The hospital financing system in Germany

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Abstract

In common with other western countries, German health expenditure had been increasing at a rapid rate in recent years, especially in the hospital sector. This paper describes the reaction of the German legislator and summarises what has happened over the last few years following the introduction of the extensive Legal Reform Act. The paper puts the main emphasis on a new differentiated benefit system for hospitals, which is a requirement from 1996 onwards, after a transitional period. It shows the single components and the modalities of the new system and the possibilities of combining the new types of payment.

Introduction

In 1993, health insurance funds (gesetzliche Krankenkassen) in the former West Germany spent nearly DM60 587 million funding recurrent expenditure in the inpatient care sector. This compares to DM6251 million spent in 1970, an increase of 870 per cent in nominal terms. In real terms (using the German health price deflator for services of physicians, hospitals and other services in the health care sector, published by the Statistisches Bundesamt 1996, pp 108, 111) the increase was 208 per cent. The rest of the expenditure of the health insurance funds increased at a slower rate of 111 per cent in real terms.

The proportion of health expenditure of gross national product (in constant prices) increased from 6.5 per cent in 1970 to 9.5 per cent in 1993. See Table 1 for further data (also in constant prices).

The figures in this paper refer to the former West Germany.
Current exchange rate, A$1 = DM1.30 (approximately)

Table 1: Increase in West German health expenditure, 1970–1993

	1970 (DM)	1993 (DM)	increase (%)
Total expenditure in the health care sector per inhabitant in constant prices (1970 = 100)	1 149	2 273	97.8
Expenditure for inpatient treatment per patient in constant prices (1970 = 100)	1 519	2 302	51.5
Expenditure for inpatient treatment per nursing day in constant prices (1970 = 100)	64	151	135.9
Expenditure for inpatient treatment per hospital bed in constant prices (1970 = 100)	20 755	47 012	126.5

Source: Statistisches Bundesamt 1996; author's calculations

Between 1936 and 1972 Germany operated under a monistic financing system. The legal health insurance funds were the single source of funding. Under the dualistic financing system which currently operates, recurrent costs are paid by the health insurance funds and capital costs are paid by the Federal Government, the federal states and the municipal authorities. This is referred to in Table 2 as 'public budget'. Capital expenditure is one small part of the public budget. Capital expenditure only increased 2.45 times between 1973 and 1993, to bring capital expenditure in nominal terms from DM3589 million to DM8808 million in 1993. This means an increase of 9.3 per cent in real terms (Statistisches Bundesamt 1996, pp 61, 70, 108, 111; author's calculations). The reason for comparing capital expenditure figures of 1973, rather than those of 1970, is that the change in the financing system means figures, which are directly influenced by the system-change, for the years before 1973 are not comparable with later years. But generally all the other figures are comparable.

As Table 2 shows, there is no change in the proportion of total expenditure funded by the public budget. It is nearly constant at 14 per cent, despite the change in the financing system. The great losers are the legal health insurance funds.

Reasons for continuing increases in health expenditure

Possible reasons for continuing increases in health expenditure are:

- lack of control mechanisms in the health market, which leads to over capacity, inefficiency and an increase in unnecessary medical treatments
- increasing proportions of elderly persons

Table 2: Health expenditure by source of funding

Source of funding:	1970 West Germany		1973 West Germany		1993 West Germany		Nominal increase	Real increase
	DM (million)	%	DM (million)	%	DM (million)	%	1970–1993 (%)	1970– 1993 (%)
Public budget	9 871	14.2	15 221	14.1	52 700	14.0	434	77
Legal health insurance funds	24 712	35.5	42 559	39.3	172 398	45.8	598	111
Pension insurance funds	6 561	9.4	9 107	8.4	25 137	6.7	283	27
Legal accident insurance	2 520	3.6	3 373	3.1	13 960	3.7	454	83
Private health insurance funds	3 616	5.2	4 739	4.4	22 102	5.9	511	102
Employers	16 495	23.7	25 537	23.6	60 719	16.1	268	22
Private budget	5 899	8.5	7 716	7.1	29 516	7.8	400	66
Total	**69 674**	**100**	**108 252**	**100**	**376 532**	**100**	**440**	**79**

