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GLOBAL BUDGETING IN GERMANY: LESSONS FOR THE UNITED STATES

by Klaus-Dirk Henke, Margaret A. Murray, and Claudia Ade

Prologue: Germany’s century-old universal health insurance plan represents a middle ground in the spectrum of approaches Western countries have adopted to protect their populations against the financial consequences of illness. Among industrialized countries, West Germany’s health insurance plan came closest during the 1980s to limiting increases in spending to a rate equal to growth of its national income; the disparity between the two measures was greatest in the United States. Nevertheless, Germany has remained concerned about the continued rise in health care expenditures, particularly because of the increased pressure that unification of East and West Germany has placed on public spending. Here Klaus Henke, Margaret Murray, and Claudia Ade discuss the latest efforts by the German government to moderate the growth of health care spending. One of the striking features of the 1993 Health care reform act in Germany, compared with the meandering puce of the U.S. reform effort, was the speed with which it was enacted. Brought before the German parliament in the full of 1992, the reform was enacted almost immediately and took effect 1 January 1993. Henke is a professor of economics at the University of Hanover. As chairman of the Council of Medical and Economic Advisers to the National Conference on Health, Henke is an influential figure in German policy circles. Murray, who holds a master’s degree in public affairs from Princeton, researched the German system while on a fellowship from the Alexander von Humboldt Foundation. During 1993-1994 she worked as a senior associate at the Alpha Center in Washington and is now with the Office of Management and Budget. Ade is a research associate in economics at the University of Hanover. Last year she was a visiting scholar at the Lyndon B. Johnson School of Public Affairs, University of Texas.
Abstract: In 1993 Germany implemented significant health reform legislation that, among other things, strengthened the global budgeting of physicians and instituted global budgeting of pharmaceutical expenditures. German physician expenditures are now capped at the growth in income of members of the sickness funds, in contrast to prior years, in which some growth above a targeted level was allowed. For the first time, dental services also are subject to the budget cap. The new reform legislation also limits growth in pharmaceutical expenditures by increasing the level of copayments and by placing physicians as a group at financial risk for growth over the limit. This paper examines the effect of these reforms during the first year and offers lessons for reform of the U.S. system.

The German health care system has often been viewed by American policymakers as a model system that controls costs while providing comprehensive benefits to virtually all citizens. Yet German policymakers are as concerned as their American counterparts about increasing health care expenditures. The percentage of gross domestic product (GDP) that Germany has devoted to health care grew from 6.0 percent in 1970 to 9.1 percent in 1991. The United States, of course, has seen an even more dramatic change, from 7.4 percent of GDP in 1970 to 13.3 percent in 1991.

To control the increasing resources being devoted to health care, in 1993 the German government implemented far-reaching reforms that are designed to attack the cost control problem in all health care sectors. Physician and pharmaceutical expenditures, which are analyzed in this paper, are to be contained by controls both on the system and on individual physicians. The systemwide reforms, which include global budgeting of physician and pharmaceutical expenditures, strengthen Germany’s use of a revenue-oriented expenditure policy and top-down budgeting. The recent reforms will control aggregate health care costs, not only by controlling price through the aforementioned global budgeting reforms, but also by controlling volume, through limits on physician supply, increased economic monitoring of physicians’ productivity, and copayments on pharmaceuticals based on quantity. As the U.S. federal and state governments still struggle with health care reform, the German reforms can serve as a timely model for cost control measures that target both price and volume.

Controlling Physician Spending

Before the 1993 reforms, control of physician spending in Germany focused primarily on price. Since both Bradford Kirkman-Liff, in one study, and Gerhard Brenner and Dale Rublee, in another, have described the development of German ambulatory care physician payment up to the first wave of reforms, which took place in 1987, we only briefly overview the system prior to 1987.

