Since 1989 we have been in a continuous process of health-care reform. On 1 January 2000 the reform of the SPD/Green coalition government was enacted and became law. The principal philosophy behind this reform is that the use of the available money should be optimized. Therefore, basic structural changes have been introduced in the sectors of outpatient care and hospital financing. Another major point is to reinforce the bases of quality assurance. In this context technology assessment has become an institutional anchor in our system.

The current hospital financing system

Hospitals in Germany are currently paid for out of individual budgets that are agreed with the health insurance funds. The reform law limits the increase to the growth rate in wages during the preceding year, which was 1.4% in the past year. There is no need to worry, however, as there are some exceptions, for example, medical progress and increased number of patients. The budget of each hospital is reimbursed by daily lump sums (75%). The rest is reimbursed by lump sum payments, a kind of self-made German DRGs for major surgeries.

The DRG system

Beginning in 2003, the reform law introduces a DRG system for the entire hospital sector, for all treatments and for all patients. Only for psychiatry will per diem payments remain. The responsibility for developing the system lies with hospital associations and the associations of sickness funds. We call these self-governing bodies. They have meanwhile decided to introduce an updated version of the Australian system. Compared with the United States AP system, the Australian DRGs are considered more notable in relation to comorbidity and complications. (Fig. 1).

Accounting

- Accounting on the basis of the costs of selected hospitals is planned. At the moment the sickness funds and hospital associations are preparing an accounting schedule.

Adjustment

- Changes in costs and prices must be considered, as must new procedures and technologies. Therefore, there is a plan to establish an institute that will monitor the development of costs in all hospitals and suggest the annual adjustment. It is agreed that the adjustment will be made once yearly by the end of September.

Grants

- The law allows for the possibility of grants to cover costs that cannot be adequately covered by the DRGs, for example, for special emergency services; this means that the self-governing bodies must also list the cases. Discussion on this point is proving very difficult. University hospitals are calling for a general grant.

Points system

- By the end of 2001 the DRGs must be weighted according to a points system. The costs of materials and medical devices will also be subject to this points system. The nationwide value of the points must be fixed in the second half of 2002.

Hospital financing with DRGs

Introduction of a DRG system is not the end of the story for the hospital financing system. In some countries DRGs are used principally as a distribution system for total spending budgets. Only in the United States is the DRG used as a pricing system. We must also decide how it should ultimately work. This requires a change in hospital law.

We plan to be finished by the end of 2001. The reform law now mandates only the introduction of the new system in a “budget-neutral” manner for individual hospitals during the first year, that is, 2003. Sickness funds and the hospital associations are now in agreement that the period for its introduction under protected conditions should be extended by 3 years.

I think the policy makers will also be in agreement. ’Protected conditions’ means use of hospitals’ individual prices to transfer the old budgets to the new system. Thereafter it will be decided whether the new system is a genuine pricing system, what the roles of individual hospital budgets are, and how to deal with quantities.
The problem with any DRG system is that there are built-in incentives for unnecessary medical treatments and for upgradings. On the other hand, we want more competition. Obviously a new reimbursement system that would lead to increasing expenditures would not be accepted. Therefore, we need some fences and ceilings, and we need adjustment on the pricing side if there is an increase in the number of cases. This could be subject to hospitals’ individual price negotiations. In this case the nationwide price would merely be the maximum price.

The other possibility is a set of general cuts in the nationwide prices. For this, the DRG payments must be integrated into a state-wide budget for hospital spending. This would mean floating point values. However the frameworks are designed, the introduction of prices for defined medical procedures instead of per diem rates brings with it a great incentive for the hospitals to be as cost-effective as possible, and this, of course, means further pressure on the prices for medical devices.

What part can the medical device industry play in this decision-making process?

In our system, industry is in a third-party position, with no formal part in this decision-making process. The self-governing partners can decide themselves how industry is to be involved. The law does not exclude a more formal involvement of industry, with the right to attend hearings held in the process of updating the system for example.

Adaptation of medical progress

How will new medical technologies be adapted to suit the new system? Of course, it will not be necessary to convince the Health Ministry of the advantages of new technologies or of changes in costs. The medical profession and the fund-holding bodies must be won over, and perhaps also the new Federal Committee on Hospital Care introduced by the reform.

The new hospital medicine committee: This committee will be run by the German Medical Association, the Federal Association of Sickness Funds, and the German Hospital Association, and it should begin its work during the course of this year. At the request of an insurance fund or the Hospital Association, the Committee will evaluate whether medical procedures and treatments are sufficient, appropriate, and economic. If the evaluation leads to the conclusion that the treatment option does not fulfill the criteria, the statutory health insurance system is not empowered to pay for the treatment.

A similar committee has already long been at work in the outpatient sector. These are the two main medicine committees in the German health system. To support their work the reform law mandates the existing federal agency for medical documentation and information (DIMDI) to build a database in which national and worldwide medical studies are listed and prepared for decisions. The agency can also initiate HTA analysis (Fig. 2). The fields investigated are linked to the decision demand of the hospital and outpatient care committees noted above.