Source: Statistisches Bundesamt 1996, pp 24, 27; author's calculations

- more emphasis on preventive medical check-ups
- improvements in medical treatments
- progress in pharmaceuticals
- innovations in highly expensive medical equipment
- the reduction of infectious diseases but with a simultaneous rise of chronic and degenerative diseases, which are more costly to treat.

The large increase in hospital expenditures resulted in a deficit for the health insurance funds of DM5590 million in 1991 and a deficit of nearly DM9100 million in 1992 (Bundesministerium für Gesundheit, German Federal Ministry of Health (228) 1997, GKV-Statistik).

The Legal Reform Act in Germany, the GSG (Gesundheitsstrukturgesetz) introduced in 1993, should help to control the increase in health expenditure and the increase in rates of subscription to the health insurance funds.

The objective of this reform Act was to control expenditure during the period 1993 to 1994–95 through immediate capping of the budget for the inpatient sector, increasing user charges for most patients, as well as some structural changes. One of the most important structural changes was the introduction of reinsurance arrangements between the health insurance funds (risk structure compensation).

With a change in the BPflV '95 (Bundespflegesatzverordnung 1995), which was already initiated by the GSG '93 (Gesundheitsstrukturgesetz 1993) and came into force in 1995, the legislator aims to carry the reform process further. After a transitional period for the implementation of the new benefit system (from 1993 to 1994–1995), the new system is a requirement from 1996 onwards. Additionally, a law exists for stabilisation of hospital expenditure for 1996 (Gesetz zur Stabilisierung der Krankenhausausgaben 1996) and a second one came into force on 1 January 1997 (Beitragsentlastungsgesetz), which effects a 1 per cent reduction in the budget of each hospital for every year from 1997 to 1999. Additionally, the law brought about a higher financial burden for insured people (for example, because of higher direct payments for medicine), on the one hand, and a decrease in contribution rates, by simultaneous decrease in medical aid, on the other.

Two further required steps of the Legal Reform Act came into force on 1 July 1997: the 1.NOG (Neuordnungsgesetz) and the 2.NOG. One of the important aims of this law should lead to more competition among the legal health insurance funds and to more efficiency in that area.

Since the BPflV came into force, the situation for the health care sector could be characterised as somewhat unstable and accompanied by continual adjustments of the legislation.

Instead of the previously used reimbursement system under which hospitals could claim reimbursement for all recurrent expenditure, a differentiated benefit system with medically fair benefits was introduced by the 1995 BPflV. One of the main aims was more control of the growth of hospital expenditure through increasing incentives for efficiency. The components of this new differentiated benefit system are outlined below.

Fallpauschalen (FP): These are single payments per patient, which should cover the whole cost from the day of admission to the day of discharge, including outsourced services (see also Figure 1 and the calculation in Table 3). The costs can be split into four groups of expenditure:

– ward services, standard care and intensive care unit
– surgical services
– investigation and treatment, for example, costs for laboratory and X-ray diagnosis, nuclear medicine and radiotherapy, electrocardiography, diagnosis of lung function, sonography and endoscopy. Some of these services may be obtained through outsourcing, for example, pathology or transportation of patients.
– support services; for further details, please see the Basispflegesätze (BP) below (legal basis is § 11 BPflV).