In 1977 the Health Care Cost Containment Act was passed into law, which codified the German goals of cost control while maintaining the
principle of social solidarity and establishing stability in the payroll deduction rate. The law limited the freedom of the sickness funds (German insurance organizations) to negotiate unrestricted physician service budgets independently with the various physicians’ associations. It created the Uniform Evaluation Standard (Einheitlicher Bewertungsmaßstab), which defined the schedule of charges for medical services and their relative point value to one another, among other reforms. This is similar to the resource-based relative value scale (RBRVS) used by Medicare. The Uniform Evaluation Standard is, in turn, used as a basis for negotiations by the sickness funds with the physicians’ associations on the overall expenditure levels and the conversion factor. The point values are translated in a deutsche Mark-valued schedule of charges by the conversion factor, so that physicians can be paid fee-for-service. This schedule of charges is the equivalent of the Medicare physician fee schedule. In an attempt to control costs, targets for the overall level of expenditures were set based on past utilization levels and growth in inflation and wages.

During the 1980s the physician payment system was further amended, to directly control the overall expenditure level. Exhibit 1 shows the growth in physician expenditures in comparison with growth in income per member of the sickness funds. Expenditure caps were first used in 1987 to limit the growth in physician expenditures to the growth in income per sickness fund member. This measure was chosen because health insurance premiums are set based on a percentage of income, up to a certain limit, split equally between employer and employee. The conversion factor was retrospectively calculated each quarter after the actual volume of services in that quarter.

Exhibit 1
Annual Growth In Physician Expenditures And Income Per Sickness Fund Member, Western Germany, 1985-1993

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was known. As a result, physicians did not know the actual fee they would be paid when the service was provided. To control expenditures even more tightly, the budget was divided into four categories, and expenditures were calculated separately for basic services, laboratory services, preventive services, and special services in ambulatory care.

At the same time, the Uniform Evaluation Standard was reformed to increase the point value of consultations, physical examinations, and preventive care relative to technical services, in an attempt to increase the level of personal medicine provided by family practitioners in relation to the level of technical medicine practiced by specialists. Brenner and Rublee found that between the last quarter of 1986 and the last quarter of 1987, while the number of points billed per sickness fund physician in their sample grew 9 percent, the overall income level of physicians grew only 0.5 percent due to the expenditure capping mechanism. The change in the relative point value had a small effect on the relative income of family practitioners versus specialists. The incomes of physicians at the top end of the income scale were brought down closer to the average, while the incomes of physicians at the bottom end were brought up closer to the average. The overall ranking of physician incomes, however, did not change dramatically.

In 1992 the expenditure cap mechanism was replaced with an expenditure targeting mechanism. Under the new expenditure targets, no longer was the growth in physician payments to be capped each quarter by the growth in the income of sickness fund members that quarter. Instead, it was to be targeted toward a yearly growth rate, and it allowed for certain expenditures above the targeted expenditure level due to volume increases that were deemed appropriate. As in prior years, a conversion factor was determined for three separate service categories. If the quarterly growth in payments per member in either of the first two quarters was greater than the growth in income per member plus 1 percent, then the value of the conversion factor would be adjusted downward in the third and fourth quarters of the year for the category that had excess expenditures. Likewise, if the growth in payments per member was less than the growth in income per member minus 1 percent, then the value would be adjusted upward in the third and fourth quarters. If the growth in payments was above the negotiated limit in the third or fourth quarter, the parties would have to negotiate new conversion factors. Thus, physicians would now know in advance how much they were to receive for each service.

Although the expenditure cap mechanism limited growth in physician payments during 1992, growth was still above the growth in income per sickness fund member. During the first three quarters of the year, physician expenditures in the western states had increased a total of 8.6 percent,
while national income subject to the payroll deduction grew 4.8 percent.
To bring cumulative year-end physician expenditures in line with growth in income, the conversion factors were adjusted downward during the fourth quarter; this resulted in growth of physician expenditures during the fourth quarter of only 3.8 percent. By the end of the year, physician expenditures were reduced to 7.2 percent—still more than two percentage points above the growth in income of 5.1 percent per member.

