The Impact of Recent Legislative Change in Germany

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Summary

Cost-containment policies introduced in Germany under the ‘Health Structure Act’ at the beginning of 1993 marked a dramatic turnaround in German healthcare policy. The traditional arms-length approach of government policy makers, under which responsibility for implementation of the measures specified in national legislation was devolved upon the representatives of healthcare providers and statutory health insurance funds, was replaced by government mandates at the national level. These mandates – including price controls, a national pharmaceuticals budget and copayment changes – had a dramatic impact on the German healthcare system and on the German pharmaceutical market in particular. Eventually, these national controls are to be phased out as the associations of healthcare providers and health insurance funds negotiate the terms for implementation of further measures specified in the ‘Health Structure Act’: regional budgets, prescription guidelines, stricter controls of prescribing behaviour and a positive list. Despite this gradual return to the federalistic principles of the German healthcare system, the German pharmaceutical market will never be the same.

1. The 1993 Health Reform Measures

The health reform measures[1] put into effect in Germany on January 1, 1993 are important not only in terms of their actual and potential effects on the German healthcare system, but also because they represent a significant deviation from past reform measures.

First, it must be kept in mind that passing the law required the cooperation of all the major political parties: the opposition Social Democrats, whose approval was necessary because their party has a majority in the Bundesrat, through which all legislation must pass; the Christian Democratic Union and the Christian Social Union, which, as populist parties, have to appeal to a broad public; and the Liberal Party, which represents primarily the interests of the self-employed and small business owners, such as physicians and pharmacists.

Second, the 1993 legislation contains almost all the measures that could possibly be found on the agenda of a politician intent on cost containment. It uses price regulation, budgeting, and reference prices; it lays the legal groundwork for the introduction of positive and negative lists, and perhaps even for the use of cost-benefit analysis as a means of determining the reimbursement status of pharmaceuticals.

Third, the current Health Minister, Horst Seehofer, used a completely different approach from that of his predecessors to rally support for his legislation. Earlier laws were passed under health ministers who – to put it mildly – were not always the best of friends with those who had something at stake in the healthcare system. Mr Seehofer, on the other hand, talked to everyone and tried to involve all those concerned in order to achieve a grand
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compromise on healthcare reform. He has proven to be a brilliant director on the political stage, thus making it very difficult to oppose his reforms.

Finally, the 1993 legislation is remarkable for the fact that it contains measures intended to result in immediate savings to the Statutory Health Insurance (SHI) system. These savings were politically necessary because a continuation of the trend in SHI expenditure at its previous level would have resulted in an increase in SHI premiums. Since health insurance premiums are deducted from the pension checks of people who have retired, an increase in SHI premiums would have halted the real growth of pensions during 1993 and 1994. This would have come at a very inopportune time for the major parties, who already have enough problems with the electorate; during 1994 there will be 8 state elections, national elections, and the European Parliament elections. With this background information in mind, it is easy to understand why the 1993 legislation, taken as a whole, is devoid of any theoretical consistency. The measures represent a political compromise covering the whole spectrum of political ideologies. They are the product of the pursuit of political success.

In this sense, however, the measures introduced in 1993 do reflect political logic in so far as some were designed to cash in immediately on savings (thus neutralising the problem of growing health insurance rates and stagnating pensions as a campaign issue) and others will be phased in over the coming years in an attempt to effect more basic structural changes in the SHI system. Health Minister Seehofer likes to term these the short term and the long term measures, but this classification is misleading, since the short term measures will have long term effects on the pharmaceutical market.

2. Effects on Prescription Medicines

The changes put into effect immediately in the area of prescription medicines were the so-called price decree, the ceiling on pharmaceutical expenditures in 1993, and the extension of cost-sharing rules to include all prescription medicines.

2.1 The Price Decree

The price decree represents the first time that German authorities have implemented a price reduction as a cost-containment measure. Under the terms of the price decree, the prices of nonreference priced products were reduced by 5% and those of over-the-counter (OTC) products by 2%, on January 1, 1993. Furthermore, the prices of these products are to remain at their May 1, 1992 level until the end of 1994. Products introduced after May 1, 1992 must be held at their market introduction price during this period. The difference between the rate of price reduction for OTC and prescription-only products is due to the fact that OTC products are reimbursed in full if they are prescribed by a physician. Since about three-fifths of the OTC market is made up of off-prescription sales paid for by patients, the 2% represents a rough average between OTC sales charged to the SHI funds and those to private individuals. The pharmaceutical industry attempted to avoid such massive intervention in the pricing system by proposing that the price reduction apply only to the amount reimbursed by the SHI funds. Since this would have led to an increase in patient cost-sharing beyond that already planned in the law, legislators did not even consider the possibility of separating pricing from reimbursement. Although the price decree is supposed to remain in effect until the end of 1994, it must be remembered that this will also be an election year. So, at this point, it is difficult to say whether the price decree will be lifted according to schedule.

2.2 Budgetary Restrictions

A more important measure, especially with regard to long term structural effects on the provision of pharmaceuticals, is the imposition of a ceiling on pharmaceutical expenditures in 1993. The roots of this budgetary approach reach back to the first cost-containment legislation enacted in 1977, which introduced revenue-based global budgets into the SHI system. To control expenditures on pharmaceuticals, the 1977 legislation also foresaw