- **Sonderentgelte (SE):** This is part of the FP, and covers the costs of an operation, that is, it remunerates for 'surgical services'. For details, please see the calculation in Table 3. It also includes outsourced services. However, there is a difference in comparison to the corresponding part of the FP. The SE calculation does not include two kinds of costs: cost of upkeep for medicine technique and goods of medical needs. These costs will be remunerated by the AP and BP (legal basis is § 11 BPflV).
- **Abteilungspflegesätze (AP):** This includes the benefits for medical and nursing work in the department which provides or arranges the service, and which are not already covered by the FP or the SE (legal basis is § 13 BPflV).
- **Basispflegesätze (BP):** This component is for non-medical and non-nursing work where the costs are not covered by any other components of the benefit system. The BP compensates for the costs of accommodation, catering, cleaning, administration and so on (legal basis is § 13 BPflV).

- **Vorstationäre Behandlung (VB):** Remuneration for medical services which happened before a hospital stay, for example, services which evaluate whether a hospital admission is necessary, or prepare the patient for the hospital stay. The VB is limited to a maximum of three treatment days during the five days before the hospital stay (legal basis is § 115a SGB V).
- **Nachstationäre Behandlung (NB):** This is remuneration for treatments after a hospital stay which are necessary to ensure the success of the hospital procedures. The NB is limited to a maximum of seven treatment days during the 14 days after the hospital stay (legal basis is § 115a SGB V).
- **Ambulantes Operieren (AO):** Remuneration for outpatient operations (legal basis is § 115b SGB V). It does not include outpatient services such as outpatient clinics for diabetics. But if a diabetic patient undergoes an outpatient operation, the clinic will get higher remuneration than for non-diabetic patients because the service for the diabetic is more costly.

Originally Germany had 40 FP and 105 SE. They are listed in the appendix of the BPflV. After the 1. Änderungsverordnung from 14 June 1995 and the 2. Änderungsverordnung from 8 August 1995, the FP and SE lists were enlarged to include obstetrics, heart and thorax surgery. This increased the number to 73 for the FP and 147 for the SE. It is planned to enlarge the FP and SE catalogue in the future.

Figure 1 shows how the new benefit system works.

Below is an example of costs for one FP and the corresponding SE, calculated as the means of 15 German hospitals for 387 patients. The example was calculated as a basis for fixing the point system in Germany, required by the Bundesministerium für Gesundheit (German Federal Ministry of Health). Tables 4 and 5 show the derived results from these calculations for the new law (BPflV).