The 1993 Health Care Reform Act

In response to the continued high growth rate in physician expenditures and other sectors, the government passed a major health care reform law (Gesundheitsstrukturgesetz, or GSG) at the end of 1992. The legislation, which took effect almost immediately in 1993, was designed to limit overall expenditures by controlling the volume as well as the price of physician services and pharmaceuticals. In addition to these changes, the 1993 law removed the limits on choice of sickness fund for certain population groups and implemented a financial risk equalization scheme. The law also reformed the hospital payment system, shifting from per diem to prospective payment based on specific rates for individual procedures and conditions. While perhaps a bit exuberant, Uwe Reinhardt has characterized the 1993 law as “easily as revolutionary within the German context as will be the forthcoming health care reform in the United States.”

Expenditure controls on physician services. The law mandates that growth in physician expenditures for 1993-1995 be capped at the growth in income of members of the sickness funds, in contrast to 1992, during which a certain amount of growth above the targeted level was allowed. The conversion factors would be calculated as they were in 1992. During the first two quarters of each year, the conversion factor would be negotiated prospectively, so that physicians could know how much they would be paid for each service. If the actual total expenditures were above the limit, the conversion factor in the third and fourth quarters would be reduced. This change is expected to contribute DM 750 million to the total net savings of DM 10 billion from the 1993 reform. While prior reforms had mainly achieved their savings on the consumer side by implementing higher co-payments and deductibles, this reform achieves most of its savings from providers. Of the DM 10 billion in savings, providers were expected to contribute DM 7.5 billion and consumers, DM 2.5 billion.

The basis for the growth during 1993 was overall physician expenditures in 1991, chosen instead of 1992 so that physicians would not be able to increase their volume of services at the end of 1992 to increase the base. Thus, the physician expenditure limit for 1993 was 1991 physician expen-

To promote the use of outpatient surgery and preventive care and to allow for the special needs of the new eastern states, these budgets were allowed a higher growth rate than were general physician expenditures. Outpatient surgery was allowed to grow as much as growth in income for 1992 and 1993 plus 10 percent, again based on 1991 expenditures. Growth in 1994 and 1995 will be based on the prior year plus growth in income plus 10 percent. Preventive services, on the other hand, will be allowed to grow as much as growth in income plus 6 percent per year. Special rules were also put in place for the new states of eastern Germany. Instead of using 1991 as the base, the new states doubled physician expenditures for the first half of 1992. The allowable expenditures for 1993 were then the new base plus growth in income for 1992 plus 4 percent and growth in income for 1993 plus 3 percent. In comparison with the year before, in which growth in physician expenditures was more than two percentage points higher than growth in income per member, during 1993 growth in physician expenditures in western Germany was limited to 3 percent, while growth in income per member was 3.9 percent.

Until the 1993 reforms, German dentists, who have a higher average salary than German physicians do, had escaped global budgeting of their services. Under the new law, however, the increase in dental expenditures also will be limited to growth in income for the years 1993-1995. In addition, fees for dentures and orthodontic services will see a 10 percent decrease from their 1992 level, fees for dental technical services will be reduced 5 percent, and dentists will be required to give a two-year warranty on every filling. The total savings from changes in dental payments were estimated to be DM 2.1 billion. While growth in dentist expenditures in western Germany had been 9.6 percent in 1992, expenditure growth was held to 2.2 percent during 1993.

To protect against possible boycotts by physicians and dentists, the new law limits the rights of providers in the case of a boycott. Physicians and dentists traditionally have been granted a legal monopoly on the provision of ambulatory medical care, in return for an agreement to provide adequate treatment and medical services to the population. Under the new law, should physicians and dentists strike, the requirement for the provision of services is transferred to the sickness funds, which could then build their own facilities or contract with other physicians and dentists. Any physician or dentist who is involved in a strike also will have to wait up to six years to practice again within the statutory sickness fund system.

