt: S. Fischer.
- Giaimo, S., and P. Manow. 1997. Institutions and Ideas into Politics: Health Care Reform in Britain and Germany. In *Health Policy Reform, National Variations, and Globalization*, ed. C. Altenstetter and J. W. Bjorkman. 175-202. New York: St. Martin's.
- Henke, K. D. 2001. The Allocation of National Resources in Health Care in Germany between Competition and Solidarity. In *Gesundheitssysteme am Scheideweg: Zwischen Wettbewerb und Solidarität (Health Care Systems at the Crossroad: Between Competition and Solidarity)*, ed. K.-D. Henke and C. Dräger, 47-57. Edition Dräger-Stiftung Band 17. Baden-Baden: Nomos Verlagsgesellschaft.
- Katzenstein, P. J. 1987. *Policy and Politics in West Germany: The Growth of the Semi-sovereign State*. Philadelphia: Temple University Press.
- Knill, C. 2002. *The Europeanisation of National Administrations: Patterns of Institutional Change and Persistence*. Cambridge: Cambridge University Press.
- Manow, P. 1994. *Strukturinduzierte Politikgleichgewichte: Das Gesundheitsstrukturgesetz (GSG) und seine Vorgänger (Institution-Caused Policy Balances: The Health Care Structure Act and Its Predecessors)*. MPIfG Discussion Paper No. 94/5. Cologne: Max-Planck Institute for the Study of Societies.
- . 1997. *Social Insurance and the German Political Economy*. MPIfG Discussion Paper No. 97/2. Cologne: Max-Planck Institute for the Study of Societies.
- Perleth, M., R. Busse, and F. W. Schwartz. 1999. Regulation of Health-Related Technologies in Germany. *Health Policy* 46: 105-126.
- Perleth, M., H. Mannebach, R. Busse, U. Gleichmann, and F. W. Schwartz. 1999. Cardiac Catheterization in Germany: Diffusion and Utilization from 1984 to 1996. *International Journal of Technology Assessment in Health Care* 15: 756-766.
- Pfaff, M., and D. Wassemer. 2000. Germany. *Journal of Health Politics, Policy and Law* 25: 907-914.
- Pierson, P. 2000. Increasing Returns, Path Dependency, and the Study of Politics. *American Political Science Review* 94: 251-267.
- Pierson, P., and T. Skocpol. 1999. Why History Matters. *APSA-CP Newsletters, Winter*, 29-31.
- . 2002. Historical Institutionalism in Contemporary Political Science. In *Political Science: The State of the Discipline*, ed. I. Katznelson and H. V. Milner, 663-721. New York: Norton.
- Riesberg, A., and R. Busse. 2003. Cost-shifting (and Modernization) in German Health Care. *Euro Observer* 5: 4-5.

- Rosewitz, B., and D. Webber. 1990. *Reformversuche und Reformblockaden in den deutschen Gesundheitswesen (Reform Attempts and Reform Blockages in the German Health Care System)*. Frankfurt am Main: Campus Verlag.
- Saalfeld, T. 2000. Germany: Stable Parties, Chancellor Democracy, and the Art of Informal Settlement. In *Coalition Governments in Western Europe*, ed. W. C. Muller and K. Strom, 32-85. Oxford: Oxford University Press.
- Schwartz, F. W., and R. Busse. 1996. Fixed Budgets in the Ambulatory Care Sector: The German Experience. In *Fixing Budgets: Experience from Europe and North America*, ed. F. W. Schwartz, H. Glennerster, and R. B. Saltman. 93-108. Chichester: Wiley.
- Statistisches Bundesamt (Federal Office of Statistics). 2002. *Gesundheit-Ausgaben 1992 bis 2000 (Health Expenditures 1992-2000)*. Wiesbaden: Statistisches Bundesamt.
- Streeck, W., and P. C. Schmitter. 1985. Community, Market, State-and Associations? The Prospective Contribution of Interest Governance to Social Order. *European Sociological Review* 1: 119-138.
- Ullrich, C. G. 2002. Reciprocity, Justice and Statutory Health Insurance in Germany. *Journal of European Social Policy* 12: 123-136.
- Wasem, J. 1997. Health Care Reform in the Federal Republic of Germany: The New and the Old Lander. In *Health Policy Reform, National Variations, and Globalization*, ed. C. Altenstetter and J. W. Bjorkman. 161-174. New York: St. Martin's. Weisner. E.
1995. How Does Quality Assurance of Ambulatory Care in the Federal Republic of Germany Work? In *Evaluation qualitatssichernder Maßnahmen in der Medizin (Evaluation of Quality Assurance in Medicine)*, ed. H. K. Selbmann. 156-169. Gerlingen: Bleicher.
- World Health Organization. 2000. *World Health Report*. Geneva: World Health Organization.
- Worz, M., M. Perleth, O. Schoffski, and F. W. Schwartz. 2002. *Innovative Medizinprodukte im deutschen Gesundheitswesen (Innovative Medical Devices in the German Health Care System)*. Baden-Baden: Nomos Verlagsgesellschaft.
- Worz, M., and M. Wismar. 2001. Green Politics in Germany: What Is Green Health Care Policy? *International Journal of Health Services* 31: 847-867.