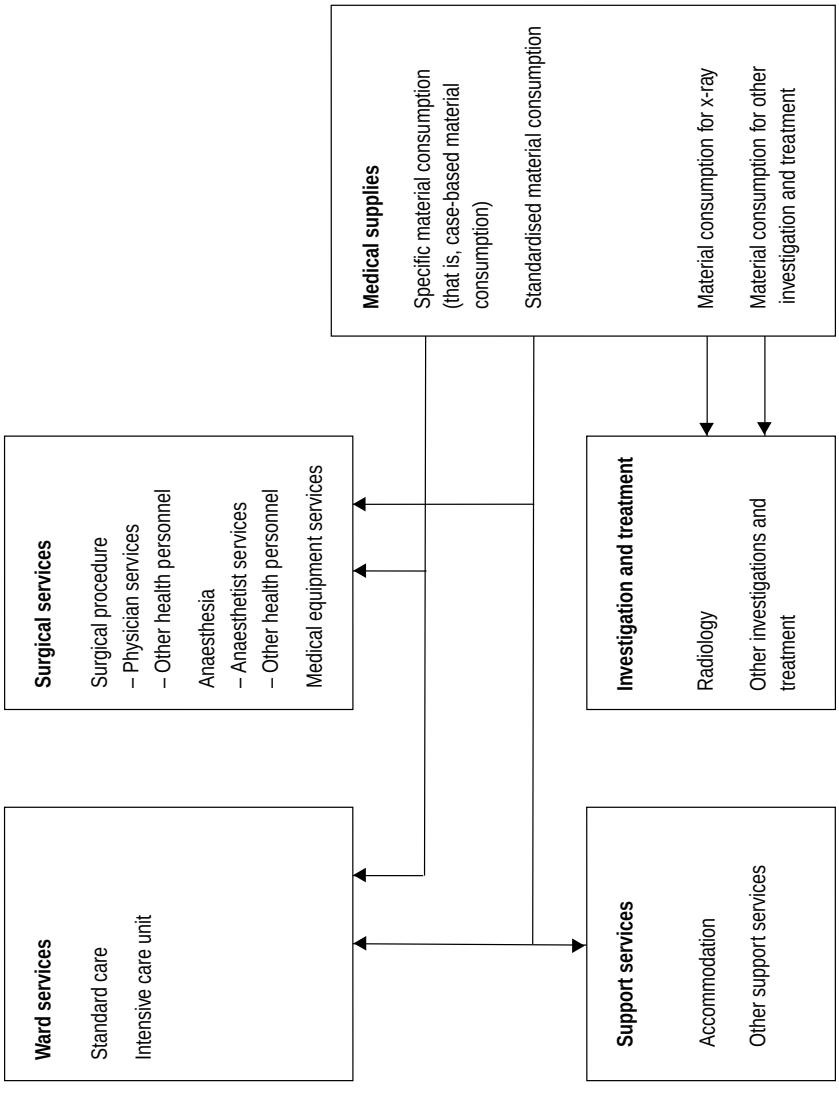

Figure 1: Model for calculation of a Fallpauschale
Source: Bundesministerium für Gesundheit, 1995, Band 45, p III 19

Table 3: Example for calculating an FP and the corresponding SE

	Means of all hospitals for FP 17.02	Means of all hospitals for SE 17.06
Characteristics:		
average age	80.56	
proportion of patients who are older than 65 years	93.65 %	
nursing days	24.60	
Ward services, standard care:	**DM**	**DM**
1. physician services	629.24	
2. nursing services	2 891.96	
3. material costs	604.40	
Total costs of standard care	*4 125.60*	
Ward services, intensive care unit:		
4. intensive physician services	109.56	
5. intensive nursing services	230.23	
6. material costs	102.85	
Total costs of intensive care unit	*442.64*	
Surgical services:		
7. physician services, surgical procedure	501.49	501.49
8. other health personnel, surgical procedure	494.70	494.70
9. physician services, anaesthesia	312.46	312.46
10. other health personnel, anaesthesia	175.86	175.86
11. medical equipment services*		
Total personnel costs, surgical services	1 484.52	1 484.51
material costs of surgical services**	2 409.20	2 353.28
Total costs of the SE (nos 7 to 11) respectively, total costs of surgical services (= part of FP)	*3 893.71*	*3 837.79*
Investigation and treatment:		
11. personnel costs	502.31	
12. material costs	174.99	
Total costs of investigation and treatment	*677.30*	
Support services:		
13. personnel costs	1 624.76	
14. material costs	1 553.72	
Total costs of support services	*3 178.48*	
Total costs, summary:		
15. personnel costs	7 472.56	
16. material costs	4 845.17	
Total costs of this kind of case/patient	*12 317.73*	

* This kind of cost will be calculated only for some particular FP or SE. One example is heart surgery. Normally a cardio-technical engineer is required for this kind of operation. For the FP 17.02 (which is calculated in the above example) a cardio-technical engineer is not required, so that there is no cost for the position 'no. 11: medical equipment services'.

** Two kinds of costs are not included in the SE calculation: cost of upkeep for medicine technique and goods of medical needs.

Source: Bundesministerium für Gesundheit 1995, Band 45, pp III 105, II 150.