Expenditure controls on pharmaceutical provision by physicians. The new reform limits growth in pharmaceutical expenditures, over which
physicians exert great influence, by placing physicians at financial risk. A limit of DM 24 billion was placed on overall pharmaceutical outlays for 1993, an amount equal to pharmaceutical expenditures in 1991. Any amount over the DM 24 billion limit, up to DM 280 million, was to reduce next year’s total physician budget. For any amount in excess of DM 280 million, the pharmaceutical industry would have to reimburse the sickness funds. Individual physicians also will have their pharmaceutical prescription level monitored. If they prescribe more than 15 percent of the average for their specialty, they will be subject to economic monitoring. If they prescribe more than 25 percent of the average, then their income will be automatically reduced. Physicians can challenge this ruling only if they can prove that their patient structure justifies their provision level.

Pharmaceutical expenditures also are controlled by directly setting prices and increasing consumer copayments. In 1993 and 1994 the price of prescription drugs that are not included in the Reference Price System (RPS) was reduced by 5 percent, while the price of over-the-counter drugs, which are outside of the RPS system, was reduced by 2 percent. In 1993 copayments were mandated based on the price of drugs. This system was replaced in 1994 by a copayment based on quantity, to reduce incentives to consume. Small quantities have copayments of DM 3, medium quantities have copayments of DM 5, and large quantities have copayments of DM 7.

During the first six months of 1993 the budget cap on pharmaceuticals led many physicians to reduce their level of prescriptions. In June 1993 the number of prescribed daily doses had fallen 10.5 percent in comparison with June 1992. This reduction in prescriptions led to an outcry among patients, exemplified by a headline in a Berlin newspaper: “Doctor Refuses Berlin Woman Cancer Medicine!” Overall expenditures on pharmaceuticals fell 28.8 percent in January 1993, compared with the level in January 1992, and 23.4 percent in February 1993 (Exhibit 2). By June 1993 pharmaceutical expenditures were still 16.2 percent below the 1992 level. These decreases followed an increase of 24.9 percent in December 1992, immediately before the law went into effect. Physicians may have overprescribed at the end of 1992 to avoid the cost controls in 1993, thereby further decreasing the level of 1993 prescriptions beyond what the cost controls were designed to encourage. As a result of this reduction in pharmaceutical revenues, pharmaceutical companies warned that they would be forced to cut back on research and development of new drugs.

By the end of 1993 pharmaceutical expenditures had reached DM 23.883 billion, just below the cap of DM 24 billion. Although the pharmaceutical cost control measure was estimated to save DM 2 billion, it may actually have increased both direct and indirect costs as physicians shifted patients to specialists or to hospitals, whose spending on pharmaceuticals was not
affected by the cap. In fact, physician referrals to other ambulatory care physicians during the first seven months of the year were 9 percent higher than in the previous year, and referrals to hospitals were 10 percent higher. These substitutions led to an additional DM 1.3 billion in direct expenditures and DM 1.5 billion in indirect expenditures.\textsuperscript{21}

**Incentives to control volume.** The current physician expenditure cap is in place only through 1995 and has no direct effect on volume. Instead, the new law attempts to control long-term expenditures by indirectly affecting the volume of services through controlling the number of practicing physicians and promoting family practitioners over specialists. The number of physicians per capita has grown enormously in Germany over the past thirty years. In 1970 Germany had 1.69 physicians per thousand residents.\textsuperscript{22} By 1980 the ratio had grown to 2.21 per thousand, and by 1990 the unified Germany had 3.11 per thousand, compared with 2.32 in the United States that year.\textsuperscript{23} These large numbers of physicians are due in part to the constitutional right of all qualified students to a state-subsidized medical education.\textsuperscript{24} As a result, Germany cannot legally reduce the number of medical students. The state can, however, reduce the number of practicing ambulatory care physicians.