Table 4: FP 17.02

FP-number	17.02
Definition	*
ICD-9	820.0,.9
ICPM	5-820.3 and .4
Points for FP	
Personnel	7 230
Material	4 330
Total	*11 560*
Maximum allowed length of stay**	34
Part of points for support services	
Personnel	1 270
Material	1 290
Total	*2 560*
Length of stay***	20.91

* Definition: fracture of the neck of femur, closed

** The maximum allowed length of stay in a hospital is derived from the length of stay (see the last row). The maximum allowed length of stay is calculated by the length of stay (last row) plus two standard deviations (calculated from the length of stay of the above-mentioned 387 patients), or plus seven days if two standard deviations are smaller than seven days. If a patient stays longer in hospital than the maximum allowed/permitted length of stay (in this case, for example, 36 days), the hospital can cash up the 34th day to the 36th day by an AP and a BP per day. The FP 17.02 covers all the costs including the 33rd day. For more details see the section on modalities of reimbursement below.

*** The last row shows the average length of stay of the above-mentioned 387 patients, which is reduced by 15 per cent because of the estimated or expected effect from the new system of reimbursement.

Table 5: SE 17.06

SE number	17.06
Definition	*
ICD-9	820.0, .8
ICPM	5-820.0 to .2
Points for SE	
Personnel	1 530
Material	2 470
Total	*4 000*

* Corresponds to FP 17.02.

German hospitals have been forced to use the new benefit system since 1 January 1996. There is an FP and an SE catalogue. Tables 4 and 5 show an excerpt of the catalogues, especially of the FP and SE explained above.

Because there is no maximum allowed length of stay in the intensive care unit for this FP and SE, it is not mentioned in these excerpts.

Scales of reimbursement

- An AP could range between DM180 and DM280 per day in 1996. It can differ from hospital to hospital and among each department of the hospitals.
- The BP was between DM100 and DM140 per day in 1996. It differs from hospital to hospital.
- The fictive lump sum (substitute for AP plus BP) was about DM260 per day in 1996.
- The value of one personnel point, for example in Bavaria, was DM1.0869 in 1996.
- The value of one material point, for example in Bavaria, was DM1.0837 in 1996.

In all the above-mentioned cases, deviations are possible in both directions, up or down.

Every FP/SE is remunerated by a special amount of points per case, in which the amount of points per case are fixed but the value of the point is variable. (Originally the value of one point was DM1 in 1993). The value of one point is negotiated between a group of representatives of the hospitals and of the health insurance providers in each federal state for the duration of one year. The values of the points for FPs and SEs as well as the remuneration for VB and NB apply for all hospitals in that federal state. So a Bavarian hospital cashes up 1.0869 x 7230 + 1.0837 x 4330 = DM12 550.71 per FP 17.02, in case the operation was in 1996. With this remuneration, all costs have to be covered from the day of admission until the day the patient is discharged.

There is a possibility for a hospital and the insurance funds to negotiate a special value of the points, that is, either a surcharge or a reduction of the FP/SE if there are special circumstances which warrant such changes.

In contrast to the FP, SE, VB, NB and the remuneration for outpatient treatment, the AP and BP have to be arranged between each hospital and the health insurance funds individually. The budget is bound for the calculations. From 1972 to 1995 the budget of every hospital was adjusted to the growth rates

in personnel and material costs every year. Additionally, until 1995 Germany had a system of flexible budgets, for example, if a hospital had more or less receipts because of more or less patients, there was a compensation to a certain degree (for details, see the old BPflV, which was valid before 1995).

For the time being, Germany has a system of fixed budgets. For example, in 1996, on the whole, there was no need to adjust the budget. The only adjustment was a single payment of DM300 per employee (see also Stabilisierungsgesetz 1996). This amount was not sufficient to cover inflation in personnel costs. One of the effects of a system of fixed budgets is as follows.

For example, if a hospital in 1996 had more receipts (that is, DM18 million instead of the agreed DM15 million) because of more patients than planned and agreed in advance, it was forced to pay back exactly that amount it received for the extra number of patients at the end of the year (in this case DM3 million). That means the hospital treated these extra people for whom they did not correctly plan without any payment. Therefore, the closer it gets to the end of a year in Germany, hospitals which are close to their agreed limit will possibly send new patients on to other hospitals or try to do the operation in the next year, if no emergency treatment is required. In 1997 hospitals will have to pay back just 75 per cent of receipts which were not planned.

In the opposite case, if a hospital has treated less patients than planned, they are allowed to keep 50 per cent of the agreed budget for covering the fixed costs (see also § 12 IV and § 11 VIII BPflV '95 in connection with § 3 Stabilisierungsgesetz '96).

Modalities of reimbursement

Every main service for a patient in a hospital which is mentioned in the FP catalogue has to be reimbursed by an FP. Every service which is mentioned in the SE catalogue has to be cashed up as an SE. If there is a service mentioned in the FP catalogue as well as in the SE catalogue, it is not possible to choose between FP or SE. In this case, a hospital is forced to cash up an FP.

With one exception (this is FP 7.01, that is, 'Tonsillektomie', which could be ICD-9: 474.0; 474.1, .8, .9 and ICPM: 5-281.0, .4, .x, .y, 5-282), all FPs have to be cashed up for patients who have already finished their 14th year of life. This age limit is not valid for SE. If a patient is too young for an FP, the hospital will cash up an SE.

Normally an FP contains all necessary additional treatments of all typical attendant symptoms (for example, various diseases of elderly patients such as

diabetes or hypertension). In this case the consequences are that hospitals will not get more money for additional treatments. If the additional treatment is very difficult or very costly, hospitals will get the FP plus an additional reimbursement.

The above-mentioned rules are the general rules. There are more specific rules for heart surgery and obstetrics, which will not be discussed here.

Possibilities for combining the new types of payment

(Source: Bundesministerium für Gesundheit 1995, Band 44)

FP + SE

It is not usual to cash up an FP plus an SE, although there are two exceptions: if it is necessary to do an additional operation in another operation field or to treat an already treated disease again, the hospital will get an SE for these additional services. This second operation could either happen during the first operation or some days later. It is important that the patient does not leave the hospital in between the two different operations. One problem is to define 'another field of operation'.

Example

Assume that we have a patient who will receive a knee prosthesis (FP 17.09, ICPM could be: 5-822.1 to .7, .9) and simultaneously a hallux valgus operation (FP 17.12, ICPM could be: 5-788.3, .4). It is not possible to reimburse for two FPs because double payment would occur. But the hospital is reimbursed for the knee prosthesis with FP 17.09 and for the hallux valgus operation with SE 17.19. Because both operations happened in the same department, namely, the orthopaedic department, there is no possibility to cash up an AP for the orthopaedic department additional to the SE. But as we see later, the combination SE + AP + BP is very common.

FP + AP + BP

For every FP there is a maximum allowed length of stay in days. This is fixed in the FP catalogue. If a patient needs to stay longer than the permitted days, the hospital can cash up the AP and BP for every additional day. The day of discharge will not be reimbursed.

Example

FP 12.05:	Appendicitis, non perforata (ICPM could be: 5-470.0, .2; 5-479.1) maximum allowed length of stay: 15 days
1st day:	admission
2nd day:	operation
17th day:	discharge
	positions to cash up:
	one FP 12.05: it covers the costs up to and including the 14th day
	two (AP + BP): it covers the costs of the 15th and 16th day

FP + a fictive lump sum per day

It could happen that (first) a department of a hospital or (second) the whole hospital gets the reimbursement just by FPs. Therefore there exists neither an arrangement for an AP (in the first case) nor an AP and BP (in the second case). If a patient stays longer in the department than the maximum allowed length of stay, the hospital will cash up these additional days by a fictive lump sum per day as a substitute for BP and AP, independent of the first or second case.

FP + VB/NB

Normally, the FP contains the treatments which are carried out before a hospital stay starts (=VB) or carried out after a hospital stay (= NB). One exception is if the patient stays longer in the hospital than the maximum allowed length of stay and a VB is necessary, a hospital can cash up the AP plus BP per day and, additionally, the NB.