First, the new law limits the licensing of new ambulatory care physicians in a region if the region is determined to have reached more than 110 percent of physician capacity. For example, in a densely populated metropolitan area, the physician-to-population ratio for internists is not to ex-
ceed one internist per 3,919 persons, while the limit in a rural district is 7,790. When the reform legislation was passed, the ministry estimated that 60 percent of all health registration districts remained open. However, so many hospital-based physicians applied for licenses prior to the restrictions that by the time the law was implemented, only 40 percent of the districts were still open. Second, beginning in 1999 physicians over age sixty-eight will have their licenses revoked, although all physicians licensed prior to 1993 will be able to remain licensed for twenty years. Third, the practice of family medicine will be financially upgraded by shifting any savings from reductions in laboratory services to family practitioners. As already mentioned, preventive services, which are primarily provided by family practitioners, will be allowed to grow by 6 percent more than the general physician budget.

The expenditure cap and the controls on the number of physicians are designed to control overall expenditures by affecting the fees paid to all doctors and, indirectly, the volume of services. Because physicians will continue to be paid fee-for-service, as the prices of services are reduced, physicians have economic incentives to increase their volume of services. To offset these incentives, physicians are subject to random audits, or economic monitoring, of their practice patterns by a committee equally representing the sickness funds and the physicians’ associations. The committee compares a physician’s overall level of services, including prescribing patterns, with the average level for the physician’s specialty group, a practice known as economic monitoring. If the physician’s level of services is 15 percent above the norm for his or her specialty, the physician will be subject to an individual audit. If provision of services is 25 percent above the norm, the physician will be required to return the funds to the physicians’ association. Physicians are allowed to challenge the committee’s ruling prior to the decrease in income, although a challenge may result in further reduction of the physician’s income. This risk can affect a physician’s decision to challenge the ruling. While economic monitoring has been taking place for decades, the threshold at which a physician’s service provision is sanctioned was codified in the recent law. Although this cost control measure is potentially quite strong, only about 7 percent of physicians are called on annually to explain their practice patterns, and only 2 percent actually have payment reductions. However, it is impossible to calculate the effect this has on physicians’ provision of services.

Unlike many of their American counterparts, German physicians are not subject to concurrent reviews of ongoing treatment plans. As a result, German physicians have maintained their right to clinical freedom, while giving up their right to set their own prices. US. physicians have made the opposite choice.
German-Style Global Budgeting In An American Context

As the United States struggles to reform its health care system, Germany's experience since 1977 with global budgeting in general and with physician expenditures in particular can offer many lessons. While the final health care reform legislation is highly unlikely to include mandatory global budgeting for all physician and pharmaceutical expenditures, global budgeting as a cost control method may be revisited in the future if the enacted cost control measures are not adequate. The German lessons could prove useful for Medicare, which now has a global budget for physician expenditures, and for state Medicaid programs, which use the Medicare RBRVS system. In addition, the state of Maryland has begun to design an RBRVS to be used by all payers in the state to pay for physician services. Each payer will set its own conversion rate; if, however, voluntary efforts to control costs do not succeed, the state has the authority to set rates for all payers.

The most important lesson that Americans designing such systems can learn from the recent German reforms is that to control expenditures in a fee-for-service environment, controls on price alone are not sufficient. Germany has initiated reforms that will attempt to control prices via expenditure caps, but also will control pharmaceutical provision and the volume of physician services through limits on the number of practicing physicians, economic monitoring of individual physician services, and higher copayments for pharmaceuticals.

U.S. policymakers have long known from experiences in Medicare and Medicaid, as well as from observing the Canadian system, that physicians will increase volume to offset reductions in payment rates. During the recent Medicare physician payment reform, the need for controls on volume as well as on price was acknowledged by the creation of the volume performance standard (VPS). However, because the VPS is not designed to offset volume or intensity increases in the current year that are higher than targeted, its direct effect on physician behavior is weak and ambiguous. Physicians still have incentives to induce demand to increase their income through the fee-for-service payment system, although collectively their overall income growth rate could be reduced in the future if the overall volume and intensity level is greater than expected. Thus, through the collective nature of the VPS, it is hoped that the physicians' associations will become more involved in cost containment through the "development and dissemination of practice guidelines, provision of both technical and political support to carriers and peer review organizations in their utilization review activities, and perhaps even altering their position on unrelated federal policy changes that would contain costs."