Example

FP 2.01:	Struma, one-sided (ICPM could be: 5-062.2) maximum allowed length of stay: 16 days
1st day:	admission
3rd day:	operation
17th day:	discharge
20th day:	NB (= treatment after a hospital stay)

positions to cash up:
one FP 2.01: it covers the costs up to and including the 15th day
one (AP + BP): it covers the costs of the 16th day
one: NB

Calculation of 'length of stay or length of treatment' in the case of FP + VB/NB:

length of stay at the hospital
\+ days of treatment before the hospital stay and after the hospital stay

An additional reimbursement is possible if the calculated length of stay/treatment exceeds the limit, that is, the maximum allowed length of stay.

Example

FP 2.01:	Struma, one-sided (ICPM could be: 5-062.2) maximum allowed length of stay: 16 days
1st day:	VB (= treatment before a hospital stay)
3rd day:	admission
4th day:	operation
16th day:	discharge
19th day:	first NB (= treatment after a hospital stay)
24th day:	second NB
	positions to cash up: one FP 2.01: it covers the cost for 15 days one: NB

Calculation of the length of stay/treatment of the example:

	length of stay at the hospital:	13 days (from the 3rd to the 15th day)
+	days of VB:	1 day (1st day VB)
+	days of NB:	2 days (19th and 24th day NB)
=	length of stay/treatment	16 days

SE + AP + BP

If we do not have the exception of cashing up an FP plus an SE (see the first case above), we have the normal situation of being reimbursed for the SE once, plus an AP and BP per day. It is important to realise that the department which has done the operation will get the BP plus 80 per cent of the AP per day. The reasoning for that is that an SE obtains the costs for surgical services and the corresponding material. The remaining costs for medical, nursing and therapeutic services will be covered by the AP. Because these costs are already partly covered by an SE, the operating department, which is reimbursed by an SE, will get only 80 per cent of the AP. In the case of an internal patient moving from the operating department to a non-operating department, the non-operating department will get the full AP plus the BP.

Example

SE 12.11:	Cholezystektomie (ICPM could be: 5-511.02, 5-511.22)
1st day:	admission to the department of internal medicine
4th day:	patient-moving to the department of surgery
5th day:	operation in accordance with SE 12.11
11th day:	discharge

positions to cash up:
one SE 12.11
three : full AP (for the department of internal medicine) + BP
seven : 80 per cent AP (for the department of surgery) + BP

SE + AP + BP + VB/NB

In addition to an SE and the AP plus BP, there is a possibility to cash up every VB or NB which is carried out.

AP + BP + VB/NB

This combination is a possibility as well: For example, a hospital will cash up an AP and a BP for each day a patient stays in the hospital (if the patient has no operation) and a VB (or NB) for each treatment before (or after) the hospital stay.

Conclusion

Some of the expected consequences of the above-mentioned measures will cause greater incentives for efficiency, an increase in competition among hospitals and a reduction in the average length of stay. Germany's average length of stay for inpatient care institutions was 12.2 days in 1993. Until March 1995, the public health insurance funds often paid for nursing. Since 1 April 1995, Germany has introduced an extra nursing insurance. So the average length of stay might decrease. In addition, these reforms should lead to better information about the costs and types of procedures carried out by hospitals, enabling more valid comparison of different hospitals as well as more scientific management. One of the most important aims is a lasting reduction of health expenditure, which has not been realised yet. The Gesundheitsstrukturgesetz, which came into force in 1993, has brought an effective limitation of health expenditure in the short run. The deficit in 1995, for example, was mainly caused by an increasing number of patients (+ 2.6 per cent) and increasing costs per patient (+3.1 per cent) compared to 1994.