Unlike the German reforms, which attempt to control price and volume
on a national level, the Medicare physician payment reforms affect only those physicians who serve the elderly or disabled populations. Were the United States to implement global budgeting of physician services and pharmaceuticals on a national level, four policy issues would need to be addressed: the flexibility of the system, additional direct or indirect controls on volume, the equity of the payment system, and the effect of such a system on managed care organizations.

flexibility. First, the system would have to be flexible enough to respond to changing economic conditions. If the expenditures devoted to physician care and pharmaceuticals were linked to growth in GDP as the U.S. Physician Payment Review Commission (PPRC) has suggested, then in times of economic growth and prosperity more new funds would be available than in times of recession and unemployment, when health care needs are likely to increase. The government could, however, set a floor for the growth rate in health expenditures in different sectors to avoid overt rationing of health care in order to remain below the cap level. Setting the limit above or below GDP growth would require the following policy considerations. If the limit on the growth of physician and pharmaceutical expenditures were above GDP growth, new and improved treatments and technologies would be available to more people, but the percentage of national income devoted to health care would increase. Setting the limit below GDP growth would reduce the percentage of national income that is devoted to health care and would reduce federal and state outlays for health care. Unless substantial savings could be garnered from ongoing efficiency gains and cost containment efforts, however, low-income people who depend on government support for health care could lose access to care.

Until 1993 the sickness funds and the physicians’ associations usually were able to reach a consensus on the overall physician expenditure budget. Only once during the past twenty-five years did the German government interfere directly in the negotiations when reaching consensus proved to be difficult. The United States, however, has a completely different political culture, which historically has not valued consensus but rather foments confrontations between warring interest groups. If such a system were to be implemented in the United States, providers, payers, and consumers would have to be flexible enough to reach consensus on an expenditure cap level, perhaps through the use of binding arbitration. Antitrust laws also would have to be made more flexible to allow nonintegrated providers to negotiate prices with third-party payers. The German experience also shows that reform is not a static process, but rather a dynamic process that needs the flexibility to be fine-tuned every three years or so.

Limits on volume. A second important policy issue is what complementary reforms need to be achieved to directly or indirectly limit the volume
of service, an issue that Germany has begun to address only recently.\textsuperscript{30} Changes in physician supply and technological capacity are needed, in response to upward trends in medical services per capita as a result of demographic and technological changes. U.S. managed care organizations control volume by employing and training physicians to be low authorizers of health services or contracting only with physicians who are expected to be low authorizers of health services. Although in many cases managed care organizations have salaried physicians or pay physicians on a capitated basis, preferred provider organizations (PPOs) and individual practice associations (IPAs) often pay physicians fee-for-service, generally somewhat below prevailing fee levels. Global budgeting, in conjunction with such volume controls, could further control costs. Additional infrastructural improvements to control volume include outcomes research, better practice guidelines, and economic profiling of physicians.\textsuperscript{31} Graduate medical education also needs to be reformed to address the maldistribution of general practitioners and specialists. It will take years for these types of infrastructural changes to have any measurable effect on costs. In the short run, rate setting with volume controls is a more efficient way to control costs. Making physicians personally responsible for the spending they authorize, such as on pharmaceuticals, also would have an immediate effect on costs.

**Equity.** A third policy consideration is the effect that different conversion factors for different payers and the level of balance billing would have on access and equity. While Germany has no balance billing, different sickness funds pay different rates to physicians. Through higher physician reimbursement, substitute funds (whose members are white-collar and certain blue-collar workers) have created the impression—not backed by observable data, however—that their members receive better medical care than members of the other funds receive.\textsuperscript{32} Allowing substantially different conversion factors for different payers in the United States may have the unwanted effect that an increasing number of physicians would refuse patients whose care was paid for by insurers with low conversion factors, such as Medicare and Medicaid. Conversely, it would be very expensive for the government to equalize Medicaid and Medicare payments to the level of private payers. The PPRC estimated that Medicare pays 59 percent of what private insurers pay, while Medicaid programs pay only 73 percent of Medicare rates.\textsuperscript{33} Balance billing could reduce physicians’ incentives to deny access to certain groups of insured persons. The government could limit the use of balance billing as it does now in the Medicare program, in which it is prohibited for poor Medicare recipients and limited to 15 percent of Medicare’s allowed fee for nonpoor recipients. Policy decisions would have to be made to achieve the appropriate trade-off between access
and equitable payment.

On the other hand, flexible and separate conversion factors should be set for different geographical areas and for different types of procedures, as both the German system and Medicare now do. Geographic or specialty conversion factors would appropriately compensate physicians for regional or specialty variation in nonphysician inputs, such as rent and wages. Thus, these targeted conversion factors would affect the behavior of individual physicians better than a broad national cap would. Conversion factors for different types of services would allow for quick adjustment in prices that were targeted only on those physicians who perform certain services.

Effect on managed-care. The last major policy consideration is the effect that the creation of an all-payer rate-setting mechanism for physician services would have on current managed care health plans that pay their physicians on a per capita basis, such as health maintenance organizations (HMOs), and on the implementation of proposed managed competition plans. HMOs, while subject to the overall expenditure caps, could be allowed to remain outside of the RBRVS payment mechanism as long as they either were federally qualified or had Medicare risk contracts. In addition, HMOs could remain outside of the rate-setting system if they used a capitation system to pay physicians, which theoretically would increase physicians’ incentives to limit care. Managed care organizations, such as IPAs and PPOs, which continue to pay physicians fee-for-service while tightly controlling utilization, could use a global fee schedule to reward physicians who reduce their lengths-of-stay, for instance, with a higher conversion factor. Interestingly, in Germany immediately following the creation of the current mandatory system in 1883, sickness funds used closed panels of physicians who were willing to accept lower fees. In 1913 a threatened strike by physicians led to the end of closed panels. Today sickness funds must contract with any doctor who belongs to a physicians’ association, giving the association a monopoly in the provision of treatment. As a result, sickness funds are prevented from acting like managed care organizations by controlling their own payments for services to individual physicians.34

Global budgeting of physician services would not rule out the implementation of managed competition, either. Rate setting could be used in the short or medium term to control costs before managed competition is fully implemented, if that is the course US. reforms take.35 After full implementation, rate setting could be used for those health plans that continue to pay physicians fee-for-service or to pay for services provided outside the panel of approved physicians.

Concluding comments. While Germany has been viewed for many years by American health care policymakers as a country that can control
costs and maintain universal access, German policymakers are increasingly worried about their ability to provide all desired services to the entire population. As the German population ages and as medical progress and medical technology become even more widespread, the Germans, like their American counterparts, are searching for new ways to control costs. Germany’s history with global budgeting of physician payments since 1977 and recently implemented controls on pharmaceutical expenditures can offer the United States many important lessons, not the least of which is that controlling prices alone is not enough to control total physician and pharmaceutical expenditures. The United States, which has a longer history with volume control via managed care organizations and practice guidelines, may be able to avoid the limitations that Germany has seen with physician global budgeting. Global budgeting of physician expenditures and pharmaceuticals combined with both direct and indirect controls on volume may be one way, in conjunction with other policies such as managed competition, to stop the health care cost spiral in the United States.

NOTES


15. Reinhardt, “Global Budgeting in German Health Care.”
16. The RPS groups similar drugs together and determines the average price for the group, adjusted for quantity. Sickness funds will pay the pharmacies only the reference price for RPS drugs, leaving consumers to pay any amount above the RPS price.
19. Medizinisch Pharmazeutische Studiensgesellschaft (MPS) e. V. (Bonn, 1993).