Table 6: Balances of legal health insurance funds

Balances (= contribution payments minus expenditure)	East Germany	West Germany
1991 (in million DM)	2770	–5590
1992 (in million DM)	–200	–9100
1993 (in million DM)	1350	9060
1994 (in million DM)	120	2090
1995 (in million DM)	–1840	–5110
1996 (in million DM)	–2140	–4640

Note: From 1995 onwards, Berlin-East will be assigned to West Germany.
From the second quarter in 1995, expenditure for constant nursing care will be paid by nursing insurance.
From 1994, the figures include payments from or to the risk structure compensation; from 1995, the figures also include payments from or to the risk structure compensation of pensioners.

Source: Bundesministerium für Gesundheit (228) 1997, GKV-Statistik

It is obvious that it will require additional expenditure, hard work and effort on the part of the hospitals to meet all the changes requested by law. Better cost systems and an improved support from electronic data processing are required to manage the new demands of the legislation. One of the problems in the future will be an additional, external quality management, which already has been

legally fixed, and should have been introduced on 1 January 1997 to all hospitals. Because of the complexity in organisation and content of the external quality management, there was a delay. At the moment, pilot projects are on the verge of getting realised. The external quality management brings a new wave of bureaucracy into the hospitals because of the necessity to document the required data. A part of the documentation could be used for calculating FPs, SEs and so on, so hospitals can use some synergy-effects. In this context, one difficult task for the legislator is to set and implement quality standards. This is a difficult task, but necessary when remuneration is per patient, as a remuneration per patient system could lead to a reduction in quality.

Abbreviations

AP	Abteilungspflegesatz
AO	Ambulantes Operieren, outpatient operations
BMG	Bundesministerium für Gesundheit, German Federal Ministry of Health
BP	Basispflegesatz
BPflV	Bundespflegesatzverordnung
DM	Deutsche Mark, German Mark/s
EBM	Einheitlicher Bewertungsmaßstab für die ärztlichen Leistungen, standardised valuation scale
FP	Fallpauschale
GSG	Gesundheitsstrukturgesetz
KHG	Krankenhausfinanzierungsgesetz
KHNG	Gesetz zur Neuordnung der Krankenhausfinanzierung
NB	Nachstationäre Behandlung
NOG	Neuordnungsgesetz
SE	Sonderentgelt
SGB V	5. Sozialgesetzbuch - Gesetzliche Krankenversicherung
VB	Vorstationäre Behandlung

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References

Bundesministerium für Gesundheit 1995, *Leitfaden zur Einführung von Fallpauschalen und Sonderentgelten gemäß Bundespflegesatzverordnung,* Düsseldorf, Köln, Kiel, München, Band 44.

Bundesministerium für Gesundheit 1995, *Kalkulation von Fallpauschalen und Sonderentgelten für die Bundespflegesatzverordnung,* Düsseldorf, Köln, Kiel, München, Band 45.

ohne Verfasser 1996, 'Regierungskoalition einigt sich auf Eckpunkte zur Fortführung der 3.Stufe der Gesundheitsreform', in: *das Krankenhaus,* October.

Sachverständigenrat der Konzertierten Aktion 1994, *Gesundheitsversorgung und Krankenversicherung 2000 – Eigenverantwortung, Subsidiarität und Solidarität bei sich ändernden Rahmenbedingungen,* Sachstandbericht. Bonn.

Statistisches Bundesamt 1996, Gesundheitswesen, Fachserie 12, Reihe S.2, Ausgaben für Gesundheit, 1970 bis 1993, Wiesbaden.

For further information please see the following.

http://www.bmgesundheit.de/ (homepage of the German Federal Ministry of Health)

http://www.statistik-bund.de/zeitreih/def/defin**g**.htm
(there are a lot of definitions, sorted alphabetically; to come to a new letter, change the bold letter "**g**" in the address)

http://www.statistik-bund.de/e_home.htm
(homepage of the Statistisches Bundesamt)

http://www.oecd.org/els/health/hc97data.htm
(to get OECD-data-series)